



Youth Empowerment Services (YES) Waiver Policies and Procedures Manual Version 7

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**YES Waiver Policy and Procedure Manual
Version 7**

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Introduction

A. Purpose of the Manual

The purpose of the Manual is to provide policy and procedure information for the Youth Empowerment Services (YES) Waiver to participating Local Mental Health Authorities (LMHAs) and Waiver Providers. The roles and responsibilities of each agency are described by topic. Additional files are provided separately as Appendices and Forms. All Forms that are given to an individual or Waiver participant and his/her LAR are available in English and Spanish.

Information in this Manual is subject to change. The Texas Department of State Health Services (DSHS) maintains a change log document and will post the current version of the Manual and change log online at the YES Waiver webpage, and will notify LMHA and Waiver Providers of postings through the DSHS YES Waiver mailbox. The LMHA and Waiver Provider shall comply with all YES Waiver policy and procedure directives (including changes to the Manual) issued by DSHS. DSHS will provide advance notice of Manual revisions whenever possible, and retroactive compliance with changes will not be expected to the extent allowed by all applicable laws, rules, or regulations.

If any conflict exists between the information in this Manual and the Waiver Provider Agreement or LMHA Memorandum of Understanding (MOU), the terms of the Waiver Provider Agreement or LMHA MOU shall prevail unless otherwise identified.

B. Program Overview

i) Background and History

The Health and Human Services Commission (HHSC) and DSHS received approval by the federal government in February 2009 to implement a 1915(c) Medicaid Home and Community-Based Services (HCBS) Waiver, called Youth Empowerment Services (YES). The YES Waiver allows for more flexibility in the funding of intensive community-based services and supports for children and adolescents, ages 3-18, with serious emotional disturbances (SED) and their families.

Texas strives to provide a continuum of appropriate services and supports for families with children and adolescents who have severe mental illness. There are some instances in which parents have turned to state custody for care when they believe they have reached or exceeded their financial, emotional or health care support resources and are unable to cover the costs of their child or adolescent's mental health treatment. The 78th and 79th Texas Legislatures directed HHSC to "develop and implement a plan to prevent custody relinquishment of youth with serious emotional disturbances," and authorized the request of any necessary waivers from the federal government. HHSC and DSHS worked collaboratively to develop the YES Waiver, and sought input throughout the process from a broad array of stakeholders.

ii) Goals of the YES Waiver

The goals of the YES Waiver include:

- Reducing out-of-home placements and inpatient psychiatric treatment by all child-serving agencies,
- Providing a more complete continuum of community-based services and supports for children and adolescents with SED and their families,
- Ensuring families have access to parent partners and other flexible non-traditional support services as identified in a family-centered planning process,
- Preventing entry and recidivism into the foster care system and relinquishment of parental custody, and
- Improving the clinical and functional outcomes of children and adolescents with serious emotional disturbance.

The objective of the YES Waiver is to provide community-based services in lieu of institutionalization to a maximum of children and adolescents (Waiver participants) at any given time.

iii) Service Array

The YES Waiver service array includes:

- Respite (In-Home and Out-Of-Home)*
- Adaptive Aids and Supports
- Community Living Supports
- Family Supports
- Minor Home Modifications
- Non-Medical Transportation
- Paraprofessional Services
- Specialized Therapies (Animal Assisted Therapy, Art Therapy, Music Therapy, Recreational Therapy, Nutritional Counseling)*
- Supportive Family-based Alternative
- Transitional Services

Pre-Engagement Service (non-Medicaid applicants); provided by LMHAs only

*The types or locations of Respite and types of Specialized Therapies available may vary depending upon which Waiver Provider is selected.

Waiver participants are also covered under the Medicaid State Plan. State Plan Services include but are not limited to:

- Targeted Case Management
- Psychiatric Evaluation
- Psychological Services
- Counseling
- Crisis Services
- Rehabilitation Services

iv) Service Areas & Capacity

The YES Waiver was piloted in Bexar and Travis Counties in April, 2010; expansion to Tarrant County began July, 2012. Collectively the three counties serve a maximum 400 Waiver participants at any given time. The waiver is scheduled for implementation into Harris County by March of 2014. Additionally, the 83rd Legislature, Regular Session, 2013, authorized the YES waiver to expand state-wide, and implementation plans are in the development stage.

C. DSHS Contact Information

Contact information for the state level offices at DSHS is as follows.

YES Waiver E-mail Address: YESWaiver@dshs.state.tx.us

YES Waiver Encounter Data & Invoicing E-mail Address: YESData@dshs.state.tx.us

Fax number: 512-206-5383

Webpage: <http://www.dshs.state.tx.us/mhsa/yes>

YES Waiver Staff:

Amy Felker
Office: 512-206-5862

Mailing Address:

Department of State Health Services
Attn: Amy Felker
P.O. Box 149347, Mail Code 2012
Austin, Texas 78714-9347

Physical Address for Hand Delivery and Overnight Mail:

Amy Felker
Department of State Health Services, Mail Code 2012
909 W. 45th Street, Building 634
Austin, TX 78751

D. Definitions

The following words and terms, when used in this document, shall have the following meanings, unless the context clearly indicates otherwise.

Administrator – The individual in charge of a Local Mental Health Authority, or Waiver Provider, or designee.

Adolescent – An individual who is at least 13 years of age, but younger than 19 years of age.

Assessment – A set of standardized assessment measures used by DSHS to determine level of need as set forth in the approved YES Waiver.

Capacity – The total number of Waiver participant slots or number of Waiver participants that a Waiver Provider is capable of providing YES Waiver Services to.

CA-TRAG or Child and Adolescent Texas Recommended Assessment Guidelines –The CA-TRAG is a set of standardized measures used in Texas to determine level of service for community-based children's mental health care.

Child – An individual who is at least three years of age, but younger than 13 years of age.

Clinical Management for Behavioral Health Services (CMBHS) - is an electronic health record created and maintained by the Department of State Health Services for the use of contracted Mental Health and Substance Abuse Services. CMBHS is utilized by Local Mental Health Authorities to enter information from the uniform assessment that includes, but is not limited to the CA-TRAG and YES waiver authorization (LOC-A=Y).

CMHC or Community Mental Health Center – An entity established in accordance with the Texas Health and Safety Code, §534.001, as a community mental health center or a community mental health and mental retardation center.

Credentialing – A process to review and approve a staff member's educational status, experience, licensure and certification status (as applicable) to ensure that the staff member meets the departmental requirements for service provision. The process includes primary source verification of credentials, establishing and applying specific criteria and prerequisites to determine the staff member's initial and ongoing competency and assessing and validating the staff member's qualification to deliver care. Re-credentialing is the periodic process of reevaluating the staff's competency and qualifications.

Critical Incident – Incident that result in substantial disruption of program operation involving or potentially affecting Waiver participants.

Crisis Plan – A plan that is developed by the Treatment Team that focuses on planning for, predicting, and preventing a crisis situation from occurring. A Crisis Plan establishes clear roles for the Treatment Team when a Waiver participant is in a crisis situation. Crisis Plans must include steps to take for a Waiver participant to access crisis services, if needed.

Direct Service Staff – An employee or a subcontractor of a Waiver Provider who provides Waiver Service(s) directly to a Waiver participant.

Eligible – An individual is designated as “Eligible” once approved for clinical and financial eligibility.

Encounter Data – Details related to the treatment or services rendered by the LMHA and Waiver Provider to the Waiver participant.

Enrolled – An individual is designated as “Enrolled” once an initial enrollment Individual Plan of Care (IPC) has been approved by DSHS.

Enrolled and Receiving Services – An individual is designated as “Enrolled and Receiving Services” once they receive their first YES Waiver service. Case Management services only do not count towards this status.

Fair Hearing – An informal proceeding requested by a consumer held before an impartial Health and Human Services Commission hearings officer in which a client appeals an agency action.

Individual – A child or adolescent who requests YES Waiver services.

Interested – An individual is designated as “Interested” until they are determined fully eligible for the YES Waiver, including Clinical and Financial eligibility.

IPC or Individual Plan of Care – A written plan which documents the necessary YES Waiver services, Non-Waiver services, and State Plan Services for a Waiver participant. The IPC is developed jointly with the Waiver participant, Legally Authorized Representative, Targeted Case Manager, and Waiver Provider and approved by DSHS. The IPC calculates annual cost for proposed services, details the quantity of services per year, and helps determine if requested services are within the approved cost limits.

Invoice – The file that a Waiver Provider will submit to DSHS as evidence of YES Waiver services provided. This file is generated by encounter data.

Inquiry List – The Inquiry List, maintained by the Local Mental Health Authority in each service area, is a log of individuals that have expressed interest in receiving YES Waiver services. The Inquiry List also establishes the priority of assessing for eligibility on a first-come, first-serve basis.

LAR or Legally Authorized Representative – A person authorized by law to act on behalf of a child or adolescent with regard to a matter described in this subchapter, including, but not limited to, a parent, guardian, or managing conservator.

Level of Care (LOC) -Designation given to the Department of State Health Services standardized packages of mental health services, based on the uniform assessment and the utilization management guidelines, which specify the type, amount, and duration of mental health community services to be provided to an individual.

LMHA or Local Mental Health Authority – An entity designated as the local mental authority by DSHS in accordance with the Health and Safety Code, §533.035(a). The LMHA, through a Memorandum of Understanding (MOU), operates under an Authority Role to provide administrative activities.

LPHA or Licensed Practitioner of the Healing Arts – A person who is:
a physician;
a licensed professional counselor;
a licensed clinical social worker;
a licensed psychologist;
an advanced practice nurse; or
a licensed marriage and family therapist.

MAC or Medicaid Administrative Claiming – MAC is a reimbursement methodology to draw down federal matching funds (also known as Federal Financial Participation (FFP) for Medicaid outreach and administrative activities (e.g. paperwork, phone calls, etc.)) prior to enrollment into health related medical services. For the purposes of MAC, health related services include: medical health, mental health, limited dental health, and limited substance abuse treatment. The medical services available are restricted to State Plan Services.

No Reject Policy – If a Waiver Provider is selected by a Waiver participant the Waiver Provider must ensure provision of the necessary services identified on the Waiver participant's IPC without delay.

Non-Waiver Services – Services provided by any funding source other than the YES Waiver. Examples include but are not limited to State Plan Services, Temporary Assistance for Needy Families (TANF), and Personal Care Services (PCS).

QMHP-CS or Qualified Mental Health Professional – Community Services – A staff member who is credentialed as a QMHP-CS who has demonstrated and documented competency in the work to be performed and:

- a. Has a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major (as determined by the LMHA or Managed Care Organization (MCO) in accordance with §412.316(d) of this title (relating to Competency and Credentialing)) in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention;

- b. Is a registered nurse; or
- c. Completes an alternative credentialing process identified by the DSHS.

Rehabilitative Services (Mental Health) – Services that are:

- individualized age-appropriate training and instructional guidance that address an individual's functional deficits due to severe and persistent mental illness or serious emotional disturbance; and
- designed to improve or maintain the individual's ability to remain in the community as a fully integrated and functioning member of that community.

Safety Plan – A plan that is developed by the Treatment Team that focuses on the prevention of a Waiver participant's risky behaviors and the interventions needed if such behaviors actually occur.

SED or Serious Emotional Disturbance – A diagnosable mental, behavioral, or emotional disorder that results in functional impairment.

Service Area – A geographical area where the YES Waiver is available. This includes, Bexar, Travis and Tarrant Counties.

State Plan Services – Services that are offered under the Medicaid State Plan service array, which may be provided by the LMHA or any other credentialed Medicaid State Plan service provider.

Subcontractor – A single person, organization, or agency that enters an agreement with a Waiver Provider to provide one or more Waiver services. A subcontractor must meet minimum qualifications defined by DSHS in the YES Waiver Service Codes, Descriptions, and Provider Qualifications Appendix of this Manual.

Support Family – A Department of Family and Protective Services (DFPS) licensed Foster Family that is trained by a Child Placing Agency to provide the Supportive Family-based Alternatives service through the YES Waiver.

TCM or Targeted Case Management – A Medicaid State Plan Service to assist a child or adolescent in gaining and coordinating access to necessary care and services appropriate to the child or adolescent's needs. Intensive Case Management Services, in conjunction with Treatment Planning Process, is a focused intervention of coordinating community-based services that assist a child or adolescent in gaining access to necessary care and services appropriate to the child or adolescent's needs. TCM also includes monitoring service effectiveness and proactive Safety Planning and Crisis Planning and management. TCM is synonymous to Care Coordination and Service Coordination. TCM is provided solely by the LMHA Targeted Case Manager.

Targeted Case Manager – The staff person employed by the LMHA that provides Targeted Case Management to Waiver participants. Targeted Case Managers will have the following qualifications: a bachelor's degree from an accredited college or university with a minimum

number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention, OR as of August 31, 2004, has received a high school diploma or equivalency certificate, three continuous years of documented full time experience in the provision of mental health case management services, and demonstrated competency in the provision and documentation of case management services. The Targeted Case Manager facilitates the Treatment Planning Process.

Treatment Plan– A plan that is developed jointly with the Waiver participant, Legally Authorized Representative, Targeted Case Manager, and Waiver Provider utilizing the National Wraparound Initiative (NWI) wraparound process, and reviewed by DSHS. The treatment plan includes goals and objectives, Safety Plans, Crisis Plans, and the Individual Plan of Care for the Waiver participant and family.

Treatment Planning Process – A wraparound (NWI) process that includes the identification of goals and objectives, Safety Planning, Crisis Planning, and the identification of types, quantities, and frequency of services, and the development of the Treatment Plan and ongoing monitoring of the IPC.

Treatment Team – A team composed, at a minimum of the Targeted Case Manager (TCM), Waiver Provider, LAR, and Waiver participant and other individuals that are requested by the LAR, Waiver participant, TCM, Waiver Provider, and who agree to participate.

Treatment Team Meeting – A regularly scheduled meeting in which the Targeted Case Manager, Waiver Provider, LAR, Waiver participant, and others meet to monitor progress, which is done by measuring the plan’s components against indicators of success selected by the team. Plan components, interventions and strategies are revised as needed.

Uniform Assessment – A standardized tool adapted by DSHS and utilized at the LMHA to gather information regarding a client, which includes demographic information, the state approved children’s mental health assessment tool, community data and the Authorized Level of Care.

Waiver – A waiver is a Medicaid program that provides services to a limited number of eligible children or adolescents, in accordance with the provisions of the waiver approved under the federal Social Security Act, §1915(c).

Waiver participant – A child or adolescent that is currently enrolled in the YES waiver and receiving services.

Waiver Provider – An agency, organization, or individual that meets credentialing standards defined by DSHS and enters into a Provider Agreement. The LMHA may be a Waiver Provider. Waiver Provider must ensure provision of all YES Waiver services directly and /or indirectly by establishing and managing a network of Subcontractors. Waiver Provider has the ultimate responsibility to comply with the Provider Agreement and Manual regardless of service provision arrangement (directly or through Subcontractors).

Waiver services – Medicaid community-based services provided under the approved YES Waiver.

Wraparound – is an intensive, holistic method of engaging individuals with complex needs (most typically children, youth and their families) so that they can live in their homes and communities and realize their hopes and dreams. Wraparound is a process that aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that results in plans that are effective and relevant to the child and family. Through the team-based planning and implementation process, wraparound also aims to develop problem-solving skills, coping skills, and self-efficacy of the young people and family members. There is an emphasis on integrating the youth into the community and building the family’s social support network.

YES Waiver slot – A “slot” refers to the number of individuals that may be enrolled in the YES Waiver. The YES Waiver may fill slots at any given time across all service areas. An available YES Waiver slot means there is availability in the program for another individual to be enrolled.

Participating Agencies/Individuals

Each agency/individual that actively participates in the YES Waiver is identified below with a corresponding list of general responsibilities.

A. Centers for Medicare and Medicaid Services

The YES Waiver is administered on the federal level by the Centers for Medicare and Medicaid Services (CMS). CMS approves Medicaid HCBS waivers under §1915(c) of the Social Security Act.

B. Texas Health and Human Services Commission

HHSC is the single state agency for Medicaid in Texas and has administrative authority in the State for Medicaid policies and operations. HHSC retains authority over the YES Waiver and provides monitoring and oversight of the performance of YES Waiver activities by other state and local/regional non-state agencies (if appropriate) and contracted entities.

HHSC, through a Directive from the Executive Commissioner of HHSC with DSHS, delineates the roles and responsibilities of each agency. The Directive outlines HHSC's monitoring and oversight functions.

HHSC is responsible for:

- 1) Approval of Medicaid provider agreements,
- 2) Establishment of a statewide rate methodology,
- 3) Rules, policies, procedures and information development governing the YES Waiver,
- 4) YES Waiver application submission to CMS,
- 5) Effective use of all federal funds,

- 6) Funds disbursement to DSHS for payment to Waiver Providers,
- 7) Quality assurance and quality improvement activities.
- 8) Monitoring DSHS' clinical, administrative and technical assistance to the Local Mental Health Authorities.

C. Texas Medicaid & Healthcare Partnership

Texas Medicaid and Healthcare Partnership (TMHP) is the Medicaid claims administrator in Texas. Traditionally, TMHP pays Medicaid providers for all claims for services provided to Medicaid participants not enrolled in managed care plans and also pays claims for mental health targeted case management and mental health rehabilitative services provided to Medicaid participants that are enrolled in managed care plans.

Waiver Providers will not submit claims for reimbursement of YES Waiver services to TMHP. Waiver Providers will submit service encounters and invoices to DSHS for YES Waiver services and DSHS will pay claims for YES Waiver services directly to Waiver Providers (see Invoicing and Payment section). Medicaid providers of State Plan Services shall submit claims for payment to TMHP, the appropriate Managed Care Organization (if applicable), or private insurance (if applicable). DSHS does not pay claims for State Plan Services or other Non-Waiver Services.

DSHS is working toward automating claims payment through TMHP and this is anticipated to be completed during 2014. In order for TMHP to pay YES Waiver claims directly to Waiver Providers, each Waiver Provider will need to be enrolled as a Medicaid provider and assigned a Medicaid provider type specific to the YES Waiver. This may require the Waiver Provider to complete additional credentialing steps at that time in order to fulfill TMHP's Medicaid Provider enrollment requirements in order to receive reimbursement for YES Waiver services. DSHS is currently working with TMHP to make this transition as smooth as possible for Waiver Providers that are not already registered Medicaid Providers.

D. Texas Department of State Health Services

HHSC has delegated to DSHS, an agency under the health and human services authority, responsibility for administration of YES Waiver services, ensuring compliance with requirements, ensuring confidentiality, and maintaining records. DSHS will report to HHSC no less than annually regarding administrative activities for which DSHS has responsibility.

DSHS is responsible for:

- 1) Waiver participant enrollment,
- 2) Waiver Provider outreach, recruitment and training,
- 3) Managing YES Waiver enrollment against approved limits,
- 4) Managing YES Waiver expenditures against approved limits,
- 5) Approval of level of care evaluations,
- 6) Approval of Waiver participants' Individual Plan of Care (IPC),
- 7) Prior authorization of YES Waiver services,
- 8) Utilization management,
- 9) Waiver Provider Credentialing and Enrollment

- 10) Managing Medicaid Provider Agreements with qualified Waiver Providers,
- 11) Rules, policies, procedures and information development governing the YES Waiver,
- 12) Quality review of Waiver Provider encounter data submissions,

- 13) Processing of Waiver Provider billing submissions, and reimbursement to Waiver Providers,
- 14) Quality assurance and quality improvement activities, and
- 15) Oversight/monitoring to ensure compliance with Waiver requirements.

E. Local Mental Health Authority

The Local Mental Health Authority (LMHA), through a MOU with DSHS, is responsible for the following local administrative activities:

- 1) Waiver participant enrollment,
- 2) Maintaining the Waiver Participant Inquiry List,
- 3) Assisting DSHS in managing Waiver enrollment and expenditures,
- 4) Evaluating individuals registered on the Inquiry List and recommending the level of care to DSHS,
- 5) Assisting individuals to obtain Medicaid eligibility (if applicable),
- 6) Development and maintenance of Waiver participant's IPC, and Treatment Plan
- 7) Utilization management,
- 8) Provision of Targeted Case Management,
- 9) Service coordination for YES Waiver and Non-Waiver Services,
- 10) Transition Planning, and
- 11) Quality assurance and quality improvement activities.

The LMHA may develop a memorandum of agreement or understanding with Waiver Providers to coordinate Waiver services.

F. Waiver Provider

Waiver Providers, through a Waiver Provider Agreement with DSHS, are responsible for:

- 1) Meeting all DSHS credentialing criteria,
- 2) Operating under a Waiver Provider Agreement with DSHS,
- 3) Providing or arranging for provision of all YES Waiver services,
- 4) Participating in required trainings,
- 5) Ensuring ongoing Waiver Provider direct service staff development,
- 6) Submission of correct billing/invoices through DSHS,
- 7) Submission of correct encounter data through DSHS,
- 8) Maintaining progress notes and Waiver participant records regarding YES Waiver service provision, and
- 9) Participating in quality management oversight activities.

Waiver Providers shall develop a memorandum of agreement or understanding with the LMHA to coordinate Waiver services.

The Waiver Provider shall provide all Waiver services directly and /or indirectly by establishing and managing a network of Subcontractors. The Waiver Provider has the ultimate responsibility to comply with the Provider Agreement and Manual regardless of service provision arrangement (directly or through Subcontractors).

G. Waiver Participant and Legally Authorized Representative

The Waiver participant and Legally Authorized Representative (LAR) may:

- 1) Choose to participate in the Waiver,
- 2) Choose any credentialed Waiver Provider in their service area,

Additional information regarding the Waiver participant and LAR's rights are identified in the Notification of Participant Rights Form.

The Waiver participant and LAR have the responsibility to:

- 1) Participate in the development of the Treatment Plan and IPC,
- 2) Participate in Waiver services as identified in the IPC,
- 3) Notify the Waiver Provider and LMHA if they receive notice from CMS, DSHS, or HHSC, or SSI that their Medicaid coverage will be, or is denied or expired, and
- 4) Notify the Waiver Provider and LMHA if their place of residence changes. This includes a residence change outside of the Waiver Service area (Bexar, Travis and Tarrant Counties) or a change in living arrangement (community setting to institutional setting).

Additional information regarding the Waiver participant and LAR's agreements and responsibilities are identified in the Consumer Choice Consent Form.

Policies and Procedures

A. Confidentiality

The exchange or sharing of confidential information, particularly protected health information or other sensitive personal information must be done via a Health Insurance Portability and Accountability Act (HIPAA) compliant secure process. All parties involved with the YES Waiver must maintain and protect the confidential information to the extent required by law.

B. Marketing and Outreach

See Forms section for the Participant Handbook and Provider Directory. In addition, the Brochures for Youth and Families may be downloaded by accessing the Youth Empowerment Services webpage online at: <http://www.dshs.state.tx.us/mhsa/yes>. See additional information below.

➤ Local Mental Health Authority

LMHA will participate in marketing and outreach for potential Waiver Providers by posting the Notice of Open Enrollment (NOE) link on respective agency websites; disseminating Waiver programmatic information (to be supplied by DSHS) through regular interaction with existing network providers, the community, and stakeholders; and responding to inquiries or requests for information. The LMHA or DSHS may refer inquiries or requests for information to each other when assistance is needed to fulfill such request.

LMHA will also participate in marketing and outreach for potential Waiver participants by posting an overview of the Waiver (to be supplied by DSHS) on the LMHA website; disseminating Waiver programmatic information (to be supplied by DSHS) through regular interaction with clients, referral sources, the community, and stakeholders; responding to inquiries or requests for information; and determining eligibility of potential Waiver participants. The LMHA or DSHS may refer inquiries or requests for information to each other when assistance is needed to fulfill such request.

Any tools or information developed by the LMHA for use in its activities as described in this section shall be approved by DSHS.

➤ **Waiver Provider**

Waiver Providers will participate in marketing and outreach for the purpose of maintaining a competent workforce.

➤ **Department of State Health Services**

DSHS will participate in ongoing marketing and outreach for potential Waiver Providers by posting the NOE link on the DSHS webpage, disseminating Waiver programmatic information through regular interaction with existing network providers, the community, and stakeholders and responding to inquiries or requests for information.

DSHS will participate in marketing and outreach for potential Waiver participants by disseminating Waiver programmatic information in the form of a brochure through regular interaction with the community and stakeholders; having a presence on websites that potential participants or parents of potential participants frequent; and responding to inquiries or requests for information.

DSHS provides the LMHA with optional screening tools to assist with identifying individuals that are likely to qualify for the Waiver. These tools may be downloaded by accessing the Forms section at the YES webpage online:

<http://www.dshs.state.tx.us/mhsa/yes>

C. Waiver Provider Credentialing

DSHS, Division for Mental Health and Substance Abuse Services, issued a Notice of Open Enrollment (NOE) requesting applications for the provision of all services covered under the Medicaid 1915(c) Waiver called Youth Empowerment Services (YES) Waiver, as described at http://esbd.cpa.state.tx.us/bid_show.cfm?bidid=82557.

To be enrolled as a provider in the YES Waiver (Waiver Provider), an application must be submitted in compliance with the requirements described in the NOE, and an applicant must meet the eligibility requirements and comply with the credentialing process described in this Notice and enter into a YES Waiver Provider Agreement (Provider Agreement) with DSHS. See Appendix C for an overview of the Waiver Provider Credentialing Process Flow.

1. Desk and On-Site Reviews

The DSHS Waiver Provider credentialing process will include a desk review, on-site review and a training component.

The **Desk Review** will include, but is not limited to, the review and verification of:

- Medicaid provider number (if applicable / not currently required*);
- National Provider Identifier (NPI) Number (required);
- Compliance with NOE instructions;
- Submission of all applicable documentation outlined on the NOE application checklist;
- Registration on Office of the Inspector General (OIG) List of Excluded Individuals / Entities available at <http://exclusions.oig.hhs.gov>; and
- Proof of General Liability Insurance.
- Disclosure of Ownership and Control Interest Statement

The **On-Site Review** will include, but is not limited to, the review and verification of:

- Information provided as a part of the NOE application;
- Ability to provide all YES Waiver services directly or indirectly through Subcontractors;
- Entity licensing, credentialing, and personnel files including review of any subcontractor agreements;
- Policies and Procedures Manuals or Operational Handbooks to include, but not limited to the following topics: Provision of service / coordination of care, quality and utilization management, personnel recordkeeping / management, critical incident reporting, personnel and client safety (behavioral management, seclusion and restraint), personnel credentialing and training, routine and emergency appointment availability / scheduling, and medication safety;
- Criminal History Background and Abuse Registry Checks for all individuals involved in the administration and provision of YES Waiver services;
- Organizational or facility environment;
- Client record keeping practices, by reviewing an existing client record; and
- Qualifications (education, experience, licensure, certification, and registration) of all individuals to provide services as described in Appendix A. This includes professional standards and regulations, including malpractice or liability insurance for professional staff.

* DSHS is working toward automating claims payment through TMHP and this is anticipated to be complete upon renewal of the YES Waiver, which would occur during 2014. In order for TMHP to pay YES Waiver claims directly to Waiver Providers, each

Waiver Provider will need to be enrolled as a Medicaid provider and assigned a Medicaid provider type specific to the YES Waiver. This may require the Waiver Provider to complete additional credentialing steps at that time in order to fulfill TMHP's Medicaid Provider enrollment requirements in order to receive reimbursement for YES Waiver services. DSHS is currently working with TMHP to make this transition as smooth as possible for Waiver Providers that are not already registered Medicaid Providers.

2. Training

The Training components include, but are not limited to, an orientation to the YES Waiver, Systems of Care, and the National Wraparound Initiative approach to service delivery. The Waiver Provider and all waiver providers must meet the following training requirements within the stated timeframes. The Waiver Provider is responsible for training all direct service staff on Waiver Provider's policies and procedures that include, but is not limited to: reporting of abuse, neglect, and exploitation; behavior management; recordkeeping, critical incident reporting.

YES Waiver Orientation

The Waiver Provider must receive this training from DSHS **prior** to the provision of YES Waiver services and/or participation on a Treatment Team. All contracted providers shall receive training from the Waiver Provider or DSHS **prior** to the provision of YES Waiver services and/or participation on a Treatment Team. The training will include, but is not limited to:

- YES Waiver background and basics
- YES Waiver service array and provider qualifications
- Individual Plan of Care Development
- Encounter Data Reporting
- Invoicing and Payment

Systems of Care (SOC) and Wraparound

The Waiver Provider and all contracted providers shall complete online training on the Introduction to Systems of Care and the Wraparound approach to service delivery **within the first six months of hire**. All contracted providers must have basic knowledge and understanding of the National Wraparound Initiative approach to service delivery core elements listed below **prior** to the provision of YES Waiver services and/or participation on a Treatment Team.

3. Criminal History and Background Checks

During the credentialing process, the applicant (individual or agency), must provide DSHS with a current (within past two years) criminal history check and abuse registry check. These checks are conducted by the applicant, in compliance with TAC Chapter 414 Subchapter K Criminal History and Registry Clearances, and are required for all staff that will be involved in the provision of Waiver services prior to performing any YES Waiver specific activities regardless of the activities the individual will be performing and provides the results to DSHS.

- a. The criminal history check utilizes a statewide database maintained by the Texas Department of Public Safety. If the individual lived outside the state of Texas at

any time during the previous two years, then the criminal history check will include submission of fingerprints to the Federal Bureau of Investigations. An individual who has been convicted of any of the criminal offenses delineated in 25 TAC, Part 1, Chapter 414, Subchapter K may not be employed or serve as a volunteer or intern.

- b. Texas maintains two statewide abuse and misconduct registries and the Waiver Provider applicant is required to conduct direct service staff screening against the relevant registry.
 - i. Nurse Aide Registry maintained by DADS
An individual who is listed as having a finding entered into the Nurse Aide Registry concerning abuse, neglect, or mistreatment of a consumer or misappropriation of property may not be employed or serve as a volunteer or intern.
 - ii. Employee Misconduct Registry maintained by DADS
An individual who is listed in the Employee Misconduct Registry as having abused, neglected, or exploited a consumer may not be employed or serve as a volunteer or intern (See Texas Health and Safety Code Sections 250.003 and 253.008).

Currently, there are three methods available to perform these required searches:

- i. Calling DADS' toll-free number at 1-800-452-3934;
- ii. searching DADS' Sanctions Database at <http://www.dads.state.tx.us/providers/NF/credentialing/sanctions/>; and
- iii. using DADS' Employability Status Search at <https://emr.dads.state.tx.us/DadsEMRWeb/>

Once credentialed and a Waiver Provider Agreement is executed, each Waiver Provider must maintain a documented process in accordance with 25 TAC, Part 1, Chapter 414, Subchapter K., related to self-reporting and subsequent criminal history and registry checks. Evidence of this process must be available to DSHS at yearly reviews and desk reviews. DSHS must be notified of any changes to the criminal history and abuse registry checks for any individual that has been involved in the provision of Waiver services.

A criminal history and registry check is conducted for all Waiver Provider direct service staff by the Waiver Provider prior to employment or assignment regardless of the activities the individual will be performing.

Waiver Providers are required to verify and maintain a documented process that attests all subcontractors providing any Waiver services have an up-to-date criminal history and registry check upon initial credentialing and subsequent addition of staff members.

➤ **Local Mental Health Authority**

The LMHA is not directly involved in the Waiver Provider Credentialing. The LMHA may participate in the training component of the credentialing process.

➤ **Waiver Provider**

To become a Waiver Provider, a potential Waiver Provider must respond to the NOE posted on the Electronic Business Daily at http://esbd.cpa.state.tx.us/bid_show.cfm?bidid=82557 and comply with and successfully complete DSHS' credentialing process.

To become credentialed, Waiver Providers have to ensure provision of all Waiver services.

Provider qualifications for YES Waiver services are outlined in Appendix A of this Manual.

An applicant will become a Waiver Provider upon execution of a Waiver Provider Agreement. The Waiver Provider must comply with the training requirements outlined above.

The Waiver Provider must perform or ensure all required direct service staff background checks, verify credentials, train staff in the necessary skills, and promote professional development. The Waiver Provider direct service staff must be capable of making service decisions that take into account the needs and preferences of the Waiver participant and/or LAR.

The Waiver Provider must maintain all credentialing requirements set forth by DSHS as a qualified YES Waiver Provider. In addition, Waiver Providers must notify DSHS of any changes to items listed under Credentialing Criteria as soon as a change has been identified.

The Waiver Provider is required to respond to requests and inquiries from DSHS and LMHA within a timeframe of 2 business days from the request/inquiry. Examples of requests or inquiries include, but are not limited to the following: emails, phone calls, voicemails, scheduling meetings, requests for progress notes, encounter submissions, invoicing corrections, and capacity limits.

If a Waiver Provider enters subcontract relationships with individuals or agencies to provide any Waiver services the following subcontracting responsibilities apply to the Waiver Provider:

- Create a subcontract agreement that includes:
 - Roles and responsibilities of the subcontractor;
 - Assumptions of responsibilities / attestation process to verification of staff qualifications, criminal history, and registry checks; and

- Rate / payment information.
- Provide copy of subcontract agreement template to DSHS
- Maintain subcontractor files that include:
 - Subcontract agreement
 - Documentation process that Waiver Provider uses to verify that subcontractor is in compliance with Subcontract agreement, including verifying staff qualifications, criminal history, and registry checks.
 - This process may vary depending on if subcontracting with an individual or an agency and should be specified in subcontract agreement. When subcontracting with an agency, it is typically the agency’s responsibility to ensure staff providing services specified in the subcontract agreement meet stated qualifications, criminal history, and registry checks. When subcontracting with an individual, the Waiver Provider should conduct a source review of subcontractor qualifications since there is no agency to do so.

In addition to the responsibilities of the Waiver Provider; when a subcontractor enters an agreement with a Waiver Provider to provide any Waiver services the following responsibilities apply to the subcontractor:

- Maintain a list of current personnel that may provide Waiver services or perform related activities;
- Provide Waiver Provider with documentation of internal requirements / process of maintaining personnel records, conducting qualification verifications, criminal history, and registry checks;
- Enter into a Subcontract agreement with Waiver Provider;
- Maintain personnel files that contain documentation used to verify qualifications, criminal history, and registry checks of all personnel providing Waiver services or perform related activities; and
- Assign direct service staff to provide selected services to the Waiver participant (if the subcontractor is an agency). If the Waiver participant is unhappy with the direct service staff, then assist with finding an alternative direct service staff. If no alternative is available, the Waiver participant may choose an alternative Waiver Provider.

Waiver Providers shall require that all subcontractors:

- certify that they are in good standing with all state and federal funding and regulatory agencies;
- are not currently debarred, suspended, or otherwise excluded from participation in federal grant programs;
- are not delinquent on any repayment agreements;
- have not had a required license or certification revoked;
- have not had a contract terminated by DSHS; and

- certify that they have not voluntarily surrendered within the past three (3) years any license issued by DSHS.

➤ **Department of State Health Services**

Upon receiving an application, DSHS will provide the applicant with a receipt confirmation and instructions for next steps. DSHS may contact the applicant at any time during the process to request additional information to assist with the review of the application. Pending receipt of all requested information, the desk review should be complete within 30 business days.

DSHS will notify the applicant via email when the desk review process is complete and to schedule the on-site review. It is anticipated that the on-site review will occur within four weeks of the completed desk review on a mutually agreed upon date.

Following successful completion of the desk and on-site review, DSHS will initiate a Medicaid Provider Agreement to be entered by and between DSHS and the Waiver Provider. To complete the credentialing process, Waiver Provider personnel will participate in DSHS sponsored training prior to participation in the provision of Waiver services.

D. Inquiry List

1. Inquiry List Management

The LMHA will establish the local Inquiry List for their respective service area. The purpose of the Inquiry List is to maintain a log of individuals that are interested in receiving YES Waiver services and to establish the priority of assessing for eligibility on a first-come, first-served basis.

The LMHA utilizes the DSHS Inquiry List document (see Forms section) to maintain the Inquiry List.

2. Inquiry List Registration

Individuals and families (Legally Authorized Representatives or LAR's) that are interested in receiving YES Waiver services must call the appropriate Inquiry List phone line based on their county of residence. Phone calls for registration on the Inquiry List will not be accepted from referral agencies on behalf of the individual or LAR. This is the starting point for enrollment into the YES Waiver.

The LMHA registers each individual/LAR on the Inquiry List who contacts the LMHA via the phone number listed above, based on the date and time that the phone call was received. There is no limit to the number of individuals that may be registered on the Inquiry List.

Refer to steps 1 and 2 of the Waiver Participant Eligibility and Enrollment Process (Section F).

3. First-Come, First-Served Policy

Available YES Waiver slots must be offered to individuals on a first-come, first-served basis according to individuals' registration date on the Inquiry List and individuals are enrolled providing all eligibility requirements are satisfied.

4. YES Waiver Slots

Although the YES Waiver may fill available slots at any time, the actual number of available YES Waiver slots will be dependent upon the Waiver Provider capacity in each service area. The LMHA shall verify with DSHS that Waiver Provider capacity exists in the applicable service area before offering a slot to the next individual on the Inquiry List. Once a service area is at capacity, the LMHA notifies DSHS of an available YES Waiver slot or of a YES Waiver slot anticipated to become available within 30 days in the LMHA's service area.

If there are no YES Waiver slots available or projected to be available within 30 days, the individuals on the Inquiry List will remain on the Inquiry List until notified by the LMHA of an available YES Waiver slot before the LMHA may determine clinical and financial eligibility for YES Waiver services.

While on the Inquiry List, individuals may receive other services they qualify for to address current needs. These services may include, but are not limited to services available through Texas Resiliency and Recovery (TRR). It is possible for an individual's personal situation to improve such that when a YES Waiver slot becomes available or projected to be available, the individual may not meet clinical eligibility criteria (when perhaps they had upon being registered on the Inquiry List). When this occurs, the individual is denied enrollment into the YES Waiver and should be referred to other known services that may be available. This takes the individual out of line for YES Waiver services and removes them from the Inquiry List. If the individual requests to be assessed again at a later date the process starts from the beginning and they are registered on the Inquiry List with the new date.

The LMHA offers the available YES Waiver slot to the individual whose registration date is earliest on the Inquiry List and enrolls the individuals that meet required demographic, clinical, and financial criteria:

5. Extending an Offer for YES Waiver Services

When a YES Waiver slot is available, the LMHA will extend an offer for YES Waiver services to the individual and LAR next in line on the Inquiry List. Notification of the offer may be made verbally but the official offer must be documented by providing the individual and LAR with the Offer Letter and the Vacancy and Deadline Notification Form either through regular United States mail or by hand delivery.

The offer of an available YES Waiver slot is valid for **30 calendar days** from the date the offer is officially made as documented by the Offer Letter and Vacancy and Deadline Notification Form. If the individual or LAR **does respond** to the offer within 30 calendar days, the LMHA must:

- Provide the individual and/or LAR both oral and written explanation of the services and supports for which the individual may be eligible, including Waiver services, Medicaid State Plan services, and other community-based services and supports.
- Assess the individual for eligibility.
- If eligible, provide the individual and/or LAR the Consumer Choice Consent Form, to document the individual's choice regarding participation in the YES Waiver.

If the individual or LAR **does not respond** to the offer within 30 calendar days, the LMHA withdraws the offer of an available YES Waiver slot, by sending the individual and LAR a Letter of Withdrawal and removes the individual from the Inquiry List.

6. Withdrawing an Offer for YES Waiver Services

The Letter of Withdrawal is utilized by the LMHA to notify individuals when the offer of Waiver services is being withdrawn. The LMHA may withdraw an offer for Waiver services under the following circumstances:

- The LMHA did not receive a response indicating the individual's interest in enrolling in the YES Waiver within 30 calendar days after the date on the Vacancy and Deadline Notification Form.
- The Consumer Choice Consent Form documenting the individual's choice of the YES Waiver program was not returned to (Name of LMHA) within ten calendar days after receiving the Form.
- The Documentation of Provider Choice documenting the individual's choice of program provider was not returned to the LMHA within 30 calendar days after the individual received the contact information from the LMHA about all Waiver Providers in the area where one is eligible to receive services.
- The individual and LAR no show for 2 scheduled intake appointments with the LMHA.
- Other Reason (LMHA Specify): Examples may include but are not limited to:
 - i. The LMHA has made multiple documented attempts to contact the individual and LAR with no success.
 - ii. The individual does not meet eligibility criteria (specific reason is documented on the Denial of Eligibility Letter).

The Letter of Withdrawal also states that the individual is removed from the Inquiry List. The LMHA does not need to provide the Inquiry List Removal Letter (see Removing an Individual from the Inquiry List) if the Letter of Withdrawal is provided.

7. Removing an Individual from the Inquiry List

When an individual or LAR fail to reply to communication from the LMHA, the LMHA may pursue removing the individual from the Inquiry List. The Inquiry List Removal Letter explains to the individual and LAR that the LMHA is trying to reach them to determine if the individual and LAR are still interested in participating in Waiver services and to confirm the individual and LAR's contact information.

- If the individual or LAR does not return the letter with the required signature or call the point of contact on the letter within 30 days expressing their continued interest, the individual's name will be removed from the Inquiry List.
- If the individual or LAR desires to obtain Waiver services after the 30 days has passed, the individual's name will be entered on the Inquiry List based on the day and time requested (this ensures the first-come, first-served approach to service provision).

8. Denial of Eligibility

The Denial of Eligibility Letter must be provided to the individual and LAR when:

- the child or adolescent is denied participation in the YES Waiver program; or
- the child or adolescent is denied continued participation in the YES Waiver program; or
- the YES Waiver program services for the child or adolescent are denied, reduced, suspended, or terminated.

➤ Local Mental Health Authority

The LMHA is responsible for maintaining an up- to- date Inquiry List. DSHS requests the LMHA to provide DSHS with a copy of the Inquiry List and related demographic information that represents all individuals interested in receiving Waiver services on a quarterly basis. The LMHA must maintain a copy of all letters and forms in the Waiver participant's clinical record (i.e. Offer Letter, Vacancy and Deadline Notification Form, Letter of Withdrawal, Inquiry List Removal Letter).

➤ Waiver Provider

The Waiver Provider does not maintain the Inquiry List. The Waiver Provider will notify DSHS of any capacity limitations by sending an Email to the YES Waiver Email Address.

➤ Department of State Health Services

DSHS does not maintain the Inquiry List. However, DSHS approves the Inquiry List management policy for each service area in the YES Waiver. DSHS will monitor the individual service capacity of each Waiver Provider and will notify the LMHA of any capacity limitations. DSHS requests the LMHA to provide DSHS with a copy of the

Inquiry List and related demographic information that represents all individuals interested in receiving Waiver services on a quarterly basis.

E. Eligibility Criteria and Evaluation of Level of Care

Waiver eligibility is determined using demographic, clinical, and financial criteria.

See Forms section for the Clinical Eligibility Determination Form, the Co-Occurring Diagnoses Needs Assessment form, and the Financial Eligibility Screening tool.

See Waiver Participant Eligibility and Enrollment Process for the steps to verify and obtain financial eligibility.

All forms and documentation used to determine eligibility and level of care must be maintained in the Waiver participant's clinical record.

1. Demographic Criteria

To participate in the YES Waiver, an individual must:

- Be between 3-18 years of age;
- Reside in a county included in the service areas
- Reside in a non-institutional setting with the individual's LAR; or in the individual's own home or apartment, if legally emancipated.

2. Clinical Criteria

To participate in the YES Waiver, an individual must meet the following clinical level of care standards:

- Have serious functional impairment or acute severe psychiatric symptomatology. This is assessed using particular domain scores from the Child and Adolescent – Texas Recommended Assessment Guidelines (CA-TRAG) as outlined below (Letter A). **AND**
- There must be a reasonable expectation that, without YES Waiver services, the individual would qualify for inpatient care under the Texas Medicaid inpatient psychiatric admission guidelines as outlined below (Letter B).

A. CA-TRAG

The 10 CA-TRAG domains are:

- 1) Ohio Youth Problem Severity Scale
- 2) Ohio Youth Functioning Scale
- 3) Risk of Self-Harm
- 4) Severe Disruptive or Aggressive Behavior
- 5) Family Resources
- 6) History of Psychiatric Treatment
- 7) Co-Occurring Substance Use
- 8) Juvenile Justice Involvement
- 9) School Behavior
- 10) Psychoactive Medication Treatment

The child or adolescent must meet the following CA-TRAG scoring criteria:

- A score of 30 or greater on the Ohio Youth Problem Severity Scale
- And** one or more of the following:
- Score of 4 or 5 on the Risk of Self-Harm dimension,
 - Score of 4 or 5 on the Severe Disruptive or Aggressive Behavior dimension,
 - Score of 4 or 5 on the Family Resources dimension,
 - Score of 4 or 5 on the School Behavior dimension, or
 - Current diagnosis of Schizophrenia, Major Depressive Disorder with psychosis, Bipolar I with the most recent episode Manic or Mixed,

The child or adolescent must be present for the CA-TRAG assessment.

Only proceed to letter B if CA-TRAG criteria are met. A Physician's signature is not required on denials of eligibility if the CA-TRAG criteria are not met. A Physician's signature is required if CA-TRAG scoring criteria are met and when the individual does not meet the additional criteria specified below in the Texas Medicaid Inpatient Psychiatric Admission Guidelines.

AND

B. Texas Medicaid Inpatient Psychiatric Admission Guidelines:

These guidelines are:

- The Medicaid eligible youth must have a valid Axis I, Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR) diagnosis as the *principle admitting diagnosis*; **And**
- Outpatient therapy or partial hospitalization must have been attempted and failed **or** a psychiatrist must have documented reasons why an inpatient level of care is required; **And**
- The Medicaid eligible youth must meet at least one of the following criteria:
 1. The Medicaid eligible individual is presently a danger to self, demonstrated by at least one of the following:
 - Recent suicide attempt or active suicidal threats with a deadly plan and an absence of appropriate supervision or structure to prevent suicide;
 - Recent self-mutilative behavior or active threats of same with likelihood of acting on the threat and an absence of appropriate supervision or structure to prevent self-mutilation (i.e., intentionally cutting / burning self);
 - Active hallucinations or delusions directing or likely to lead to serious self-harm or debilitating psychomotor agitation or retardation resulting in a significant inability to care of self; or
 - Significant inability to comply with prescribed medical health regimens due to concurrent Axis I psychiatric illness and such failure to comply is potentially hazardous to the life of the

- individual. A medical diagnosis of Axis III which must be treatable in a psychiatric setting.
2. The Medicaid eligible individual is a danger to others. This behavior should be attributable to the individual's specific Axis I, DSM-IV-TR diagnosis and can be adequately treated only in a hospital setting. This danger is demonstrated by one of the following:
 - Recent life-threatening action or active homicidal threats of same with a deadly plan and availability of means to accomplish the plan with the likelihood of acting on the threat;
 - Recent serious assaultive or sadistic behavior or active threats of same with the likelihood of acting on the threat and an absence of appropriate supervision or structure to prevent assaultive behavior; or
 - Active hallucinations or delusions directing or likely to lead to serious harm of others.
 3. The Medicaid eligible individual exhibits acute onset of psychosis or severe thought disorientation, or there is significant clinical deterioration in the condition of someone with chronic psychosis rendering the child or adolescent unmanageable and unable to cooperate in treatment, and the individual is in need of assessment and treatment in a safe and therapeutic setting.
 4. The Medicaid eligible individual has a severe eating or substance abuse disorder, which requires 24-hours-a-day medical observation, supervision, and intervention.
 5. The proposed treatment / therapy requires 24-hours-a-day medical observation, supervision, and intervention.
 6. The Medicaid eligible individual exhibits severe disorientation to person, place, or time.
 7. The Medicaid eligible individual's evaluation and treatment cannot be carried out safely or effectively in other settings due to severely disruptive behaviors, and other behaviors which may include physical, psychological, or sexual abuse.
 8. Medicaid eligible individual requires medication therapy, or complex, diagnostic evaluation where the individual's level of functioning precludes cooperation with the treatment regimen.

An individual not meeting the listed criteria is not eligible for participation in the YES Waiver. In addition, an individual is not eligible for YES Waiver services if they are enrolled in foster care. Also, individuals cannot be dually enrolled or receive services from other 1915(c) Waiver programs. These programs include, but are not limited to:

- Department of Aging and Disability Services (DADS) Waiver programs such as CLASS, HCS, MDCP, CWP, DBMD, CBA, and TX Home Living; and
- HHSC STAR+PLUS community-based Waiver.

Co-Occurring Diagnoses Needs Assessment

See Forms Section for the Co-Occurring Diagnoses Needs Assessment form.

Additional assessment and planning will need to occur for individuals that have co-occurring diagnoses from the following Intellectual and Developmental Disabilities (IDD) and Pervasive Developmental Disorder (PDD) categories.

- IDD Diagnoses: Mental Retardation (Mild, Moderate, Severe, Profound, or Unspecified Severity); or
- PDD Diagnoses: Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and PDD Not Otherwise Specified.

The community-based services and supports received through the YES Waiver must address the individual's needs that arise as a result of their serious emotional disturbance. The Individual Plans of Care (IPC's) for individuals with identified needs related to the co-occurring diagnoses must include identified services and supports to meet those needs in the sections of the IPC designed for Non-Waiver Services.

Other Non-Waiver Medicaid State Plan Services
Non-Waiver Services – Services Provided by other Funding Sources

DSHS may request to review treatment plan goals, objectives, and strategies to assist in the IPC approval process. DSHS may request progress note documentation at any time to verify reimbursed services are being provided in accordance with the requirements of the waiver.

3. Financial Criteria

See Waiver Participant Eligibility and Enrollment Process for the steps to verify and obtain financial eligibility (Section F).

To participate in the YES Waiver, an individual must be eligible for Medicaid, under a Medicaid Eligibility Group included in the approved YES Waiver.

Individuals who receive services under the YES Waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan.

- Low income families with children as provided in 1931 of the Act
- SSI recipients
- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)
- All State Plan groups except for: 1634(b) Early Aged Widow(er); 1634(d) Disabled Widow(er); 1634(c) Disabled Adult Children; and the following Foster Care Groups: 1902(a)(10)(A)(i)(I) and 1902(a)(10)(A)(ii)(XVII)

HHSC and DSHS will determine financial eligibility for services under the YES Waiver from standards used to determine eligibility for Medicaid in institutions (special waiver income group). Under these standards, parental income and resources are not counted. Individuals in the special HCBS waiver group are eligible in accordance with a special income level equal to 300% of the SSI Federal Benefit Rate. Individuals that apply and are approved for Medicaid under these conditions will be assigned Medicaid Type

Program (TP) 14 Base Plan (BP) 13, ME Waiver. TP14/BP13 is traditional, fee-for-service Medicaid.

Individuals that meet YES Waiver financial eligibility under their current Medicaid benefit (See financial eligibility screening tool for list of TP/BP's) will continue under that Medicaid benefit and may be either fee-for-service or managed care while enrolled in the YES Waiver. For example:

- A child that is already Medicaid eligible and enrolled in STAR upon approval for the YES Waiver will continue to be enrolled in STAR. Waiver services will be provided by YES.
- A child that is approved for YES under Type Program 14/Base Plan 13 will always be Traditional, fee for service Medicaid, and is not eligible for STAR.

The LMHA assists individuals with meeting financial criteria if the current status of Medicaid eligibility is denied, no record of eligibility, or record is showing a future eligibility end date. See Waiver Participant Eligibility and Enrollment Process for more details.

Individuals must be determined disabled to be eligible for the YES Waiver and other Medicaid programs. If the individual is drawing a Social Security, Railroad Retirement, or SSI Disability, the disability requirement is met. For all others, the HHSC Eligibility worker must seek a disability determination. The LMHA assists with the completion of a Disability Determination (if applicable) by completing select sections of form 3034 and 3035. See Waiver Participant Eligibility and Enrollment Process for more details.

- Form 3034: <http://www.dads.state.tx.us/forms/H3034/>
- Form 3035: <http://www.dads.state.tx.us/forms/H3035/>

Medicaid Effective Date

For individual's that must apply for financial eligibility to gain Medicaid benefits, the Medicaid Effective Date is the date Medicaid benefits begin for services identified on an approved IPC. HHSC establishes the Medicaid Effective Date. DSHS will provide HHSC with the date that approved services began. The Medicaid Effective Date:

- Will traditionally be dated back to the 1st of the month of the date of application. For example, if the financial application was signed on 6/17/10, the Medicaid Effective Date would be 6/1/10 once the financial determination was completed.
- Services cannot begin prior to the submission of a financial application (if applicable).
- May be prior to or after the YES Waiver Authorization date.
- Must be on or before the Annual IPC Begin Date, IPC Start Date (Prior-Auth), and IPC Effective Date.

Note: If the individual is awaiting a Medicaid financial determination, the LMHA may proceed with enrolling the individual as long as the individual and/or LAR is informed in writing that if Medicaid is denied for any reason, they may no longer be eligible for YES

Waiver services. In addition, the LMHA and Waiver Providers are not guaranteed payment for services provided if Medicaid eligibility is denied.

Question: How long can it take to obtain full Medicaid eligibility determination for individuals that must submit a financial application?

- HHSC Medicaid Eligibility workers have up to 45 days to make a determination once a complete application is received.

Question: What can the LMHA and DSHS do to expedite a Medicaid eligibility determination?

- The LMHA will assist the individual and/or LAR with completing the application to ensure all required information is provided.
- The LMHA will assist the individual and/or LAR with completing portions of the disability determination forms and submits with the financial application.
- The LMHA may provide a scanned image of the application to DSHS via a secure email that DSHS will, in turn, forward on to the HHSC Medicaid Eligibility workers. The LMHA must mail the signed hardcopy to DSHS to forward on to HHSC.
- DSHS will request HHSC Medicaid Eligibility workers to identify any “red flags” that may delay a determination or result in a denial upon receipt of the application.
- HHSC will notify DSHS of any requests for additional information. DSHS will inform the LMHA of the request and the LMHA will work with the individual and family to provide the necessary information.

Question: What would lead to a denial based on not meeting financial requirements?

- The individual’s income and resources would each need to be greater than the monthly limit of \$2,022. Parental income and resources are not included in the calculation.
- If the individual exceeds the monthly limit, there is an option for the individual to establish a Qualified Income Trust in order to meet financial eligibility criteria.

Qualified Income Trust

If a Waiver participant’s income exceeds the financial limit (\$2,022 per month), deeming them ineligible due to Waiver financial eligibility requirements, then an option is available for the Waiver participant to set up a Qualified Income Trust (QIT) in order to meet the financial requirements. It is the responsibility of the individual and LAR to set up a QIT.

Financial eligibility for a Waiver participant with a QIT is determined by Medicaid Eligibility for the Elderly and People with Disabilities (MEPD) staff at HHSC. When a Waiver participant has a QIT and is enrolled in the YES Waiver, there is a co-pay required by the Waiver participant. The Waiver Provider collects the co-pay prior to billing DSHS for services. The MEPD staff calculates the amount of income available from the trust for co-payment and provides the amount to DSHS.

4. Level of Care Evaluation and Updates

For the evaluation process, see LMHA, Waiver Provider, and DSHS sections below and the Waiver Participant Eligibility and Enrollment Process (Section F).

In order for an individual to be determined to need YES Waiver services, an individual must require the provision of at least one YES Waiver service, as documented in the IPC. Re-evaluations of the level of care are required every twelve months. The LMHA will perform a CA-TRAG update every 90 days. The updates will not affect level of care determinations as eligibility is for 12 months.

5. Temporary Inpatient Services

See forms section for the Critical Incident Reporting Form.

Waiver participants may need to access temporary inpatient services while enrolled in the YES Waiver. If the situation is temporary (90 days), not permanent, the Waiver participant's eligibility is not affected as long as the LMHA is monitoring the individual monthly, concluding that the Waiver participant still is in need of Waiver services. When a Waiver participant is either hospitalized or discharged, the LMHA must complete and submit the Critical Incident Reporting Form to DSHS within 72 hours of the date notified of hospitalization, and within 72 hours of the date notified of hospitalization discharge. The LMHA must submit an updated IPC within 30 days of a hospitalization discharge.

➤ Local Mental Health Authority

The LMHA shall maintain records of evaluations and re-evaluations of level of care in the Waiver participant's clinical record that includes, but is not limited to, applicable YES Waiver forms (i.e. Clinical Eligibility Determination Form).

A licensed master's level clinician (licensed clinical social worker (LCSW), licensed marriage and family therapist (LMFT), licensed professional counselor (LPC) or licensed psychologist) assesses individuals for Waiver eligibility using the Uniform Assessment process in addition to the Texas Medicaid Inpatient Psychiatric Admission Guidelines. The licensed master's level clinician completes the Clinical Eligibility Determination Form and recommends a level of care regarding the YES Waiver to DSHS Waiver Staff according to the two scenarios below. See Waiver Participant Eligibility and Enrollment Process more information.

1. Recommend Level of Care of YES Waiver: Submit the Clinical Eligibility Determination Form to DSHS Waiver Staff with required signatures if the assessment indicates that all demographic and clinical eligibility criteria are met.
2. Not Eligible for YES Waiver: When the individual does not meet clinical eligibility criteria, a copy of the Clinical Eligibility Determination Form

complete with required signatures for that denial must be retained by the LMHA. A Physician's signature is only required to verify / concur with any recommendation to deny level of care if CA-TRAG scoring criteria are met but the individual does not meet the Texas Medicaid Inpatient Psychiatric Admission Guidelines. The Physician's signature is to be documented on the Clinical Eligibility Determination Form, if applicable. Do not submit the Clinical Eligibility Determination Form to DSHS Waiver Staff. Provide the individual and LAR with the Denial of Eligibility Letter and Letter of Withdrawal and remove the individual from the Inquiry List. The LMHA shall refer the individual to other services as appropriate.

The Waiver participant and LAR will be informed of the services offered under the YES Waiver at the time the LMHA has determined that the individual may qualify to receive services. The LMHA will also inform the individual and LAR of other treatment options such as hospitalization.

The LMHA will provide a copy of DSHS's *Handbook of Consumer Rights, Mental Health Services* in either English or Spanish as appropriate to the individual and LAR. This handbook documents the Waiver participant's and representative's right to participate in the development of the IPC. The documentation includes the Waiver participant's right to request that other individuals be involved and the Waiver participant's right to an explanation should the request be denied.

The LMHA will inform the individual and LAR of the conditions in which the right to request a Medicaid Fair Hearing apply. The method used to communicate the information will be designed for effective communication, tailored to meet each person's ability to comprehend, and responsive to any visual or hearing impairment. Oral communications of rights will be documented on the Notification of Participant Rights Form bearing the date and signatures of the Waiver participant and/or LAR and the staff person who explained the rights. The Notification of Participant Rights Form will be filed in the Waiver participant's clinical record.

The LMHA will inform the Waiver participant and the LAR of the process for reporting allegations of abuse, neglect or exploitation (ANE) and given the toll free number for the Texas Department of Family and Protective Services (DFPS). Oral and written communication of this information will be documented on the Notification of Participant Rights Form bearing the date and signatures of the Waiver participant and/or LAR and the staff person who provided this information.

Re-evaluation of Level of Care

Re-evaluations of the level of care are required every twelve months. The Re-evaluation date is based on the end date of the YES Waiver authorization in CMBHS. The LMHA Targeted Case Manager completes the assessment and the Clinical Eligibility Determination Form. The LMHA master's level clinician reviews and confirms the recommendation and makes a recommendation to DSHS regarding level

of care (Recommend Level of Care of YES Waiver or Not Eligible for YES Waiver) by submitting the Clinical Eligibility Determination Form.

A Physician's signature is only required to verify / concur with any recommendation to deny level of care if CA-TRAG scoring criteria are met but the individual does not meet the Texas Medicaid Inpatient Psychiatric Admission Guidelines. The Physician's signature is to be documented on the Clinical Eligibility Determination Form.

90-day Uniform Assessment Updates

The LMHA will perform a uniform assessment update (CA-TRAG) every 90 days. The updates will not affect level of care determinations as eligibility is for 12 months.

➤ **Waiver Provider**

The Waiver Provider is not directly involved in determining eligibility and recommending a level of care to DSHS. The Waiver Provider may be consulted by the LMHA upon completion of annual re-evaluation. The Waiver Provider becomes involved in enrollment when the LMHA reaches reach step 7 with the Waiver participant (Selection of the Waiver Provider).

➤ **Department of State Health Services**

Records of evaluations and reevaluations of level of care are maintained at DSHS and the LMHA.

DSHS is the approval authority for all eligibility criteria and level of care evaluations. DSHS verifies current Medicaid status upon receipt of the Clinical Eligibility Determination Form and provides a response to the LMHA regarding clinical and financial eligibility. DSHS receives applications for Medicaid and submits them to HHSC's Medicaid Eligibility Staff with the appropriate referral form for processing. DSHS informs the LMHA when a Medicaid eligibility determination has been made.

6. Temporary Out-of-Home Living Arrangement

Yes Waiver participants may need to access temporary out-of-home living arrangements that are not covered under the YES Waiver service array.

A temporary out-of-home living arrangement is defined as any temporary living arrangement, not funded through the YES Waiver Respite or Supportive Family-based Alternatives services, where the Waiver participant is residing on a daily basis in a setting that is not with their legally authorized representative or in the Waiver participant's own home or apartment, if legally emancipated. Examples include, but are not limited to, temporary placement in a shelter, group home, residential treatment center, or other facility based setting. The temporary living arrangement may last up to 90 consecutive or cumulative days per Individual Plan of Care year. During this time period, the Waiver participant may remain enrolled but is placed on Inactive status and shall not receive YES Waiver services.

YES Waiver covered Respite or Supportive-Family-based Alternatives must be considered as an initial option for meeting the Waiver participant's need for a temporary out-of-home living arrangement. If it is determined that an alternative temporary out-of-home living arrangement is more appropriate to address the current needs of the Waiver participant, then the following guidelines apply. This policy does not apply to Temporary Inpatient Hospitalizations.

These guidelines apply when additional Waiver participant capacity is available. When capacity is maximized, DSHS may provide additional guidance.

➤ **Local Mental Health Authority**

The Local Health Mental Authority shall provide DSHS with prior notification of the start date for the temporary out-of-home living arrangement and a rationale as to why the YES Waiver covered services are not being utilized.

Case management must occur on a monthly basis to coordinate and document the Waiver participant's plan to transition back to residing with the LAR or in the Waiver participant's home or apartment, if legally emancipated. Case management shall be provided in accordance with the applicable billing guidelines. Monthly status updates on transition plan shall be provided to DSHS.

The LMHA shall contact DSHS once the Waiver participant is no longer in temporary out-of-home living arrangement, and shall coordinate with DSHS on the date for YES Waiver services to resume and will provide an updated Individual Plan of Care if participant has been inactive for 90 days. A revised IPC must be submitted within 30 days after participant is no longer in temporary out-of-home living arrangement.

➤ **Department of State Health Services**

Maintains records of dates of Inactive and Active Status, reviews monthly reports regarding transition planning, and approves an updated Individual Plan of Care prior to Waiver participant coming off the Inactive status list, if necessary.

F. Waiver Participant Eligibility and Enrollment

DSHS YES Waiver Staff may contact the LMHA with requests for additional information when necessary at any time during the Eligibility and Enrollment process.

The LMHA may contact DSHS YES Waiver Staff at any time for additional information about eligibility determination and enrollment.

DSHS YES Waiver Staff has a direct line of communication with the Medicaid Eligibility Workers from HHSC and will serve as a liaison between the LMHA and HHSC on determination of financial eligibility.

All transmission of sensitive information must be sent via a HIPAA compliant secure method. The process is currently outlined using secure E-mail transmission to DSHS YES Waiver Staff at YESWaiver@dshs.state.tx.us.

The LMHA shall maintain original forms provided to the individual and LAR in the Waiver participant's clinical record and provide the individual and LAR a copy (i.e. Offer Letter, Vacancy and Deadline Notification, Notification of Participant's Right's Form, Documentation of Provider Choice, Clinical Eligibility Determination Form, Denial of Eligibility Letter, Consumer Choice Consent Form, and Individual Plan of Care Form.

1. Status of Individual (Interested, Eligible, Enrolled, Enrolled In Service)

Interested: An individual is designated as "Interested" until they are determined fully eligible for the YES Waiver, including Clinical and Financial eligibility (Steps 1 – 7).

Eligible: An individual is designated as "Eligible" once approved for clinical and financial eligibility (Steps 7-8).

Enrolled: An individual is designated as "Enrolled" once an initial enrollment Individual Plan of Care (IPC) has been approved by DSHS (Step 9).

Enrolled and Receiving Services: An individual is designated as "Enrolled and Receiving Services" once they receive their first YES Waiver service (Step 10). Case Management services only do not count towards this status.

2. Process Flow (Steps 1-12)

See Appendix D for the Enrollment and Eligibility Process Flow.

Step 1: Register Individual on the Inquiry List

1. A Legally Authorized Representative (LAR) for the individual interested in receiving YES Waiver services must call the appropriate Inquiry List phone line maintained by the LMHA based on their county of residence. Phone calls for registration on the Inquiry List will not be accepted from referral agencies on behalf of the individual or LAR. This is the starting point for enrollment into the YES Waiver.

Note: Individuals interested in receiving services under the YES Waiver may or may not be current clients of the LMHA, may be referred to the YES Waiver Inquiry List from a variety of community resources, or may contact the Inquiry List phone line requesting the YES Waiver without a referral.

2. The LMHA registers each individual on the Inquiry List on a first-come, first-served basis, based on the date and time the telephone call or voice message was received. Responses to voice messages by the LMHA must occur between 24 and 48 hours upon receipt of the message.

Step 2: Provide General Information

1. The LMHA may refer to the Optional Screening Tools and the Participant Handbook and Provider Directory located in the Forms section, or the Youth and Family Brochures located on the YES Waiver Webpage.
2. The LMHA provides general information about the YES Waiver to the individual and/or LAR. The information that may be provided at any time during the Eligibility and Enrollment Process includes, but is not limited to:
 - a. Demographic eligibility criteria;
 - b. Clinical eligibility criteria;
 - c. Financial eligibility criteria; and
 - d. Service array description.
3. The LMHA informs the individual that if enrolled in the YES Waiver, he/she will not be eligible to participate in a TRR service package or another Medicaid 1915c home and community-based waiver concurrently.
4. The LMHA reviews all topics in the Notification of Participant Rights Form with the individual and LAR including: Abuse, Neglect and Exploitation Reporting, Consumer Services and Rights Protection Complaints; Ombudsmen Complaints; the DSHS Handbook of Consumer Rights; and how to request a Fair Hearing. The LMHA obtains appropriate signatures on this form.

Only proceed to Step 3 when a YES Waiver slot is available or is projected to be available within 30 days. There will likely be a pause at this point once a service area is operating at enrollment capacity or if a limited provider capacity exists.

Step 3: Notification of an Available YES Waiver Slot

1. The LMHA notifies the next individual and LAR on the Inquiry List of an available YES Waiver slot (first-come, first-served) and documents the notification using the following forms:
 - a. Offer Letter; and
 - b. Vacancy and Deadline Notification Form.
2. The LMHA schedules an appointment with the individual to conduct an eligibility assessment. The LMHA shall conduct Assessments in the order of registration on the Inquiry List to the extent possible.

Step 4: Determine Demographic and Clinical Eligibility

1. The LMHA verifies that the individual meets demographic eligibility criteria. To participate in the YES Waiver an individual must:
 - a. be between the ages 3 and 18;
 - b. live in county served by the YES waiver; and
 - c. reside in a non-institutional setting with their LAR, or in their own home or apartment, if legally emancipated.

2. The LMHA assesses each individual (that meets demographic criteria) for clinical eligibility and completes a Clinical Eligibility Determination Form.
3. If clinical eligibility **is** met, the LMHA:
 - a. Submits the Clinical Eligibility Determination Form to the YES Waiver E-mail Address for official verification and approval by DSHS YES Waiver Staff. Electronic signatures are accepted; however the LMHA must maintain actual hardcopy signatures in the Waiver participant's clinical record.
 - b. **The subject line must read:** Eligibility Verification Request (*insert applicants initials, XXXX and last four digits of CARE ID*).

Prior to the start of YES Waiver service, a clinical eligibility determination is valid for 90 days from the date approved by DSHS. If 90 days elapses before YES Waiver services begin, DSHS will request an updated clinical eligibility determination prior to approving the enrollment IPC.

Once approved, Clinical Eligibility is valid for 12 months based on the YES Waiver Authorization date in CMBHS.

If the individual requires or requests immediate inpatient hospitalization and/or other services, follow standard protocol in accessing those services. Temporary Inpatient Hospitalization does not affect eligibility for the YES Waiver.

Additional assessment and planning will need to occur for individuals that have co-occurring diagnoses from the following Intellectual and Developmental Disabilities (IDD) and Pervasive Developmental Disorder (PDD) categories. See Forms Section for the Co-Occurring Diagnoses Needs Assessment form.

- IDD Diagnoses: Mental Retardation (Mild, Moderate, Severe, Profound, or Unspecified Severity); or
- PDD Diagnoses: Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and PDD Not Otherwise Specified

4. If demographic or clinical eligibility criteria **are not met**, the LMHA:
 - a. does not submit the Clinical Eligibility Determination Form to DSHS;
 - b. provides the individual and LAR with a Denial of Eligibility Letter that includes notification of the right to a fair hearing;
 - c. provides the individual and LAR with a Letter of Withdrawal that informs the individual that they are no longer on the Inquiry List for YES Waiver services. If the individual requests to be assessed again at a later date the process starts from the beginning and they are registered on the Inquiry List with the new date; and
 - d. refers the individual to other services available through the LMHA or other known community resources.

Step 5: Determine Financial Eligibility (Current Medicaid Status)

1. DSHS will provide the official verification and approval of the individual's current Medicaid Status to the LMHA.

The LMHA may refer to the Financial Eligibility Screening Tool for general information on what income and resource categories and limits are associated with assessing individuals for financial eligibility (for those not currently on Medicaid).

2. When DSHS receives the Eligibility Verification Request email with the Clinical Eligibility Determination Form, DSHS will automatically conduct a review and verification of Clinical Eligibility and current Medicaid Eligibility (financial) status.
 - a. DSHS communicates a verification result by replying to the LMHA's original email request within 5 business days.
 - b. **The subject line will read:** RE: Eligibility Verification Request (*insert applicant's initials, XXXX and last four digits of CARE ID number*).
 - c. The contents of the email will state if the individual:
 - i. meets clinical eligibility for the YES Waiver (Yes or No);
 - ii. is currently Medicaid eligible for the YES Waiver (Yes or No); and
 - iii. If individual **is** currently Medicaid Eligible, next steps will be to submit an IPC to DSHS for approval; or
 - iv. If individual **is not** currently Medicaid Eligible, next steps will be to submit a financial application, disability determination paperwork, and an IPC Projection to DSHS.

If individual **is** currently Medicaid Eligible, refer to the "Medicaid Yes Tab" on the Enrollment and Eligibility Process Flow.

If individual **is not** currently Medicaid Eligible, refer to the "Medicaid No Tab" on the Enrollment and Eligibility Process Flow.

Note: If the individual is awaiting a Medicaid financial determination, the LMHA may proceed with enrolling the individual as long as the individual and/or LAR is informed in writing that if Medicaid is denied for any reason, they may no longer be eligible for Waiver services. In addition, the LMHA and Waiver Providers are not guaranteed payment for services provided if Medicaid eligibility is denied.

Step 6: Obtain Financial Eligibility (only applicable for individuals who are not currently Medicaid Eligible)

6a: Submit an application for Financial Eligibility (if applicable)

1. The LMHA assists the individual and/or the LAR in obtaining and completing an application for Medicaid Eligibility. Tips to submit a complete application:
 - a. Complete application in terms of income and resources of the individual applying for Medicaid. If parental / guardian information is also listed, please notate that the income / resources is the parents and not the child's;

- b. Provide the Diagnosis Review;
- c. Provide the most recent **physician** signed medical treatment records with diagnosis; records from the most recent twelve months is preferable;
- d. Provide copy of individual's Birth Certificate
- e. Provide copy of individual's Private Insurance Card, front and back (if applicable); include policy values;
- f. All resources must be listed (i.e. bank accounts), financial verification (i.e. 3 consecutive monthly bank statements dated to first of month of application date complete with ending balance and account holder names) must also accompany the application or will be requested by HHSC; and
- g. Submit the application and documentation to the YES Waiver Email box and mail the hardcopy DSHS YES Waiver address, within 30 days of participant approved clinical eligibility.

Note:

Information from other sources may also help show the extent to which an individual's impairment(s) affects his or her ability to function in a work setting; or in the case of a child, the ability to function compared to that of children the same age who do not have impairments. Other sources include public and private agencies, non-medical sources such as schools, parents and caregivers, social workers and employers, and other practitioners such as naturopaths, chiropractors and audiologists.

2. The following is a list of application options in the situation that the current status of Medicaid eligibility is denied, no record of eligibility, or record is showing a future eligibility end date.
 - a. H1200 Medical Assistance Only Application (MAO) located at <http://www.dads.state.tx.us/forms/H1200/>. The MAO should be used for individuals that are likely to qualify for financial eligibility based on the Special YES Waiver Income Group guidelines. In addition the MAO can be used to determine whether the individual may qualify for any other Medicaid programs. (Recommended Application)
 - b. H1010E – Application for Assistance located at <http://www.dads.state.tx.us/forms/H1010%2DE/>. This is an integrated application for requesting additional programs/services outside the scope of Medicaid Aged and Disabled (i.e. SNAP, TANF). (Recommended if other such programs are desired in addition to YES Waiver)
 - c. H1010B – Texas Works Advisor Form located at <http://www.dads.state.tx.us/forms/H1010%2DB/>. This is an application for TANF and Children and Pregnant Women programs only and **will not** have all the information needed to determine YES Waiver eligibility if the individual is not eligible for another Medicaid program.
 - d. Social Security Income Application located at <http://www.socialsecurity.gov/applyfordisability/child.htm>. Due to the timeframe that Supplemental Security Income (SSI) applications can be pending status, the LMHA may consider submitting an H1200 or H1010E application to DSHS for the purpose of applying for the YES Waiver. Note:

YES Waiver services must be denied if SSI determines the individual is not disabled.

3. Individuals must be determined disabled to be eligible for the YES Waiver and other Medicaid programs. If the individual is drawing a Social Security, Railroad Retirement, or SSI Disability, the disability requirement is met. For all others, the HHSC Eligibility worker must seek a disability determination.

The LMHA assists with the completion of a Disability Determination (if applicable) by completing select sections of form 3034 and 3035 (outlined below) and submitting those forms with the emailed and hardcopy application.

- a. Form 3034: <http://www.dads.state.tx.us/forms/H3034>
 - i. Section II. CASE IDENTIFICATION is completed by the HHSC Eligibility worker (HHSC regional specified worker for YES Waiver) through a phone interview with the individual's legal guardian. LMHA staff may enter client information in letter A (leaving Case Number blank) if desired. LMHA staff do not complete B-E. Please note that date needed for onset of eligibility will be the first of the month that YES Waiver services are anticipated to begin.
 - ii. Section III. SOCIO-ECONOMIC INFORMATION may be completed by LMHA staff and medical records that document the information provided must also be provided. If the HHSC completes this section then medical records will be requested as a follow-up item for the family, which the LMHA may need to assist with obtaining.
 - iii. Section IV. NOTES – when a local staff assists the legal guardian with completing the form, the name of the LMHA staff and contact information must be identified in this section. Insert in this section that the disability is expected to last at least one year, and have a physician/psychologist sign the document. If current medical records are not available, please note it in this section.
 - iv. The HHSC Eligibility worker will complete the remaining portions of the form and may contact the LAR to request information.
 - b. Form 3035: <http://www.dads.state.tx.us/forms/H3035/>
 - i. LMHA staff should obtain signature from LAR on Section II. HHSC regional specified worker for YES Waiver completes the rest of the form.
4. The LMHA submits a scanned copy of the completed Application and Disability Determination (if applicable) to the YES Waiver E-mail address to expedite processing.
 - a. **The subject line must read:** Application for Financial Eligibility (*insert CARE ID*).
 - b. The contents of the email must include a scanned copy of the completed, signed and dated Application and Disability Determination (if applicable).

5. The LMHA submits the original completed hardcopy Application (signed and dated) and disability determination (if applicable) to the DSHS YES Waiver Staff at the address listed under the DSHS Contact Information Section of this Manual. Without the completed hardcopy Application containing original signatures, the Application process cannot be completed.
6. DSHS sends the Application to HHSC with appropriate referral form within 72 hours or 3 business days of receiving the Application (via email and hardcopy) and notifies the LMHA via email when a determination has been finalized. The email will contain the determination result (approved or denied) and if approved, the Medicaid ID number and Medicaid effective date.

In the instance in which there is a period of time before a YES Waiver slot is projected to be available, the individual may apply for regular Medicaid by submitting an application to DSHS YES Waiver Staff for processing. DSHS YES Waiver staff will facilitate the processing of this application letting HHSC Medicaid Eligibility Workers know that the individual is on the Inquiry List for YES Waiver services. If regular Medicaid is granted, the individual is entitled to such services while waiting for a YES Waiver slot.

6b: Submit IPC Projection (only applicable for individuals who are not currently Medicaid Eligible)

1. The LMHA completes and submits an IPC Projection within 30 days of clinical eligibility to DSHS YES Waiver Staff to document medical necessity at the YES Waiver E-mail Address by replying to the original email chain with subject: IPC Projection (*insert applicant's initials, XXXX and last four digits of CARE ID number*).
 - a. The anticipated IPC Start Date (Prior-Auth) of YES Waiver services should be within 30 days.
 - b. IPC Projections are not required to have the signature of the Waiver Provider as they may not have selected a Waiver Provider at this point in the process.
 - c. IPC Projections are not required to have an Annual IPC Begin Date or Annual IPC End Date as these dates are based on the date the individual is authorized for YES Waiver in CMBHS, and this may not have occurred at this point in the process.

A Medicaid Eligibility Determination cannot be completed until an IPC Projection has been approved by DSHS. DSHS must provide notice of an approved IPC to HHSC within 45 days of submitting the Application or the Application will be placed on hold until the notice of an approved IPC has been received by HHSC.

2. DSHS YES Waiver Staff will notify the LMHA, within 72 hours or 3 business days, via replying to the LMHA's original email request when a final Medicaid eligibility determination has been made by HHSC.

Step 7: Obtain Consumer Choice Consent Form

1. The LMHA discusses all aspects of the Consumer Choice Consent Form with the individual and LAR, which includes:
 - a. Statement of Services Selection / Verification of Freedom of Choice (signatures required); and
 - b. Participant Agreement of Responsibilities (signatures required).
2. Individuals cannot be dually enrolled in other 1915(c) waivers and may not receive services from those programs if enrolled in the YES Waiver. These programs include, but are not limited to:
 - a. DADS Waiver programs such as CLASS, HCS, MDCP, CWP, DBMD, CBA, and TX Home Living; and
 - b. HHSC STAR+PLUS community-based Waiver.
3. If not already completed, the LMHA obtains a signed Notification of Participant Rights Form after reviewing the content of the form with the individual and LAR.

The Consumer Choice Consent Form must be returned to the LMHA documenting choice of participation in the YES Waiver within **10 calendar days** after receiving the Form. If the Consumer Choice Consent Form is not returned within 10 calendar days after receiving the Form, the LMHA may remove the individual from the Inquiry List.

Step 8: Select Waiver Provider

1. The LMHA assists the Waiver participant and LAR in the selection of a Waiver Provider and documents Waiver participant's choice of Waiver Provider by completing the Documentation of Provider Choice Form. The LMHA must:
 - a. provide a list of all approved Waiver Providers serving the Waiver participant's county of residence to the Waiver participant and the LAR;
 - b. provide all available written material and verbal information on each Waiver Provider to the Waiver participant and the LAR;
 - c. provide the Waiver participant and LAR with the selected Waiver Provider's location, contact information, and phone number; and
 - d. maintain a copy of the Documentation of Provider Choice Form within the Waiver participant's clinical record.
2. A Waiver Provider must be selected and documented on the Documentation of Provider Choice Form within **30 calendar days** after the individual and/or LAR has received the information regarding all Waiver Providers in the LMHA's service area.
3. LMHA coordinates referral to the Waiver Provider (when the Waiver Provider is not the LMHA) by preparing and submitting the Participant Referral Form to the selected Waiver Provider.
4. The Waiver participant, LAR, and other necessary parties sign consent to a Release of Information form that allows the LMHA and the selected Waiver

Provider to coordinate care and perform IPC monitoring functions. This consent is developed by the LMHA.

Step 9: Coordinate the Wraparound Treatment Planning Process and Develop the IPC

1. The Targeted Case Manager (TCM) leads the comprehensive Wraparound Treatment Planning Process with the members of the Treatment Team that includes, but is not limited to, the identification of goals and objectives, Safety Planning, Crisis Planning, and the development of the IPC, and ongoing monitoring of the IPC. IPC development includes:
 - a. The identification of types of YES Waiver services;
 - b. The identification annual quantity of YES Waiver services;
 - c. Calculations of annual cost for proposed services;
 - d. State Plan Services; and
 - e. Non-Waiver services (i.e. DSHS general revenue flexible funds).
2. The Targeted Case Manager coordinates the development of the Treatment Plan and IPC which shall include, but is not limited to, the following parties: the Waiver participant; LAR and/or family; and selected Waiver Provider.
3. The Targeted Case Manager monitors the Treatment Plan and the IPC, Waiver participant health and welfare, and assesses how well Waiver services are meeting the Waiver participant's needs and enabling the Waiver participant to achieve the stated goals and outcomes.
4. The Annual IPC Begin Date is the date the individual was initially authorized for the YES Waiver in CMBHS.
5. The Annual IPC End Date is the date one year from the Annual IPC Begin Date. Example: IPC Begin Date = 4/1/10, IPC End Date = 3/31/11.
6. The IPC Start Date (Prior-Auth) is identified by the LMHA on the IPC form, with the default being the date that the IPC is submitted to DSHS. If the start date of the revision is requested on a date *earlier* than the date the IPC was submitted, the LMHA must identify the reason for starting services prior to receiving approval from DSHS.

Step 10: Obtain IPC Approval

The LMHA obtains approval from DSHS for each Waiver participant's IPC.

1. The LMHA sends a completed IPC to DSHS YES Waiver Staff at the YES Waiver E-mail Address.
 - a. **The subject line must read:** IPC Approval Request (*insert participant's initial, XXXX and the last four digits of CARE ID number*).
 - b. The contents of the email must include the Individual Plan of Care Form. Electronic signatures are accepted; however the LMHA must maintain actual hardcopy signatures in the Waiver participant's clinical record.
2. The DSHS YES Waiver Staff receives the email request, conducts a review of the IPC internally, and communicates the result by replying to the LMHA's original email request within 5 business days.
 - a. **The subject line will read:** RE: IPC Approval Request (*insert participant's initials, XXXX and the last four digits of CARE ID number*).

- b. The contents of the email will state if the submitted IPC is approved by DSHS (Yes or No). If No, DSHS will provide a reason and the LMHA will respond with necessary information if applicable.
3. The IPC Effective Date is the date DSHS approves the IPC to be in effect, with the default being the IPC State Date (Prior-Auth). If the start date of the revision is requested on a date *earlier* than the date the IPC was submitted, the LMHA must identify the reason for starting services prior to receiving approval from DSHS. Examples include, but are not limited to, covering treatment planning time for IPC development or the critical need to provide services immediately to prevent a crisis.

Step 11: Begin YES Waiver Services

1. The Targeted Case Manager continuously monitors the Treatment Plan, IPC, Waiver participant health and welfare, and assesses how well Waiver services are meeting the Waiver participant's needs and enabling the Waiver participant to achieve the stated goals and outcomes.
2. The Targeted Case Manager must conduct 90 day CA-TRAG updates and reviews of the treatment plan.

Step 12: IPC Revisions

1. The Targeted Case Manager initiates updates to the IPC in coordination with the members of the Treatment Team.
2. The DSHS YES Waiver Staff receives the email request, conducts a review of the IPC internally, and communicates the result by replying to the LMHA's original email request within 5 business days.
The subject line will read: RE: IPC Revised Approval Request (*insert participant's initials, XXXX and the last four digits of CARE ID number*).
3. The contents of the email will state if the submitted IPC is approved by DSHS (Yes or No). If No, DSHS will provide a reason and the LMHA will respond with necessary information if applicable.
4. Mark the appropriate IPC Type: Revision
5. The Annual IPC Begin and End dates remain the same as on the initial / enrollment IPC.
6. The IPC Start Date (Prior-Auth) is identified by the LMHA on the IPC form, with the default being the date that the IPC is submitted to DSHS. If the start date of the revision is requested on a date *earlier* than the date the IPC was submitted, the LMHA must identify the reason for starting services prior to receiving approval from DSHS.
7. Signatures from the Waiver participant and / or LAR are required on IPC revisions when any changes to the types or amounts of services requested and approved are being made.
8. Follow "Obtain IPC Approval".

G. Freedom of Choice

1. Consumer Choice Consent

See Forms Section for the Consumer Choice Consent Form.

The Consumer Choice Consent Form documents the individual's selection of the YES Waiver providing they meet the eligibility requirements.

By choosing to participate in the YES Waiver and receive YES Waiver services, the Waiver participant is aware of the following:

- Medicaid State Plan services are available, while enrolled in the YES Waiver.
- The services received will be identified on the IPC.
- The expectation of services includes a minimal use of residential services.
- If determined to be a danger to self or others, and adequate safety cannot be assured in the community, they will be placed in a more restrictive setting.
- Of the freedom to choose a Waiver Provider. This includes choice of direct service staff that will provide YES Waiver services through the selected Waiver Provider.
- They and LAR are full and active members of the Treatment Team that will determine which services are received and that additional Treatment Team team members may be requested at any time.
- They will not be eligible to participate or receive services through Texas Recovery and Resiliency, or in another 1915(c) home and community-based waiver such as CLASS, HCS, MDCP, CWP, DBMD, CBA, TX Home Living, and HHSC STAR+PLUS.

The Consumer Choice Consent Form documents the individual's agreement to the following responsibilities:

- To be an active member of the Treatment Team and participate fully in the services identified on the IPC;
- The IPC will be reviewed and updated by the Treatment Team at least every 90 days and that modification of my IPC may occur at any time;
- They must continuously meet necessary demographic and financial eligibility criteria and failure to do so may result in termination from the program (clinical eligibility is determined upon initial enrollment to the YES Waiver and upon yearly assessment);
- To notify the LMHA and Waiver Provider of any changes to living arrangement or location of residence; and
- To notify the LMHA and Waiver Provider of any changes to financial status including personal income and resources (parental income is not counted). This includes receiving notification that Medicaid benefits are denied, will be denied, or requires additional information.

The Consumer Choice Consent Form must be returned to the LMHA documenting choice of participation in the YES Waiver within **10 calendar days** after receiving the Form. If the Consumer Choice Consent Form is not returned within 7 calendar days after receiving the Form, the LMHA may remove the individual from the Inquiry List.

2. Waiver Provider Selection

See Forms Section for the Documentation of Provider Choice Form.

The Waiver participant's choice of Waiver Provider is recorded on the Documentation of Provider Choice Form. The LMHA assists the Waiver participant and LAR in completion of this form.

The Documentation of Provider Choice Form must be updated at least annually.

The YES Waiver operates with a No Reject Policy. This means if a Waiver Provider is selected by a Waiver participant the Waiver Provider must ensure provision of the necessary services identified on the Waiver participant's IPC without delay.

Initial Selection

Waiver participants will select one Waiver Provider initially.

Change of Waiver Provider

At any time, a Waiver participant may choose to change their selection of Waiver Provider from whom they wish to receive services, if an alternative is available within their county of residence. The Waiver participant's right to choose their Waiver Provider extends to the specific Waiver Provider direct service staff that will be providing YES Waiver services. The Waiver participant's and LAR's selection of Waiver Provider personnel must be documented on the IPC, by the Targeted Case Manager, and retained in the Waiver participant's clinical record.

The Waiver participant may choose an additional or a new Waiver Provider (if more than one Waiver Provider is available in a county) if their selected Waiver Provider does not offer a particular type of service within a service category (ex. Music Therapy) that is identified as a needed service on the IPC. The Waiver participant may also choose an additional or a new Waiver Provider (if more than one Waiver Provider is available in a county) if their selected Waiver Provider does not have alternative direct service staff to choose from, in the event the Waiver participant is not satisfied with the current direct service staff.

➤ **Local Mental Health Authority**

Consumer Choice Consent Form

The Consumer Choice Consent Form is to be completed by the Waiver participant and/or LAR and LMHA representative. A Consumer Choice Consent Form must be obtained at least annually. When the Consumer Choice Consent Form is completed, it is filed in the Waiver participant's clinical record at the LMHA and a copy of the Form must be provided by the LMHA to the Waiver participant and LAR.

The LMHA provides the individual with information about:

- The types of institutional services available; and
- The services available through the YES Waiver.

Waiver Provider Selection

The LMHA maintains open communication and coordination with each Waiver Provider by obtaining appropriate written consent from each Waiver participant for the disclosure of protected health information or other sensitive personal information.

The LMHA will provide the Waiver participant and/or LAR with a list of all Waiver Providers within the county. This list will be provided annually when a Waiver participant is determined eligible based on re-evaluation for YES Waiver services and any time upon request of the Waiver participant and/or LAR. The selected Waiver Provider will provide all services in the Waiver service array. A choice of more than one Waiver Provider must be offered to the Waiver participant or LAR (if more than one Waiver Provider is available in a county). Initial selection of Waiver Provider on the Documentation of Provider Choice Form shall be filed in the Waiver participant's clinical record. A copy of the Documentation of Provider Choice Form must be provided to the individual/LAR once signed.

Once a Waiver Provider is selected by a Waiver participant, the Targeted Case Manager will complete the Participant Referral Form and will submit the referral to the selected Waiver Provider (if the Waiver Provider is not the LMHA). The Targeted Case Manager is responsible for contacting the selected Waiver Provider and involving Waiver Provider direct service staff in the development of a Waiver participant's IPC.

Change of Waiver Provider

When a Waiver participant chooses to change their selection of Waiver Provider, the Targeted Case Manager must obtain a revised Documentation of Provider Choice Form with the required signatures. When the Documentation of Provider Choice Form is completed or updated, it is filed in the Waiver participant's clinical record at the LMHA and a copy of the Form must be provided by the LMHA to the Waiver participant and LAR.

When the Waiver participant chooses a different Waiver Provider, a new Participant Referral Form must be completed by the Targeted Case Manager and sent to the newly selected Waiver Provider (if the Waiver Provider is not the LMHA) to notify them of the Waiver participant's selection. In addition, the LMHA must submit a revised IPC to the YES Waiver E-mail Address with the box "Transfer" marked and the new Waiver Provider's signature agreeing to provide all Waiver services listed on the IPC.

The Targeted Case Manager must inform DSHS and the Waiver Provider that is being unselected when a Waiver participant chooses a different Waiver Provider. The reason for the Waiver participant's change of Waiver Provider shall be documented in the Waiver participant's clinical record by the Targeted Case Manager.

➤ **Waiver Provider**

Waiver Providers set the limit of their capacity to serve Waiver Participants after entering into to a Waiver Provider Agreement with DSHS. Prior to accepting Waiver participants into services, Waiver Providers will inform DSHS of their capacity by emailing DSHS YES Waiver Staff at the YES Waiver E-mail Address and providing a specific number of Waiver participants they can serve. Waiver Providers may determine their capacity to serve Waiver participants by evaluating direct service staff resources, subcontractor staff resources, administrative staff resources and other characteristics. Waiver Providers do not have the ability to deny provision of service to any Waiver Participant, unless the Waiver Provider does not have the capacity to serve the Waiver Participant.

If a Waiver Provider determines their capacity to serve Waiver participants will increase or decrease, the Waiver Provider must provide advance or immediate notice to DSHS and the LMHA as soon as the determination is made.

The Waiver Provider maintains open communication and coordination with the LMHA through written consent (initiated by the LMHA) from each Waiver participant for the disclosure of protected health information or other sensitive personal information.

Waiver Provider Selection

The Waiver Provider will be notified of a Waiver participant's selection by the Targeted Case Manager submitting a Participant Referral Form to the Waiver Provider (if the Waiver Provider is not the LMHA). The Targeted Case Manger is responsible for contacting the Waiver Provider and involving Waiver Provider direct service staff, in the development of the Treatment Plan and IPC. The Waiver Provider must maintain a copy of the Participant Referral Form in the Waiver participant's clinical record.

Change of Waiver Provider

The Waiver Provider will be informed by the LMHA of a Waiver participant choosing a different Waiver Provider from which to receive Waiver services. The reason for the change of Waiver Provider shall be documented in the Waiver participant's clinical record.

➤ **Department of State Health Services**

DSHS will conduct periodic reviews to ensure that the LMHA objectively assists the Waiver participant and LAR in the process of selecting a Waiver Provider.

DSHS will post a current list of credentialed Waiver Providers online at <http://www.dshs.state.tx.us/mhsa/yes>. The list will include each Waiver Provider's contact information and other available information.

Change of Waiver Provider

DSHS will be made aware of a Waiver participant changing their selection of Waiver Provider by the LMHA submitting a revised Documentation of Provider Choice Form. In addition DSHS will also receive a revised IPC in via e-mail from the LMHA with the box “Transfer” marked and the new Waiver Provider’s signature agreeing to provide all Waiver services listed on the IPC.

H. Consumer Rights

See Forms Section for the Notification of Participant Rights Form.

1. Complaints

DSHS Consumer Services and Rights Protection Unit staff operates a toll free phone line with TTY (telecommunication device for the deaf) capabilities from 8:00am – 5:00pm Monday - Friday. Complaints can also be submitted via email or written correspondence.

- Complaints may be anonymous.
- There is no restriction on the types of complaints that Waiver participants may register.
- All complaints are acted upon immediately. Given the variety of complaints, there is no mandated time line for resolution to the complaint.
- Consumer Rights and Protection Staff have access to all departments and units to resolve the Waiver participant’s complaint.

Contact Information:

**Texas Department of State Health Services
Office of Consumer Services and Rights Protection
Mail Code 2019
P.O. Box 12668
Austin, TX 78711-2668**

**Toll Free Number: 1-800-252-8154
Local Number: 512-206-5760
Relay Texas, Voice: 1-800-735-2988
Relate Texas, TTY: 1-800-735-2989**

Complaints involving allegations of Abuse, Neglect and Exploitation are referred immediately to the Department of Family and Protective Services (DFPS) the department with statutory responsibility for investigation of such allegations.

HHSC's Office of the Ombudsman assists the public when DSHS' normal complaint process cannot or does not satisfactorily resolve an issue. The Waiver participant and their families also have the option of contacting the Office of the Ombudsman directly for assistance. The Ombudsman's services include:

- Conducting independent reviews of complaints concerning agency policies or practices;
- Ensuring policies and practices are consistent with the goals of HHSC;
- Ensuring Waiver participants are treated fairly, respectfully and with dignity; and
- Making referrals to other agencies as appropriate.

The process to assist with complaints and issues is as follows:

1. Member of the public, individual, or provider makes first contact with HHSC or with DSHS to request assistance with an issue or complaint.
2. If not able to resolve the issue or complaint, the Office of the Ombudsman may be contacted.
3. The Office of the Ombudsman will provide an impartial review of actions taken by the program or department.
4. The Office of the Ombudsman will seek a resolution and may use mediation if appropriate. Often it is necessary for the Office of the Ombudsman to refer an issue to the appropriate department. If so, the Office of the Ombudsman will:
 - Follow-up with the complainant to determine if a resolution has been achieved.
 - Refer complainant to other available known resources.

Contact Information:
Texas Health and Human Services Commission
Office of the Ombudsman
Mail Code: H-700
P. O. Box 85200
Austin, TX 78708

Phone: 877-787-8999
Fax: 512-706-7130 (not toll free)

E-mail: contact@hhsc.state.tx.us

2. Fair Hearings

In accordance with TAC §419.8 (YES - Right to Fair Hearing):

The LMHA must notify the child or adolescent, and LAR, of the right to a fair hearing, conducted in accordance with the rules in 1 TAC, Chapter 357, Subchapter A (relating to Uniform Fair Hearing Rules). The LMHA provides notification of the right to a fair

hearing through the Notification of Participant Rights Form, the Denial of Eligibility Letter, and the Participant Handbook and Provider Directory.

The conditions under which the individual and / or LAR may request a Fair Hearing include, but are not limited to:

1. An individual is denied participation in the YES Waiver, unless the reason for the denial is the program participation limit;
2. An individual is denied continued participation in the YES Waiver;
3. YES Waiver services for an individual are denied, reduced, suspended, or terminated; or
4. The individual's request for eligibility for the YES Waiver is not acted upon with reasonable promptness.

The individual (appellant) and LAR have the right to appeal within 90 days from, the date on the notice of agency action, or the effective date of the agency action, whichever is later. This date will be specified on the Denial of Eligibility Letter. Only the appellant or the appellant's authorized representative has the right to appeal and action by an agency. During the appeal process, the appellant has the right to receive continued benefits under the program if required by state or federal regulation or statute. The appellant must request continued benefits when requesting a Fair Hearing, if applicable. Individuals not currently enrolled may not request continued benefits.

Requests for a Fair Hearing must be made to DSHS' Office of Consumer Services and Rights Protection. An authorized representative of the appellant may make the request for a Fair Hearing by completing and mailing the form enclosed with the Denial of Eligibility Letter or by calling the Office of Consumer Services and Rights Protection. The DSHS Office of Consumer Services and Rights Protection will receive and enter the formal request for a Fair Hearing into the TIERS database and HHSC will provide notification of a scheduled hearing date no less than 14 days prior to the Fair Hearing. A decision by the Fair Hearing's officer must be made by 90 days from the date the appeal request is received. All Fair Hearings will be conducted according to the rules in TAC, Chapter 357, Subchapter A (relating to Uniform Fair Hearing Rules).

Once an appeal is filed, only the appellant or the appellant's representative may withdraw the request. The appellant must make the request in writing to the hearings officer or the local office and give the reason for requesting to withdrawal (1 TAC [§357.19\(c\)](#)).

Contact Information:

**Texas Department of State Health Services
Office of Consumer Services and Rights Protection
Mail Code 2019
P.O. Box 12668
Austin, TX 78711-2668**

Toll Free Number: 1-800-252-8154
Local Number: 512-206-5760
Relay Texas, Voice: 1-800-735-2988
Relate Texas, TTY: 1-800-735-2989

3. Abuse, Neglect, and Exploitation (ANE)

Cases of suspected ANE shall be reported by the LMHA/Waiver Provider to the appropriate investigative authority immediately, and within one business day after the allegation, a Client Abuse and Neglect Reporting form must be submitted to the Department of Family and Protective Services

The DSHS Child Abuse Screening, Documenting, and Reporting Policy for Contractors/Providers Revised Effective 1/1/2009, general reporting guidelines, and the Child Abuse Reporting Form (see Forms) are located at the following webpage:
http://www.dshs.state.tx.us/childabuserreporting/gsc_pol.shtm.

Reports of abuse or indecency with a child shall be made to:

- A. Texas Department of Family and Protective Services (DFPS):
 - 1. Texas Abuse Hotline at 1-800-252-5400 operated 24 hours a day, 7 seven days a week,
 - 2. by DFPS fax at 1-800-647-7410,
 - 3. online at <https://www.txabusehotline.org/Default.aspx>; or
- B. Any local or state law enforcement agency; or
- C. The state agency that operates, licenses, certifies, or registers the facility in which the alleged abuse occurred; or
- D. The agency designated by the court to be responsible for the protection of children.

When the alleged or suspected abuse involves a person responsible for the care, custody, or welfare of the child, the report must be made to DFPS.

DFPS receives allegations of ANE of Waiver participants from the LMHA and Waiver Provider. DFPS has investigative authority of allegations involving Waiver participants when the LMHA or an agent or subcontractor of the LMHA is the alleged perpetrator. DFPS also has investigative authority over all allegations involving Waiver participants if the alleged perpetrator is a parent or primary caregiver. Law enforcement has investigative authority if the alleged perpetrator is not a parent (and not an agent or contractor of the LMHA).

The LMHA and Waiver Provider shall comply with the provisions of state law as set forth in Chapter 261 of the Texas Family Code relating to reporting suspected child abuse and the provisions of DSHS policy (DSHS Child Abuse Screening, Documenting, and Reporting Policy for Contractors/Providers Revised Effective 1/1/2009). .

The LMHA and Waiver Providers shall develop, implement and enforce a written policy that includes at a minimum the DSHS Child Abuse Screening, Documenting, and Reporting Policy for Contractors/Providers and train all direct service staff on reporting requirements. Waiver Providers shall use the Child Abuse Reporting Form as required by DSHS. Waiver Providers shall retain reporting documentation on site and make it available for inspection by DSHS when requested. The LMHA and Waiver Providers shall submit a Critical Incident Reporting Form (see Forms) to DSHS YES waiver program within 72 hours of an alleged ANE report.

All contacts related to reporting of suspected ANE must be documented by all direct service staff. This documentation, at a minimum, shall include date of contact, name of member the report is being made on behalf of, brief synopsis of allegations, name of the DFPS employee taking the report.

State Hotline for Reporting Suspected ANE: 1-800-647-7418

DFPS Secure Website for Reporting Suspected ANE:

<http://www.txabusehotline.org/>

(This website is only for reporting situations that do not require an emergency response. It may take up to 24 hours to process a report made through the website.)

Emergency:

Call 911 or your local law enforcement

4. Critical Incident Reporting

LMHA's and Waiver Providers are required to report any critical incidents that result in substantial disruption of the program operation involving or potentially affecting Waiver participants within 72 hours of notification of an incident. (See Section H, item 3. for additional ANE reporting requirements).

The LMHA's and all Waiver Providers are required to complete a Critical Incident Report Form (see Forms) that includes, but is not limited to, the following information:

- Date, time, and location of incident;
- Client identifying or demographic information;
- Staff making report, witnesses, and associated contact information;
- Categories of Critical Incidents: ANE, Injury, Medical Emergency, Behavioral or Psychiatric Emergency (including psychiatric hospitalizations), Allegation against client rights, Criminal Activity, Death, Restraint, Medication Error, Client Departure (missing, runaway, attempted departure); and
- Detailed description of the incident.

➤ Local Mental Health Authority

The Local Mental Health Authority TCM is responsible for submitting all Critical Incident Reporting Forms to DSHS within 72 hours of notification of an incident, including those initiated by Waiver Providers. The LMHA TCM is responsible for re-submitting the form within 72 hours of notification of outcome of the incident with updated information. If psychiatric hospitalization (or other institutionalization) occurs, the LMHA TCM must update the Treatment Plan and submit a revised IPC to DSHS within 30 days of discharge.

➤ **Waiver Provider**

The Waiver Provider is responsible for submitting all Critical Incident Reporting Forms to the LMHA TCM within 72 hours of notification of an incident report. The LMHA TCM submits the form to DSHS, and the LMHA is responsible for resubmitting the form within 72 hours of notification of outcome of the incident with updated information. If psychiatric hospitalization (or other institutionalization) occurs, the LMHA TCM must update the Treatment Plan and submit a revised IPC to DSHS within 30 days of discharge.

Critical incident training for Waiver Provider direct service staff will be provided by the Waiver Provider.

In the case of critical incidents, Waiver Providers are expected to take immediate action to resolve, when feasible, and to report to the appropriate state and/or law enforcement entities.

➤ **Department of State Health Services**

DSHS is the agency that is responsible for overseeing the reporting of and response to critical incidents that affect Waiver participants. Critical incidents are managed as part of the contract oversight process by DSHS.

When reviews of the LMHA or Waiver Provider occur, critical incident reports are reviewed. DSHS will report data from critical incident reviews to HHSC on a quarterly basis.

➤ **Local Mental Health Authority**

Complaints

The LMHA (while reviewing the Notification of Participant Rights Form) will inform the Waiver participant and LAR of the contact information for DSHS Consumer Rights and Protection, DFPS, and the Office of the Ombudsman. The LMHA must also give this information to the Waiver participant and LAR when requested, and when a need is identified or thought to exist.

The LMHA informs the Waiver participant that filing a grievance or making a complaint is not a prerequisite or substitute for a Fair Hearing.

The Notification of Participants Rights Form must be updated annually.

Fair Hearings

The LMHA (while reviewing the Notification of Participant Rights Form) will inform the individual and LAR of the individual's right to a Fair Hearing regarding the YES Waiver. If the individual is denied YES Waiver services, the LMHA will provide a Denial of Eligibility Letter to the LAR stating the conditions under which the denial occurred. Included in this standardized letter is a form and instructions on how to request a Fair Hearing. The notice informs the youth as to the right to continue to receive services while the hearing is pending and the actions the youth must take for services to continue. The Denial of Eligibility Letter and accompanying request for Fair Hearing form is offered in both English and Spanish. The LMHA must maintain a copy of any Denial of Eligibility Letter in the Waiver participant's clinical record. The Targeted Case Manager shall assist the individual or LAR with the fair hearing process if needed, including the preparation and submission of documentation

Note: The LMHA does not complete and submit the historical form 4800. This form is now completed online by the Office of Consumer Services and Rights Protection once the request for Fair Hearing is received.

Abuse Neglect & Exploitation

For ANE reports, the LMHA and Waiver Provider are required to submit accurate and timely information to DSHS. The LMHA and Waiver Provider must report any incidents that result in substantial disruption of program operation involving or potentially affecting Waiver participants to DSHS YES Waiver Staff within 72 hours of notification on an incident, including allegations of ANE.

The Local Mental Health Authority TCM is responsible for submitting all Critical Incident Reporting Forms regarding ANE to DSHS within 72 hours of notification of ANE, including those initiated by Waiver Providers. The LMHA TCM is responsible for re-submitting the form within 72 hours of notification of outcome (if known) of an ANE report.

The LMHA (while reviewing the Notification of Participant Rights Form) will inform the individual and the LAR of the process for reporting allegations of ANE and the toll free number for DFPS.

The name, telephone number, and mailing address of the LMHA and Waiver Provider's rights protection officer must be prominently posted in every area that is frequented by Waiver participants. Waiver participants desiring to contact the rights protection officer must be allowed access to the LMHA and Waiver Provider's telephones to do so.

The LMHA and Waiver Providers are required to train staff on identifying, preventing, and reporting ANE in accordance with the DSHS Child Abuse Screening, Documenting, and Reporting Policy for Contractors/Providers Revised Effective 1/1/2009, located at: http://www.dshs.state.tx.us/childabusereporting/gsc_pol.shtm.

The LMHA and Waiver Provider will cooperate with and assist HHSC, DSHS, and any state or federal agency charged with the duty of identifying, investigating, sanctioning or prosecuting suspected fraud and abuse, including the Office of Inspector General at HHSC.

If the perpetrator or alleged perpetrator is an employee or agent of the LMHA or Waiver Provider, or the perpetrator is unknown, then the Administrator of the LMHA, or Waiver Provider, or their designee shall ensure that a Client Abuse and Neglect Reporting form is completed within 14 calendar days of the receipt of the investigative report or decision made after review or appeal using the CANRS Definitions and the CANRS Classifications. Within one working day after completion of the Client Abuse and Neglect Reporting form, the Administrator of the LMHA, or Waiver Provider, or their designee shall ensure that:

- the information contained in the completed Client Abuse and Neglect Reporting form is entered into the Client Abuse and Neglect Reporting System (CANRS); or
- if access to CANRS is unavailable, a copy of the completed Client Abuse and Neglect Reporting form is forwarded for data entry to the DSHS Office of Consumer Services and Rights Protection.

The LMHA or the Waiver Provider may not change a confirmed finding made by a DFPS investigator. The LMHA or the Waiver Provider may request a review of the finding or the methodology used to conduct the investigation.

➤ **Waiver Provider**

For ANE reports, the LMHA and Waiver Provider are required to submit accurate and timely information to DSHS. The LMHA and Waiver Provider must report any incidents that result in substantial disruption of program operation involving or potentially affecting Waiver participants to DSHS YES Waiver Staff within 72 hours of notification on an incident, including allegations of ANE.

The Waiver Provider is responsible for submitting all Critical Incident Reporting regarding ANE to the LMHA TCM within 72 hours of notification of an incident report. The LMHA TCM submits the form to DSHS, and the LMHA TCM is responsible for resubmitting the form within 72 hours of notification of outcome (if known) of the incident with updated information.

The LMHA and Waiver Providers are required to train staff on identifying, preventing, and reporting ANE in accordance with the DSHS Child Abuse Screening, Documenting, and Reporting Policy for Contractors/Providers Revised Effective 1/1/2009, located at: http://www.dshs.state.tx.us/childabusereporting/gsc_pol.shtm.

The LMHA and Waiver Provider will cooperate with and assist HHSC, DSHS, and any state or federal agency charged with the duty of identifying, investigating, sanctioning or prosecuting suspected fraud and abuse, including the Office of Inspector General at HHSC.

If the perpetrator or alleged perpetrator is an employee or agent of the LMHA or Waiver Provider, or the perpetrator is unknown, then the Administrator of the LMHA, or Waiver Provider, or their designee shall ensure that a Client Abuse and Neglect Reporting form is completed within 14 calendar days of the receipt of the investigative report or decision made after review or appeal using the CANRS Definitions and the CANRS Classifications. Within one working day after completion of the Client Abuse and Neglect Reporting form, the Administrator of the LMHA, or Waiver Provider, or their designee shall ensure that:

- the information contained in the completed Client Abuse and Neglect Reporting form is entered into the Client Abuse and Neglect Reporting System (CANRS); or

if access to CANRS is unavailable, a copy of the completed Client Abuse and Neglect Reporting form is forwarded for data entry to the DSHS Office of Consumer Services and Rights Protection.

The LMHA or the Waiver Provider may not change a confirmed finding made by a DFPS investigator. The LMHA or the Waiver Provider may request a review of the finding or the methodology used to conduct the investigation.

➤ **Department of State Health Services**

DSHS is the agency that is responsible for overseeing the reporting of and response to critical incidents that affect Waiver participants. Critical incidents are managed as part of the contract oversight process by DSHS. When reviews of the LMHA or Waiver Provider occur, critical incident reports are reviewed. DSHS will report data from critical incident reviews to HHSC on quarterly basis.

DSHS submits data quarterly to the Department of Family and Protective Services to ensure that all reports of ANE have been submitted to DSHS by the LMHA/Waiver Providers.

I. Treatment Planning Process

See Forms Section for the Individual Plan of Care Form.

See Waiver Participant Eligibility and Enrollment Process Flow for additional information.

The LMHA assigned Targeted Case Manager leads the Treatment Planning Process with the members of the Treatment Team that includes the identification of goals and objectives, Safety Planning, Crisis Planning, and the identification of types, quantities, and frequency of services. This process utilizes the National Wraparound Initiative for service delivery utilizing a strengths- based approach to address unmet needs across all life domains. The Waiver participant, LAR and additional family members (if applicable) are involved in all aspects of treatment planning.

The Treatment Planning Process incorporates information obtained from the Waiver participant and LAR regarding the Waiver participant's strengths, needs, natural supports, responsiveness to previous treatment, as well as preferences for and objections to specific treatment. The need for family education and support services related to the Waiver participant's serious emotional disturbance should also be addressed.

1. Treatment Team

The Treatment Team is composed, at a minimum of the Targeted Case Manager, Waiver Provider, LAR, and Waiver participant. The Treatment Team must include other individuals that are requested by the Waiver participant and LAR that agree to participate. The Treatment Team may include additional service providers, neighbors, clergy, and other individuals who currently do, or may in the future, provide support to the family to ensure that the Waiver participant's and family's needs, strengths, and preferences are taken into consideration. The Treatment Team will choose the services that will most support the Waiver participant's recovery goals specified in the treatment plan. The Targeted Case Manager, in coordination with the Treatment Team, assigns responsibility for completion of the action steps associated with each strategy.

2. National Wraparound Initiative

The National Wraparound Initiative has defined a set of ten principles about how family members, people in their support system, and service providers should work together to support the family or individual who needs assistance or coordination of services. These principles include family voice and choice, utilizes a team-based approach to service delivery, utilizes natural supports, is collaborative, is community-based and culturally and linguistically competent, is individualized, strength-based, unconditional, and outcome-based.

To effectively operationalize these principles, four key elements are necessary to ensure a high fidelity process and quality practice is occurring. These elements are:

1. Wraparound is grounded in a Strengths Perspective, which is a commitment to strength seeking, strength generating and strength building, of *all* participants used in all decision making and service delivery options.
2. Wraparound is driven by Underlying Needs, and the process is organized to meet needs rather than superficial or spoken needs. The team develops an understanding and construct responses to address the underlying causes of behavior or situations, therefore focusing on meeting needs rather than containing problems.
3. Wraparound is supported by an Effective Team Process, which is predicated on the notion that working together around common goals, objectives and team norms are likely to produce more effective outcomes.
4. Wraparound is Determined by Families, which means the family's perspective and opinions are first and able to influence

team decision making, families are supported to live in a community rather than a program, and it is about access, voice and ownership.

Wraparound utilizes the “Family’s Story” to obtain the family’s view from a variety of sources that elicit family possibilities, capabilities, interests and skills. The family’s view and the blending of perspectives from a variety of involved sources are heard and summarized in order to elicit the meaning behind a behavior or situation related to the family’s current situation, thus enabling the family and team to understand the underlying needs that will drive the development of the treatment plan..

This process focuses on the development of functional strengths and assets rather than the elimination of deficits. The approach is responsive to cultural issues and the family’s preferences and overarching goal for the individual. With this information, a Family Vision is constructed by the participant and family that describes how they wish things to be in the future, individually and as a family.

Consistent with the Wraparound approach, the Treatment Team prioritizes the individual’s top 3-5 needs. The Treatment Team develops goals and measurable outcomes for each prioritized need, and decides how each outcome will be measured. Outcome statements are chosen by the Waiver participant and LAR. Multiple strategies are generated and evaluated for the extent to which they will meet the prioritized need, achieve the measurable outcome, are community-based, are built on or incorporate strengths, and are consistent with the family’s values and culture. The selected strategies are based on the Waiver participant’s and LAR’s preferences.

3. Safety Plans and Crisis Plans

Waiver participants are at high risk of out of home placement for mental health treatment or are returning from such placements. Therefore, initial Safety Plans and Crisis Plans are developed at the first meeting with the family. Safety Plans and Crisis Plans are then expanded as needed and incorporated into the Treatment Plan with all team members knowing the roles they will play if/when crises arise. Crisis Plans must be individualized and include steps to take for a Waiver participant to access crisis services, if needed. Crisis Plans focus on planning for, predicting, and preventing a crisis situation from occurring. Safety Plans focus on the prevention of risky behavior and interventions needed for such behaviors. When developing Safety Plans, the safety of the Waiver participant and all other family members must be addressed to the satisfaction of all team members. This approach to crises helps prevent crises and ensures crises are addressed immediately. If the Waiver participant has transition issues, transition plans are also developed at the first meeting of the Treatment Team and incorporated into the Treatment Plan.

Individuals may be enrolled into the YES Waiver as long as identification of accessible crisis related services are included in the Treatment Plan developed by the members of the Treatment Team. This could include stabilization through Medicaid funded crisis or

emergency services (outside of the YES Waiver) such as mobile crisis outreach services, emergency departments, or psychiatric hospitals.

4. Individual Plan of Care

The IPC is a written plan that describes the YES Waiver services provided to the Waiver participant, and the Non-Waiver services and supports (regardless of funding source), including State Plan Services, that complements the YES Waiver services in meeting the needs of the Waiver Participant. The community-based services and supports received through the YES Waiver must address the individual's needs that arise as a result of their serious emotional disturbance. The IPC's for individuals with identified needs related to co-occurring diagnoses must include identified services and supports to meet those needs in the sections of the IPC designed for Non-Waiver Services.

The purpose of the Treatment Plan and IPC is to:

- promote the Waiver participant's inclusion into the community;
- protect the Waiver participant's health and welfare in the community;
- supplement, rather than replace, the Waiver participant's natural and other non-waiver program support systems and resources;
- prevent or reduce the likelihood of the Waiver participant's admission to an inpatient psychiatric facility; and
- identify the most appropriate type and amount of services to meet the Waiver participant's assessed risk factors, needs, and personal and family goals

The IPC is developed and updated jointly by the members of the Treatment Team and submitted to DSHS for approval. The IPC calculates the estimated annual cost for approved services, details the quantity of services per year, and helps determine if the requested services are within the approved cost limits.

The LMHA must:

- a. provide the Waiver participant and LAR with a copy of the IPC; and
- b. maintain a copy of the IPC within the Waiver participant clinical record.

The LMHA will inform the Waiver participant and LAR of the limits upon enrollment and will refer the Waiver participant to other community and state resources as needed.

The Treatment Plan including the IPC must be reviewed every 90 days or more frequently when necessary to assess the appropriateness and adequacy of the identified services, as Waiver participant needs change. The IPC must be reviewed and submitted to DSHS no less than every 90 days regardless of whether or not the review resulted in changes to the Treatment Plan or IPC. A current IPC must be in place for the Waiver Provider to bill for waiver services. Current IPCs are defined as those which have been updated and submitted to DSHS for approval within the past 90 days.

There may be circumstances in which it is imperative that a Waiver participant receive YES Waiver services immediately, prior to DSHS approving an IPC, to avoid a crisis situation. In this circumstance, the LMHA may provide State Plan Services and may also coordinate with the Waiver Provider to provide YES Waiver services. If a YES Waiver service is provided prior to DSHS approving the Waiver participant's IPC, the LMHA must identify the first date that the service(s) occurred and the reason for providing the service(s) prior to submitting the IPC for approval.

5. Individual Plan of Care Projection

The IPC Projection is only necessary when an individual is determined to not be currently eligible for Medicaid and needs to submit a financial application (See Eligibility and Enrollment Process). The LMHA completes an IPC Projection to document medical necessity. The anticipated IPC Start Date (Prior-Auth) of YES Waiver services should be within 30 days. The Annual IPC Begin Date and Annual IPC End Date are not required when submitting an IPC Projection.

The IPC Projection is an estimate of the YES Waiver services, Non-Waiver services, and State Plan Services that will be needed by a Waiver participant once enrolled. The IPC Projection is developed and updated jointly with the Waiver participant, LAR, and Targeted Case Manager and is submitted to DSHS for approval. The IPC Projection calculates annual cost for proposed services, details the quantity of services per year, and helps determine if the requested services are within the approved cost limits.

6. Individual Plan of Care Revisions

The Targeted Case Manager initiates updates to the IPC in coordination with the members of the Treatment Team. Modifications to quantity and/or type of services listed on a Waiver participant's IPC may occur. Reasons for this to occur include but are not limited to the following:

- Quantity of Service and/or Types of Service specified in the most recent IPC are no longer clinically appropriate for the Waiver participant;
- Quantity of Service and/or Types of Service are adjusted to meet the current treatment needs of the participant as identified by the Treatment Team;
- Change in selection of Waiver Provider – if a Waiver participant chooses to change their Waiver Provider, the newly selected Waiver Provider will have to sign the IPC and agree to provision of all Waiver services outlined on the IPC;
- Waiver participant ages out of services (an adolescent is no longer eligible upon their 19th birthday);
- Waiver participant's place of residence changes and is not within the geographic area of counties served by the YES Waiver;
- Waiver participant's place of residence changes to an institutional setting or the participant is no longer living with their LAR (if required);
- Waiver participant or LAR opts out of services; and

- Waiver participant frequently unable to keep appointments with the LMHA or the Waiver Provider such that it is negatively affecting treatment.

The LMHA and the Waiver Provider shall not modify, discontinue or refuse services to a Waiver participant unless documented efforts have been made with the Waiver participant and/or LAR to resolve the situation that triggers such modification or discontinuation or refusal to provide services.

7. Individual Plan of Care Dates

Annual IPC Begin Date

The Annual IPC Begin Date is the date the Waiver participant was initially authorized for the YES Waiver in CMBHS for the 12-month eligibility period. The Annual IPC Begin Date must match the initial LOC-A = Y date in CMBHS. The YES Waiver Authorization Date determines the Annual IPC Begin Date so that the annual authorization timeframe and Annual IPC begin and end dates are consistent. The Annual IPC Begin Date is not required when submitting an IPC Projection.

Annual IPC End Date

The Annual IPC End Date is the date one year from the Annual IPC Begin Date. Example: IPC Begin Date = 4/1/10, IPC End Date = 3/31/11. The Annual IPC End Date is not required when submitting an IPC Projection.

IPC Start Date (Prior-Auth)

The IPC Start Date (Prior-Auth) is identified by the LMHA on the IPC form, with the default being the date that the IPC is submitted to DSHS. If the start date of the revision is requested on a date *earlier* than the date the IPC was submitted, the LMHA must identify the reason for starting services prior to receiving approval from DSHS.

The IPC Start Date (Prior-Auth):

- Must be dated on or before actual date of service provision.
- May be dated prior to IPC Approval Date. If any YES Waiver or State Plan services were provided prior to IPC approval in circumstances where immediate service provision was clinically necessary or to allow for reimbursement of IPC development and Treatment Team meetings.
- Must be dated on or after the Medicaid Effective Date.

IPC Approval Date

The date DSHS approves the IPC.

IPC Effective Date

The IPC Effective Date is the date DSHS approves the IPC to be in effect, with the default being the IPC State Date (Prior-Auth).

➤ **Local Mental Health Authority**

The Targeted Case Manager has the ultimate responsibility for Treatment Planning, IPC Development, and the IPC Projection. The Targeted Case Manager has the responsibility of coordinating the agreed upon services and supports identified on a Waiver participant's treatment plan and IPC. The Targeted Case Manager must monitor compliance to the overall treatment plan including the IPC, Waiver participant health and welfare, and assess how well services are meeting a Waiver participant's needs and enabling the Waiver participant to achieve the stated goals and outcomes. The Targeted Case Manager initiates updates to the IPC in coordination with the Treatment Team.

The LMHA coordinates treatment planning by contacting the selected Waiver Provider and scheduling a meeting location, date and time.

The Targeted Case Manager and Waiver Provider must include information obtained from the Waiver participant and the LAR regarding the Waiver participant's strengths, needs, natural supports, responsiveness to previous treatment, as well as preferences for and objections to specific treatment. The Targeted Case Manager must also identify the LAR or family member's needs for education and support services related to the Waiver participant's emotional disturbance and facilitate the LAR or family member's receipt of the needed education and support services. The Targeted Case Manager and Waiver Provider must involve the Waiver participant and the LAR in all aspects of planning the Waiver participant's treatment. If the Waiver participant has requested the involvement of additional team members, then the Targeted Case Manager and Waiver Provider must involve the specified person who agrees to participate, in all aspects of planning the Waiver participant's treatment.

The Targeted Case Manager will provide TCM at the intensive level. For example, the average expected utilization of intensive case management under TRR is 18.75 hours per every 90 days. Per the TCM standards, the Case Manager and Treatment Team must meet in person with the Waiver participant at least once every 90 days. The Case Manager shall make contact with the Waiver participant's LAR no less than once every 90 days. At least once every 90 days, or more frequently if clinically indicated, the Targeted Case Manager must review each Waiver participant's Treatment Plan and IPC to assess the appropriateness and adequacy of the services as each Waiver participant's needs change. An updated IPC must be submitted to DSHS for approval at least every 90 days. The purpose of the required contacts is to verify the following:

- the Safety Plan and Crisis Plan is working as intended;
- services and supports are being implemented and provided in accordance with the IPC and continue to meet the Waiver recipient's needs, goals, and preferences;

- the Waiver participant and LAR are satisfied with the implementation of services;
- the Waiver participant's health and welfare are reasonably assured; and
- the Waiver participant or LAR exercises free choice of Waiver Providers and accesses Non-Waiver services including health services.

The LMHA will provide oversight to the Targeted Case Manager's efforts ensuring that the required contacts occur, modifications to the IPC occur as necessary, and that the documentation generated by the Targeted Case Manager provides evidence of compliance with the requirements.

The Targeted Case Manager and Waiver Provider will identify on the Treatment Plan any necessary contingency plans to ensure provision of YES Waiver services. The name and contact information for an alternate Targeted Case Manager must be identified and recorded on the IPC.

Case management functions are delivered under State Plan Services as a Targeted Case Management service by the Targeted Case Manager at the intensive level.

The LMHA must maintain a copy of the IPC and the IPC Projection (if applicable) within the Waiver participant's clinical record.

➤ **Waiver Provider**

Upon selection of the Waiver Provider by Waiver participant and/or LAR, the Waiver Provider will be contacted by the LMHA to meet and participate in the development of the IPC and participate in the treatment planning process. The Waiver Provider shall ensure that each direct service staff receives a copy of the Treatment Plan.

The Waiver Provider must maintain a copy of the IPC within the Waiver participant's clinical record.

➤ **Department of State Health Services**

DSHS conducts a review of each IPC prior to approving. If the IPC is denied, DSHS will provide the LMHA with justification of the denial and the LMHA will submit a revision for further consideration.

DSHS approves all criteria, processes, and documentation requirements related to the IPC.

<p>J. Service Provision</p>

All YES Waiver services, Non-Waiver Services, and State Plan Services shall be identified during the treatment planning process on the Individual Plan of Care Form.

All YES Waiver services must be prior authorized by DSHS. YES Waiver services shall be provided in accordance with the Waiver participant's approved IPC.

1. YES Waiver Service Array

See Appendix A for YES Waiver Service Codes, Descriptions, and Provider Qualifications.

The community-based services and supports received through the YES Waiver must address the individual's needs that arise as a result of their serious emotional disturbance.

The YES Waiver service array includes:

- Respite (In-Home and Out-Of-Home)*
- Adaptive Aids and Supports
- Community Living Supports
- Family Supports
- Minor Home Modifications
- Non-Medical Transportation
- Paraprofessional Services
- Specialized Therapies (Animal Assisted Therapy, Art Therapy, Music Therapy, Recreational Therapy, Nutritional Counseling)*
- Supportive Family-based Alternatives Transitional Services

Pre-Engagement Service (LMHA only)

*The types or locations of Respite and types of Specialized Therapies available may vary depending on which Waiver Provider is selected.

Individuals may be enrolled into the Waiver as long as identification of accessible crisis related services are included in the Treatment Plan developed by the LMHA in collaboration with the Waiver Provider, Waiver participant, LAR and other identified members of the Treatment Team. This could include stabilization through Medicaid funded crisis or emergency services (outside of the Waiver) such as mobile crisis outreach services, emergency departments, or psychiatric hospitals.

Waiver Provider shall provide all YES Waiver services directly or indirectly by establishing and managing a network of Subcontractors. The Waiver Provider has the ultimate responsibility to comply with the Waiver Provider Agreement and the Manual regardless of whether Waiver Provider provides services directly or through Subcontractors.

2. Case Management

Case management functions must be delivered under State Plan Services as a TCM service by the Targeted Case Manager at the intensive level.

The Targeted Case Manager monitors the IPC, Treatment Plan, including Waiver participant health and welfare, and assesses how well Waiver services are meeting the Waiver participant's needs and enabling the Waiver participant to achieve the stated goals and outcomes.

3. State Plan Services

Waiver participants are also covered under the Medicaid State Plan. State Plan Services include but are not limited to:

- Psychiatric Evaluation
- Psychological Services
- Counseling
- Rehabilitative Services
- Crisis Services
- Other State Plan Services

Waiver Providers may provide State Plan Services if they are a credentialed Medicaid Provider with a Medicaid Provider ID number. The Waiver participant may choose their provider of State Plan Services and the chosen provider is identified on the IPC.

4. Flexible Funds – DSHS General Revenue

DSHS approves the use of Flexible Funding (Flex Funds) for individuals authorized for the Youth Empowerment Services (YES) Waiver in accordance with the following guidelines:

- The source and amount of the Flex Funds will remain in accordance with the Local Mental Health Authority's (LMHA) current allocation and future allocations as they are granted. The LMHA will not receive an increase in funding for the purpose of using Flex Funds for individuals served under the YES Waiver.
- The LMHA will follow the same requirements and guidelines that exist regarding the use and reporting of Flex Funds for Texas Recovery and Resiliency, including but not limited to the requirements and guidelines outlined within the Performance Contract, the Performance Contract Notebook Attachment, Information Item D, Information Item G, the TRR Utilization Management Guidelines, and the DSHS Community Mental Health Service Array.
- All services provided with Flex Funds must be identified on YES Waiver participant's Individual Plans of Care (IPCs) for review and prior-approval by DSHS. DSHS will review to ensure that the indicated service does not fall within the scope of the YES Waiver service array before approving. Services shall be documented on the IPC under the "Non-Waiver Services – Services Provided by Other Funding Sources" section with Specific Type of Service (i.e. Tutoring), Name of Provider, and Funding Source (i.e. DSHS Flex Funds) completed by the LMHA.

5. DADS Funded Supported Services

Individuals may continue to receive Supported Services funded by the Department of Aging and Disability Services (DADS) while enrolled in the YES Waiver.

6. Service Rates

The published rates are available on the HHSC Rates Analysis for Long-Term Care Services website at <http://www.hhsc.state.tx.us/rad/long-term-svcs/yes/index.shtml>

Room and board are not included in the YES Waiver service array and is the responsibility of the Waiver participant except where room and board are provided under the Waiver as part of out-of-home respite.

7. Participant Termination of Services

A Waiver participant shall be terminated from the YES Waiver when one of the following occurs:

- The Waiver participant no longer meets eligibility criteria for YES Waiver services upon re-evaluation;
- The Waiver participant no longer resides in a county included in the service areas (Travis, Bexar or Tarrant Counties);
- The LMHA can no longer certify that the quality and quantity of services and supports provided are able to meet the needs of the Waiver participant in the home or community;
- The cost of services and supports provided in the home or community exceeds the cost neutrality guidelines of the YES Waiver;
- The Waiver participant turns nineteen (19) years of age;
- The Waiver participant and/or LAR chooses hospital or institutionalization services rather than the YES Waiver;
- The Waiver participant and/or LAR chooses to discontinue participation in the YES Waiver;
- The Waiver participant and/or LAR has chosen not to receive a waiver service or have not responded to requests to contact the LMHA regarding waiver services for 90 consecutive days; or
- The Waiver participant expires.

➤ **Local Mental Health Authority Service Array**

The LMHA will provide TCM and may provide other State Plan Services to Waiver participants that are identified on a Waiver participant's approved IPC.

The LMHA may provide YES Waiver services, if the LMHA has entered a Waiver Provider Agreement with DSHS. For guidance on the LMHA providing Waiver services, see information under the Waiver Provider for this topic.

Participant Termination of Services

When an individual terminates from the YES Waiver, a revised IPC shall be submitted to the YES Waiver E-mail Address with the box “Eligibility Termination” marked and a reason for termination described.

The LMHA notifies the Waiver Provider and DSHS of a Waiver participant terminating out of the YES Waiver.

The Targeted Case Manager must inform the Waiver participant and/or the LAR in writing of the termination from the YES Waiver. The reason for termination and all agency referrals shall be documented in the Waiver participant's clinical record.

The LMHA and the Waiver Provider shall not modify, discontinue or refuse services to a Waiver participant unless documented efforts have been made with the Waiver participant and LAR to resolve the situation that triggers such modification or discontinuation or refusal to provide services.

➤ **Waiver Provider
Service Array**

Waiver Providers are required to provide all YES Waiver services either directly or indirectly through subcontract arrangements.

The Waiver Provider is responsible for the provision of all YES Waiver services and service quantities detailed on the IPC, including those provided through subcontract arrangements.

A Waiver Provider may provide State Plan Services to a Waiver participant in accordance with the approved IPC if the Waiver Provider has a Medicaid Provider Identification number and can bill TMHP directly for the provision of State Plan Services. The Waiver participant is entitled to a choice of provider for State Plan Services (except for TCM and Rehabilitative services).

After the provision of any respite services, in which a relative is the direct service staff, the Waiver Provider must have the LAR sign the Respite Relative Provider Form indicating the date(s), time, and duration of the provision of the respite services. The Respite Relative Provider Form will also include a statement as to the location of service provision (e.g., relative’s home, waiver recipient’s home). The Waiver Provider must maintain the Respite Relative Provider Form in the Waiver participant’s clinical record.

Documentation requirements for the provision of Non-Medical Transportation include:

- Date of Contact,
- Mileage log with Start and Stop Time,
- Printed name of service provider, and
- Signature and credentials of service provider.

A Transportation Log Template has been provided in the Forms Section for the documentation requirements of Non-Medical Transportation. The Waiver Provider must maintain Transportation Log or an alternative mileage log in the Waiver participant's clinical record.

Waiver Providers are responsible for the administration of medications to Waiver participants who cannot self-administer and/or have responsibility to oversee Waiver participant self-administration of medications.

Participant Termination of Services

The Waiver Provider will be informed by the LMHA of a Waiver participant terminating from YES Waiver services.

The reason for termination and all agency referrals shall be documented in the Waiver participant's clinical record.

The LMHA and the Waiver Provider shall not modify, discontinue or refuse services to a Waiver participant unless documented efforts have been made with the Waiver participant and LAR to resolve the situation that triggers such modification or discontinuation or refusal to provide services.

➤ **Department of State Health Services**

Service Array

DSHS does not provide YES Waiver services.

DSHS monitors the utilization of YES Waiver services through the approved IPC and Encounter Data (See Section 3.L. for more information).

Participant Termination of Services

DSHS will be made aware of Waiver participants terminating from YES Waiver services by the LMHA submittal of a Waiver participant's updated IPC that is marked as "Eligibility Termination".

K. Transitioning

1. Adolescents Aging Out

A Waiver participant will age out of the YES Waiver at the end of the month prior to the month of the Waiver participant's 19th birthday. For example: if an adolescent's 19th birthday is April 3rd, YES Waiver services end on March 31st. If an adolescent's 19th birthday is April 29th, YES Waiver services end on March 31st.

2. Waiver Provider Agreement Termination

If the Waiver Provider Agreement is terminated between a Waiver Provider and DSHS, all Waiver participants that Waiver Provider is serving must be appropriately transitioned to another Waiver Provider (if available) prior to the termination.

➤ **Local Mental Health Authority**

Adolescents Aging Out

The LMHA, under its agreement with HHSC and DSHS will be required to ensure that adolescents who turn 19 while in services are transitioned to adult services at least six months before their 19th birthday. A transition plan must be developed in consultation with the Waiver participant, the LAR, current Waiver Provider, and the future providers with adequate time to allow both current and future providers to transition the adolescent into adult services without a disruption in services.

The transition plan must include:

1. a summary of the mental health community services and treatment the adolescent received as a Waiver participant,
2. the Waiver participant's current status (e.g., diagnosis, medications, level of functioning) and unmet needs,
3. information from the Waiver participant & the LAR regarding the Waiver participant's strengths, preferences for mental health community services, and responsiveness to past interventions, and
4. a plan of care that indicates the mental health and other community services the Waiver participant will receive as an adult and allows for the Waiver participant's continuity of services without disruption.

The LMHA notifies the Waiver Provider and DSHS of a Waiver participant transitioning out of the YES Waiver. A transition plan must be submitted to DSHS at least 30 days prior to termination of the participant from the Waiver.

When an adolescent transitions out of the YES Waiver, a revised IPC shall be submitted to DSHS with the box "Eligibility Termination" and a reason for termination.

Waiver Provider Agreement Termination

If the Waiver Provider Agreement is terminated between a Waiver Provider and DSHS, Waiver participants must choose another Waiver Provider to receive services from. Refer to the Consumer Choice Section in this Manual on specific details for transferring a Waiver participant from one Waiver Provider to another.

➤ **Waiver Provider**

Adolescents Aging Out

The Waiver Provider will be informed by the LMHA of a Waiver participant transitioning out of YES Waiver services. The Waiver Provider participates in developing the transition plan and follows the plan to transition the Waiver participant out of services.

Waiver Provider Agreement Termination

If the Waiver Provider Agreement is terminated between a Waiver Provider and DSHS, Waiver participants must choose another Waiver Provider to receive services from. Refer to the Consumer Choice Section on specific details for transferring a Waiver participant from one Waiver Provider to another.

➤ **Department of State Health Services**

Adolescents Aging Out

DSHS will review and approve the IPC termination.

Waiver Provider Agreement Termination

DSHS will be aware of any potential terminations of Waiver Provider Agreements because DSHS holds agreements with all Waiver Providers. DSHS will receive an updated IPC from the LMHA notating the transfer.

L. Transfers

When a participant and his/her LAR relocate to a county within Texas that is served by the YES Waiver, the participant remains eligible for the waiver. However, if the participant and his/her LAR move to a county where the YES waiver is not available, the participant is no longer eligible for the waiver and must be terminated.

Local Mental Health Authority

The LMHA in which the participant presently resides is responsible for the coordination of the transfer activities to another LMHA coordinating YES waiver services. The LMHA initiating the transfer of the participant must do all of the following:

- Immediately contact DSHS YES waiver staff by encrypted email to the DSHS YES Waiver mailbox with the expected date of transfer and destination of the transfer;
- Obtain a release of information from the family within five working days to facilitate communication and coordination with the new LMHA;
- Contact the new LMHA where the family will reside to inform them of the impending transfer;
- Prepare a packet of information to forward to the new LMHA. This packet must contain a copy of the Clinical Eligibility Form, the current Treatment Plan and IPC, current CA-TRAG assessment, Medicaid card, progress notes, and any other information pertinent to participant's service delivery;
- Periodically check to ensure the transfer process is proceeding;
- Contact DSHS YES waiver staff by encrypted email to the DSHS YES Waiver mailbox within five working days confirming the actual date of the participant's transfer and their last date of services in that county; and
- Submit a Revised IPC to DSHS marked Transfer and the reason (transferring to XXXX County) for the transfer noted once the transfer has been completed.

The LMHA at the new LMHA must do all of the following:

- Review the transfer packet;
- Contact the family and schedule a meeting
- Identify the Treatment Team

- Work with the Treatment Team to determine if current Treatment Plan will be adopted as written, revised or a new Plan will be developed;
- Submit a Revised IPC to DSHS based on the adopted, revised or new Treatment Plan, marked Transfer and the reason (transferred from XXXX County) for the transfer; and
- Complete a CA-TRAG if necessary (90 day update; annual renewal).

M. Encounter Data Reporting

See Forms Section for the Encounter and Invoicing Template and detailed instructions. The encountering system and invoicing system are linked together in one Excel workbook.

➤ **Local Mental Health Authority**

YES Waiver Service Reporting

When the LMHA is a Waiver Provider, the LMHA shall submit to DSHS, a monthly encounter data report that includes all YES Waiver service encounters for that specific month, using the Encounter and Invoicing Template with the monthly invoice. A month is defined as the first day of a calendar month to the last day of a calendar month. Submission of invoice occurs no later than 5:00pm (Central Standard Time) the 15th calendar day of each month for the previous month. The monthly encounter report shall be submitted via HIPAA compliant encrypted email to the Encounter & Invoicing E-mail Address or uploaded to the LMHA's secure Sharepoint website that is maintained by DSHS.

Pre-Engagement Service Reporting

The LMHA shall submit to DSHS, a monthly encounter data report for any Pre-Engagement Service billing for that specific month, using the Encounter and Invoicing Template, Pre-Engagement Encounter Data sheet. A month is defined as the first day of a calendar month to the last day of a calendar month. Submission of invoice occurs no later than 5:00pm (Central Standard Time) the 15th calendar day of each month for the previous month. The encounter report shall be submitted via HIPAA compliant encrypted email to the Encounter & Invoicing E-mail Address or uploaded to the LMHA's secure Sharepoint website that is maintained by DSHS.

State Plan Service, other Non-Waiver services, and Assessment Reporting

The LMHA shall submit encounter data to the Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW) for all Non-Waiver services provided by the LMHA (i.e. State Plan Services, uniform assessment intakes and updates, services funded through flexible funds) including all required data fields and values in the current version of the DSHS Community Mental Health Service Array. The current version of DSHS Community Mental Health Service Array (i.e., Report Name: INFO Mental Health Service Array Combined) can be found in the MBOW in the General Warehouse Information, Specifications subfolder.

The number of Waiver participants will be factored into the LMHA's calculation of Children's Service Targets in accordance with the YES Waiver Special Provision of the LMHA's Performance Contract with DSHS.

➤ **Waiver Provider**

YES Waiver Service Reporting

Submit to DSHS, a cumulative monthly encounter data report that includes all YES Waiver service encounters, using the Encounter and Invoicing Template or an alternative report format with prior approval of DSHS, no later than the 15th of each month for the previous month. A month is defined as the first day of a calendar month to the last day of a calendar month. The monthly encounter report shall be submitted via HIPAA compliant encrypted email to the Encounter & Invoicing E-mail Address. The Waiver Provider must have prior approval by DSHS to submit the encounter report through a method other than encrypted email.

State Plan Service Reporting

A Waiver Provider may provide State Plan Services to a Waiver participant in accordance with the approved IPC if the Waiver Provider has a Medicaid Provider Identification number. A Waiver Provider, who is not the LMHA, does not submit encounters for State Plan Services to DSHS. A Waiver Provider, who is not the LMHA, shall coordinate encounter data reports with the LMHA that summarize all State Plan service encounters for the purpose of coordinating and monitoring the Waiver participants' IPCs.

➤ **Department of State Health Services**

DSHS receives all YES Waiver encounter data reports from the LMHA and Waiver Provider. DSHS conducts quality checks on the YES Waiver encounter data for accuracy and completeness, and reviews the amounts against approved limits on the IPC.

DSHS will provide a cumulative report to the LMHA with YES Waiver Service encounter data for each Waiver participant upon receipt of monthly submission from the Waiver Provider. When the Waiver Provider is the LMHA, DSHS will not submit encounter data reports to the LMHA because the LMHA will already have access to the information.

DSHS may collect any needed encounter data information from the LMHA and Waiver Provider by accessing other data sources such as MBOW and TMHP, or requesting records from the LMHA and Waiver Provider.

N. Billing Guidelines

See Appendix E for Billing Guidelines for each YES Waiver service.

Services provided without prior authorization are subject to non-payment.

Room and board is not included in the YES Waiver service array and is the responsibility of the Waiver participant except where room and board are provided under the Waiver as part of out-of-home respite.

1. Schedule of Billable Events

15-minute units

- The entire unit must be provided.
- Must be face to face.

Daily units

- The entire unit is billed when this service is provided for a 24-hour time period or any portion of time during that 24-hour period.
- Must be face to face (not applicable to Supportive Family-based Alternatives or the Child Placing Agency rate for DFPS Residential Child Care Out-of-Home Respite).

Hourly units

- Partial units are billable in ¼ increments according to the schedule below.
- The entire 15 minute increment must be provided.
- Must be face to face.

Billing Partial Units (hourly services)

15 minutes of service = unit (.25)

30 minutes = unit (.5)

45 minutes = unit (.75)

60 minutes = 1 unit (1.0)

Mileage

- For Non-Medical Transportation round mileage to nearest whole mile (up or down) using the following rounding rule:
 - .01-.49 ROUND DOWN
 - .50-.99 ROUND UP
- For reimbursement of bus passes or cab vouchers divide the cost of the pass or voucher by the mileage reimbursement rate to calculate miles for encounter reporting purposes. Indicate on IPC if bus pass or cab voucher will be or has been used and document receipt of such pass or voucher in Waiver participant's clinical record. For example: Cost of bus pass is \$10.00 / \$0.55 = 18 miles.
- Must be face to face.

Total Cost

- Round calculations of total cost to two decimal places (\$.xx) using the following rounding rule:
 - .01-.49 ROUND DOWN
 - .50-.99 ROUND UP

Transportation Time by Service Provider

Waiver Providers and direct service staff may not bill for service time spent transporting a Waiver participant. All transportation funded by the Waiver shall be billed in accordance with the Non-Medical Transportation service and the schedule of billable events for mileage.

Group Services

The following services may be provided in a group setting if identified as clinically appropriate by the Treatment Team and in accordance with the approved IPC. Groups may consist of no more than 6 individuals (excluding service providers). Multiple service providers of the same service component may perform an activity at the same time for the same individual if multiple service providers are needed to perform the activity (must be documented and approved on IPC).

- Community Living Supports
- Family Supports
- Paraprofessional Services
- Specialized Therapies

Formula: Group Services Billable Events

Use the following formula to calculate the billable units. One unit = 15 minutes. The entire unit must be provided. If the Billable time is between 15-minute increments, Waiver Providers must bill for the number of entire units provided (round down). The billable units per participant may be partial units according to the formula. The basic formula is:

Number of direct service staff	×	time spent delivering services	=	Billable Units	÷	number of Waiver participants served	=	Billable units per Waiver participant
Examples								
1 provider	×	60 minutes	=	4	÷	1	=	4
1 provider	×	50 minutes	=	3	÷	2	=	1.5
1 provider	×	60 minutes	=	4	÷	3	=	1.3
2 providers	×	60 minutes	=	8	÷	3	=	2.6

Example: CLS - Bachelors Level

1 direct service staff and 5 Waiver participants served for 90 minutes

1 direct service staff X 90 minutes = 6 units

6 units ÷ 5 Waiver participants = 1.2 billable units per Waiver participant

1.2 billable units per Waiver participant X rate (\$7.14) = \$8.57 billable per Waiver participant

Note: The group services billable events refers to one service provided by one or more direct service staff to more than one Waiver participant.

Respite

The full respite rate is billed for each Waiver participant in a respite setting in accordance with the billable event guidelines and limitations above. The number of individuals in a respite setting shall be in accordance with associated licensure (if applicable) or other standards and account for the individual needs of each Waiver participant.

Participation in Treatment Planning / IPC Development Meetings

The Waiver Provider may bill the following services when qualified direct service staff participate in Treatment Planning and IPC development / maintenance meetings when the Waiver participant has an identified need for the service:

- Community Living Supports,
- Family Supports, and
- Paraprofessional Services.

Multiple Services

Only one Waiver service can be provided at a time.

Exceptions:

- A qualified Community Living Supports, Family Supports, and Paraprofessional direct service staff may be present and bill for time providing service as a part of the treatment planning and IPC development / maintenance meetings when the Waiver participant has an identified need for the service.
- Family Support services may be provided to the primary caregivers while the Waiver participant is receiving another Waiver service.
- Other exceptions will be considered on a case by case basis and requests must be submitted to DSHS for approval. The request for exception can be submitted with the IPC. There must be a documented legitimate rationale of clinical need for more than one service to occur. Documentation must identify that the services being provided are non-duplicative.

2. Service Rates and Requisition Fees

Services with No Requisition Fee

For all services that do not have an associated requisition fee, the administrative portion of the rate is already included in the service rate. The Waiver Provider may negotiate payment to employees / subcontractors for these services.

- Community Living Supports,
- Family Supports,

- Paraprofessional services
- Supportive Family-based Alternatives
- Respite (except for Camp setting and DFPS Residential Child Care setting - Mandated Family Rate)
- Non-Medical Transportation
- Professional Service-Nutritional Counseling

Ceiling Per Hour

DSHS will directly reimburse the Waiver Provider for the amount up to the rate ceiling. The Waiver Provider may negotiate payment to employees / subcontractors.

- Respite - Camp

Mandated Family Rate (DFPS Residential Child Care Respite and Supportive Family-based Alternatives)

DSHS will directly reimburse the Waiver Provider for the Mandated Family Rate amount for each service. The Waiver Provider must provide the entire Mandated Family Rate to the family providing the service. The administrative portion for these service categories is included in the Child Placing Agency rate, and the Waiver Provider may negotiate this rate with direct service providers / subcontractors.

Services with Requisition Fee

The requisition fee is the administrative portion of the rate. The Waiver Provider bills for and retains the requisition fee associated with the provision of the following services.

The Waiver Provider bills for the total cost per identified support / modification.

- Minor Home Modifications
- Adaptive Aids and Supports
- Transitional Services (one-time fee per Waiver participant)

Ceiling Per Hour

The following Specialized Therapies have a rate ceiling per unit for the actual direct service cost. The Waiver Provider bills for the actual direct service cost, up to the rate ceiling.

- Art Therapy
- Animal Assisted Therapy
- Recreational Therapy
- Music Therapy

3. Pre-Engagement Service

➤ **Local Mental Health Authority**

Purpose

The pre- engagement fee provides reimbursement for those services provided in an effort to enroll clients onto the waiver who are not Medicaid-eligible or who become Medicaid-eligible because the client enrolls in the waiver under the special home and community-based waiver group under Title 42 of the Code of Federal Regulations, Part 435, Section 217 with a special income level up to 300% of the SSI Federal Benefit Rate. This is a one-time billable fee.

Eligibility for the Pre- Engagement Fee

This fee can only be billed in the following instances:

- The LMHA, in an effort to determine if a client is eligible for the waiver, provides case management services to a potential waiver client who becomes Medicaid-eligible only because the **client enrolls** in the waiver under the special home and community-based waiver group under Title 42 of the Code of Federal Regulations, Part 435, Section 217 with a special income level up to 300% of the SSI Federal Benefit Rate. Case management services may refer to assessments, child and family contacts, assistance obtaining paperwork necessary for determining Medicaid eligibility, development of the IPC Projection, and any other services necessary for waiver eligibility and enrollment.
- The LMHA, in an effort to determine if a client is eligible for the waiver, provides case management services to a non-Medicaid eligible potential waiver client **and the client does not enroll**. Case management services may refer to assessments, child and family contacts, assistance obtaining paperwork necessary for determining Medicaid eligibility, development of the IPC Projection, and any other services necessary for waiver eligibility and enrollment.

At a minimum, a Clinical Eligibility assessment must be completed for all potential waiver clients in order to bill for the Pre- Engagement Fee. If the individual decides not to enroll in the waiver, documentation of all contacts, services provided, and the Clinical Eligibility form should be kept in the individual's paper or electronic chart to be reviewed during an annual site review.

Billing for the Pre- Engagement Fee

Billing for the pre- engagement fee should be submitted monthly using the Pre- Engagement Encounter Data tab of the Encounters and Invoicing template (see Forms)

- The service **begin date** for the encounter should be the date on which you began enrollment activities with the client
- The service **end date** for the encounter should be the date on which the client is enrolled in the waiver
- If the client does not enroll in the waiver, this date will be the final date on which the client notified you of the decision not to enroll

4. Annual Cost Limits

Requisition fees are not included in the \$5,000 collective annual limit for Minor Home Modifications and Adaptive Aids and Supports. Requisition fees are included in the annual cost ceiling for the Waiver participant.

The Transitional Services fee is not included in the \$2,500 cost limit of the service, but is included in the annual cost limit per Waiver participant.

The annual cost ceiling must be observed.

O. Invoicing and Payment

See Forms Section for the Encounter and Invoicing Template and detailed instructions. The encountering system and invoicing system are linked together in one Excel workbook.

1. YES Waiver Services

See information below.

2. State Plan Services

See information below.

3. State Match

See information below.

➤ Local Mental Health Authority

YES Waiver Services

The LMHA shall submit invoicing for the provision of YES Waiver services if the LMHA holds a Waiver Provider Agreement with DSHS. Refer to the Waiver Provider Section for details.

Pre-Engagement Service

The LMHA shall submit invoicing for the provision of the Pre-Engagement Service.

State Plan Services

Medicaid providers of State Plan Services shall submit claims for payment to TMHP, the appropriate Managed Care Organization (if applicable), or private insurance (if applicable). DSHS does not pay claims for State Plan Services or other Non-Waiver Services. Medicaid is the payer of last resort and any claims that may be covered under a private insurance benefit shall be submitted for payment to the private insurance prior to submitting the claim to Medicaid (TMHP or Managed Care Organization).

State Match

The LMHA shall provide all State Match for TCM and other State Plan Services to which such match would apply in accordance with Section 3.11 of the General Provisions in the DSHS Performance Contract.

➤ **Waiver Provider**

YES Waiver Services

Waiver Provider shall submit to DSHS, a monthly invoice, using the Encounter and Invoicing Template, for YES Waiver services no later than the 15^h of each month for the previous month. A month is defined as the first day of a calendar month to the last day of a calendar month. The invoice shall be submitted via HIPAA compliant encrypted email to the Encounter & Invoicing E-mail Address or uploaded to the LMHA's secure Sharepoint website that is maintained by DSHS. The Waiver Provider must have prior approval by DSHS to submit the encounter report through a method other than encrypted email.

The Waiver Provider shall maintain documentation of service provision for each invoiced amount within the Waiver participant's clinical record. DSHS may access the Waiver participant's clinical record at any time to compare invoiced amounts with documentation of service provision.

DSHS will review each invoice within 5 business days upon receipt to ensure all required information is provided and that the amount requested is within approved limits of the IPC. Any anomalies will require DSHS staff to make additional inquiries until a complete invoice is received and approved. The invoice review will include:

1. Verifying the Waiver participant's eligibility for the YES Waiver services on the date of service delivery. Waiver services provided outside of YES Waiver eligibility will not be reimbursed.
2. Comparing the invoice to each Waiver participant's approved IPC and applicable service and cost limits. Services that are not on the approved IPC and/or exceed the limits approved by DSHS will not be reimbursed.
3. Verification that a current IPC was in place at the time of service delivery. Services provided on a date in which a current IPC was not in place will not be reimbursed.

The Waiver Provider will accept the current Waiver service reimbursement rate, found online at <http://www.hhsc.state.tx.us/rad/long-term-svcs/yes/index.shtml>, or the rate as it may hereafter be amended, as payment in full for performance under the Provider Agreement and make no additional charge to the Waiver participant, any member of the Waiver participant's family or any other source, including a third-party payer, except as allowed by federal and state laws, rules, regulations and the Medicaid State Plan.

DSHS, on behalf of HHSC and Medicaid, will provide payment to a Waiver Provider in accordance with the terms of the Provider Agreement and the current YES reimbursement rate. Payment will be made to the Waiver Provider within 30 days of receiving a complete invoice, as determined by DSHS. Waiver Provider is responsible for making any necessary corrections determined by DSHS. Please visit the State Comptrollers Office for additional information on Payment Services at <https://fm.x.cpa.state.tx.us/fm/payment/>. Texas' "prompt payment law" establishes

when some types of payments are due. The law says that payments for goods and services are due 30 days after the goods are provided, the services completed, or a correct invoice is received, whichever is later.

Example: A Waiver Provider submits an invoice to DSHS on the 5th of January for services provided in December, DSHS records the day received as January 5th. If the invoice is determined complete, DSHS will make payment to the Waiver Provider within 30 days after the date received (Jan. 5th) in accordance with the State Comptrollers Guidelines. However, if the invoice is determined incomplete, DSHS will notify the Waiver Provider and request a revised invoice. The Waiver Provider submits a revised invoice on Jan. 12th and DSHS determines the invoice is complete. DSHS will provide payment within 30 days of Jan. 12th.

State Plan Services

Medicaid providers of State Plan Services shall submit claims for payment to TMHP, the appropriate Managed Care Organization (if applicable), or private insurance (if applicable). DSHS does not pay claims for State Plan Services or other Non-Waiver Services. Medicaid is the payer of last resort and any claims that may be covered under a private insurance benefit shall be submitted for payment to the private insurance prior to submitting the claim to Medicaid (TMHP or Managed Care Organization).

➤ **Department of State Health Services**

DSHS will receive and process invoices from Waiver Providers.

DSHS, on behalf of HHSC and Medicaid, will provide payment for YES Waiver services to a Waiver Provider within 30 days of receiving a complete invoice and in accordance with the terms of the Provider Agreement and the current YES reimbursement rate, found online at:

<http://www.hhsc.state.tx.us/rad/long-term-svcs/yes/index.shtml> or the rate as it may hereafter be amended.

DSHS will review each invoice within 5 business days upon receipt to ensure all required information is provided and that the amount requested is within approved limits of the IPC. Any anomalies will require DSHS staff to make additional inquiries until a complete invoice is received and approved. The invoice review will include:

1. Verifying the Waiver participant's eligibility for the YES Waiver services on the date of service delivery. YES Waiver services provided outside of YES Waiver eligibility will not be reimbursed.
2. Comparing the invoice to each Waiver participant's approved IPC and applicable service and cost limits within the Waiver. Services that are not on the IPC and or exceed the limits approved by DSHS will not be reimbursed.

DSHS' annual review of the Waiver Providers will compare the invoiced services to the services documented in the Waiver participant's clinical record. DSHS may access the Waiver participant's clinical record at any time to compare invoiced amounts with documentation of service provision.

DSHS will review the billings in relation to YES Waiver requirements and authorize payment through the state's accounting system. DSHS will submit data to HHSC for draw-down of the federal share.

O. Utilization Management / Oversight

The primary Utilization Management (UM) activities will be related to monitoring of service utilization for each Waiver participant.

➤ **Local Mental Health Authority**

The LMHA will perform UM activities that include the following:

1. Monitoring service utilization for compliance with the approved IPC for each Waiver participant.
2. Assisting DSHS in the management of enrollment of Waiver participants against approved enrollment limits. The LMHA will maintain a current Inquiry List of individuals who are seeking Waiver services. The LMHA shall offer Waiver services to individuals on a first-come, first-served basis according to the date of the individuals' registration on the Inquiry List. The ceiling of participants in the Waiver is set per LMHA; however this allocation may need to be adjusted by DSHS depending on the number of YES Waiver slots available between the service areas and the status of the Inquiry List.
3. Assisting DSHS in the management of expenditures approved under each IPC. DSHS will assist the LMHA in UM activities by requesting monthly encounter data from the Waiver Providers (who are not the LMHA) and will provide the LMHA with YES Waiver-specific service encounter data and cost data at similar intervals for each Waiver participant.

The Targeted Case Manager has access to all Non-Waiver service data through the LMHA, clinical records, and TMHP.

The LMHA will participate collaboratively with DSHS in ongoing quality improvement and assurance activities. Either the LMHA or DSHS may identify issues and suggest potential remedies. The LMHA monitors service utilization for compliance with the approved IPC for each Waiver participant.

➤ **Waiver Provider**

DSHS performs UM oversight of the LMHA and Waiver Providers through encounter data reporting and regular desk and site reviews.

Waiver Providers are required to repay any identified overpayment. Encounters are linked to paid claims and any identified invalid services are expected to be repaid by the Waiver Provider.

The Waiver Provider will participate collaboratively in ongoing quality improvement and assurance activities. Either the Waiver Provider or DSHS may identify issues and suggest potential remedies.

➤ **Department of State Health Services**

DSHS staff will monitor service utilization data in coordination with the approved IPC, as well as all service encounter claims. DSHS will conduct UM functions and develop quality indicators.

DSHS will monitor the LMHA on the performance of YES Waiver activities and conduct regular data verification of Waiver participants via desk review. DSHS conducts yearly recoupment of any identified overpayments that are not repaid. DSHS will perform quarterly desk reviews of samples from those claims identified as paid correctly. These data verification reviews include verification of diagnosis, treatment plan, medical necessity, server credentials, as well as service documentation.

DSHS will participate collaboratively with LMHA in ongoing quality improvement and assurance activities. Either the LMHA or DSHS may identify issues and suggest potential remedies.

Second line monitoring is conducted through an on-going process of retrospective analysis of the Medicaid utilization data by DSHS.

P. Quality Management

See Appendix B for Quality Management Plan.

Quality Management (QM) activities will be performed by DSHS, HHSC, and locally by the LMHA.

The foremost responsibility of any service system is to ensure the health, welfare and safety of individuals being served. Within Texas' Mental Health service delivery system, protocols are in place to ensure that health and welfare standards are continuously met and that Medicaid services, including those funded through YES Waiver are implemented in accordance with Medicaid statute, YES Waiver requirements and programmatic standards. Components of the YES Waiver QM system include:

- Development and review of the IPC
- Annual required reviews of each Waiver Provider
- Service utilization and billing analysis
- Clinical outcomes analysis

- Review and investigation of health and safety complaints by protective agencies
- Training and Technical Assistance
- Review and follow-up on critical incident reports
- Collection and analysis of critical incident data to identify trends and initiate quality improvement strategies
- Waiver participant satisfaction

➤ **Local Mental Health Authority**

The LMHA will perform QM activities that include the following:

1. Informing DSHS of concerns or known issues with Waiver Providers and the implementation of services identified in any Waiver participant's IPC.
2. Implementing QM operating practices for YES Waiver services and activities such as monitoring that the required contacts occur, modifying each IPC as necessary, and ensuring that the documentation generated by the Targeted Case Manager provides evidence of compliance with the requirements.

The LMHA should extend their standard QM practices to services and activities that will be carried out by the LMHA. DSHS and the LMHA will collaborate on identifying, developing, and implementing utilization management, quality assurance & improvement activities specific to the YES Waiver.

➤ **Waiver Provider**

DSHS performs QM oversight of the Waiver Providers through encounter data reporting and regular desk and on-site reviews.

Waiver Providers allow DSHS and/or HHSC access to records related to YES Waiver services.

Waiver Providers must participate in Quality Improvement activities as identified by DSHS.

➤ **Department of State Health Services**

DSHS staff reviews each sampled record's service plan to verify that demographic, clinical, and financial eligibility has been met and that any applicable service and cost limitations have not been exceeded.

DFPS will provide DSHS copies of each investigation of ANE allegations involving an individual enrolled in the YES Waiver. Regardless of the investigation findings, DSHS reviews each investigative report.

At least once each year, DSHS will review the LMHA's compliance responsibilities specified in the MOU and this Manual.

DSHS will develop, implement, and monitor compliance with rules, policies, procedures, and other guidance governing the YES Waiver.

DSHS will conduct interviews with Waiver participants to verify Waiver participant satisfaction and verify the delivery of services.

The Quality Management Plan delineates specific indicators related to each sub-assurance. Data from these reviews will be reported to HHSC via these indicators and associated reports. HHSC will coordinate with DSHS to discuss findings and trends and, when necessary to develop and monitor remediation plans.

Q. Training and Technical Assistance

See information below.

➤ **Local Mental Health Authority**

DSHS staff will provide clinical, administrative, and technical assistance to the LMHA. The LMHA may identify Training and Technical Assistance needs to DSHS at any time by contacting the YES Waiver Staff. The LMHA or DSHS may identify issues and suggest potential remedies.

All direct service staff shall be trained on program philosophy, policies and procedures, including identifying, preventing, and reporting of critical incidents and ANE.

All direct service staff shall be trained in the safe use of personal restraint if applicable.

The LMHA and Waiver Providers must comply with all applicable state and Federal child/elder abuse and other reporting laws. It is the responsibility of the LMHA and Waiver Provider to understand and comply with professional and legal requirements within the state of Texas.

➤ **Waiver Provider**

DSHS staff will provide clinical, administrative, and technical assistance to the Waiver Provider. The Waiver Provider may identify Training and Technical Assistance needs to DSHS at any time by contacting the YES Waiver Staff. Waiver Providers or DSHS may identify issues and suggest potential remedies.

Waiver Providers will hire direct service staff that possess or exceed the minimum skills and training required to provide the assigned YES Waiver service and to meet the primary objective of protecting and promoting the health, safety and well-being of Waiver participants. Each Waiver Provider, when assigning direct service staff, will match the skills of a direct service staff with the most recent assessment of the particular Waiver participant. All Waiver Provider direct service staff will attend and satisfactorily complete the relevant DSHS-sponsored YES Waiver specific training prior to the provision of YES Waiver services or within designated timeframe. Waiver Providers must maintain training documentation in personnel files.

All direct service staff must be trained on program philosophy, policies and procedures, including the prevention, identification, and reporting of critical incidents and ANE.

All direct service staff shall be trained in the safe use of personal restraint, if applicable.

The LMHA and Waiver Providers must comply with all applicable state and Federal child/elder abuse and other reporting laws. It is the responsibility of the LMHA and Waiver Provider to understand and comply with professional and legal requirements within the state of Texas.

➤ **Department of State Health Services**

DSHS will conduct training and technical assistance concerning YES Waiver requirements. Trainings will consist of a four hour web-based training session on the National Wraparound approach to service delivery. Training will include the following topics:

- a. Systems of Care core values and guiding principals
- b. Wraparound essential elements
- c. Roles and responsibilities of the Waiver participant, family, and other Treatment Team members
- d. Plan of care development
- e. Crisis and safety planning

The web-based training will produce a certificate upon completion of the training and must be available in each provider's personnel chart for review by DSHS at quarterly desk/annual site reviews. The need for training and technical assistance may be identified through results of DSHS' Waiver Provider monitoring, technical assistance contacts, and the use of newly developed quality indicators.

DSHS YES Waiver staff will provide clinical, administrative, and technical assistance to the LMHA. The DSHS YES Waiver staff will identify inefficiencies and barriers to desired outcomes and make recommendations for program and administrative modifications.

The LMHA and Waiver Provider may identify Training and Technical Assistance needs to DSHS at any time by contacting the YES Waiver Staff by email, phone, or in person. The LMHA and Waiver Providers or DSHS may identify issues and suggest potential remedies. In addition to direct reports from the LMHA and Waiver Provider, DSHS will utilize data sources (such as submitted and approved IPCs, encounter reporting, and invoicing) to identify Training and Technical Assistance needs.

R. Evaluation

The LMHA and Waiver Providers must allow representatives of DSHS, HHSC, DFPS, Office of Attorney General Medicaid Fraud, and United States Department of Health and Human Services full and free access to direct service staff, Waiver participants, and all locations where the LMHA, Waiver Providers or subcontractors perform activities related to the YES Waiver.

➤ **Local Mental Health Authority**

DSHS will conduct quarterly site reviews and annual site reviews of the LMHA compliance with the administrative functions and related activities outlined in the MOU between DSHS and each LMHA.

DSHS is responsible for the oversight of the LMHA. DSHS will conduct quarterly desk reviews and annual site reviews of the LMHAs compliance with the functions delegated in the approved YES Waiver Application. These reviews will examine LMHA policies, procedures and operation of the functions delegated in the approved YES Waiver Application. These reviews will also monitor Waiver Provider compliance with requirements for criminal history and registry checks. DSHS will aggregate the data annually and report to HHSC.

DSHS and the LMHA will maintain open communication regarding the costs associated with administrative functions performed by the LMHA, and collaborate on identifying and implementing a mutually agreed upon methodology for identifying such costs. DSHS and the LMHA agree to review costs associated with administrative activities performed by the LMHA under the MOU every six months. If DSHS and the LMHA agree that the LMHA's costs are above the normal cost of doing business, DSHS will inform its executive leadership of these costs.

➤ **Waiver Provider**

DSHS will conduct quarterly desk reviews and annual on-site reviews of each Waiver Provider to evaluate compliance with the YES Waiver policies. The reviews will include an evaluation of the Waiver participant clinical records to ensure that the Waiver Provider is providing adequate oversight and that the Waiver Provider is responsive to findings. These reviews will monitor Waiver Provider compliance with requirements for criminal history and abuse registry checks in accordance with Texas Administrative Code (TAC) Chapter 414 Subchapter K Criminal History and Registry Clearances. Part of DSHS' annual review of each Waiver Provider will consist of a comparison of the billed services to the services documented in the Waiver participant's clinical record.

Intermittent reviews will also be conducted if a pattern of unresolved complaints or critical incidents is detected or if a Waiver Provider's past performance warrants more frequent review.

➤ **Department of State Health Services**

DSHS staff will conduct desk reviews for any requests made by a Waiver Provider for prior authorizations.

DSHS conducts quarterly data verification via desk review. This process can also generate a corrective action plan if deficiencies are discovered.

DSHS conducts quarterly reviews of reported service encounters to verify the validity of the service. Encounters are linked to paid claims and any identified invalid services are expected to be repaid by the Waiver Provider. These data verification reviews include verification of diagnosis, treatment plan, demographic, clinical and financial eligibility, server credentials, as well as service documentation.

DSHS will identify inefficiencies and barriers to desired outcomes and make recommendations to the LMHA and/or HHSC for program and administrative modifications.

S. Medication Management

➤ **Local Mental Health Authority**

If the LMHA performs medication management activities, follow the guidelines under the Waiver Provider section.

➤ **Waiver Provider**

The Waiver Provider is responsible for ensuring that Waiver Provider direct service staff act within the scope of their respective licenses in relation to medication management. If the IPC includes medication management activities, the Waiver Provider will document these activities in the Waiver participant's clinical records. Any errors must be reported to DSHS as critical incidents, and a Critical Incident Reporting Form (see Forms) must be completed and faxed to the LMHA TCM within 72 hours of notification of the incident.

Waiver Providers are responsible for the administration of medications to Waiver participants who cannot self-administer and/or have responsibility to oversee Waiver participant self-administration of medications.

- The Waiver Provider must be qualified under the scope of their licensure to administer medications.
- The LAR must sign an authorization for the Waiver Provider to administer each medication according to label directions.
- The medication must be in the original container labeled with the Waiver participant's full name and expiration date.
- The Waiver Provider must administer the medication according to the label directions or as amended by a physician.
- The Waiver Provider must administer the medication only to the Waiver participant for whom it is intended.

- The Waiver Provider must not administer the medication after its expiration date.
- The Waiver Provider may provide non-prescription medications if the Waiver Provider obtains consent from the parent or LAR prior to administration of the medication. Consent may be given over the phone and documented as such by the Waiver Provider.

The Waiver Provider must document the following when medication is administered:

- Full name of the Waiver participant to whom the medication was given,
- Name of the medication,
- Date, time, and amount of medication given, and
- Full name of direct service staff administering the medication.

All medication records must be kept for three months after administering the medication. The Waiver Provider must store medications as follows:

- Out of reach of children or in locked storage,
- In a manner that does not contaminate food,
- Refrigerate if required, and
- Kept separate from food.

Unused prescription medications must be returned to the LAR.

Self-administration of medications may occur under the supervision of Waiver Provider direct service staff. The direct service staff must ensure:

- The LAR has signed an authorization for the Waiver participant to self-administer each medication according to label directions.
- The medication must be in the original container labeled with the Waiver participant's full name and expiration date.
- The Waiver participant administers the medication in amounts according to the label directions or as amended by a physician.
- The Waiver participant must administer the medication only to him or herself.
- The Waiver participant must not administer the medication after its expiration date.
- The Waiver participant may provide self-administration of non-prescription medications if the Waiver Provider obtains consent from the LAR prior to the self-administration of the medication. Consent may be given over the phone and documented as such by the Waiver Provider.

The Waiver Provider must document the following during self-administration of medication:

- Full name of the Waiver participant who self-administered the medication,
- Name of the medication,
- Date, time, and amount of medication given, and

- Full name of Waiver Provider direct service staff supervising the self-administration of the medication.

The LMHA and Waiver Provider direct service staff that are responsible for medication administration are required to both record and report medication errors to DSHS. Medication errors that Waiver Providers are required to record are as follows:

- Medication given to the wrong person,
- giving the person the wrong medication,
- giving the incorrect dosage,
- failing to give the medication at the correct time,
- failing to use the correct route, or
- failing to accurately document the administration of the medication.

All medication errors are reported as critical incidents by the waiver provider agencies.

➤ **Department of State Health Services**

DSHS conducts surveys and monitors Waiver Providers for compliance with licensing requirements. When harmful or non-compliant practices are identified, corrective action is taken to bring the facility back into compliance. DSHS includes medication management review as part of its quarterly risk review of contracted Waiver Providers. CMS 372 reports and all state rules for Waiver program operations are coordinated with and approved by HHSC. HHSC and DSHS analyze data regarding each assurance through reports presented at Quality Review Team meetings no less than annually, and when potentially harmful practices are identified, will develop remediation or improvement plans, as needed. In the case of medication management, it is likely that the remediation plans will involve communication and other technical assistance to Waiver Providers about issues and trends identified through the quality process.

DSHS is responsible for monitoring the performance of providers administering medications to Waiver participants. DSHS enforces requirements through quarterly risk assessment and review of critical incidents.

T. Seclusion and Restraint

The use of restraints or seclusion is permitted during the course of the delivery of Waiver services. Per TAC §415.254, the use of chemical restraint is prohibited. Per TAC §415.256 the use of mechanical restraints and seclusion are also prohibited. The TAC §415.253 defines personal restraint as, "The application of physical force alone restricting the free movement of the whole or a portion of the waiver recipient's body to control physical activity." Personal restraint is used only as last resort after less restrictive measures have been found to be ineffective or are judged unlikely to protect the Waiver participant or others from harm. The intervention is used for the shortest period possible and terminated as soon as the Waiver participant demonstrates the release behaviors specified by the ordering physician.

Per TAC §415.254, a prone or supine hold shall not be used except as a last resort when other less restrictive interventions have proven to be ineffective. The hold shall be used only to transition a client into another position, and shall not exceed one minute in duration. Except in small residential facilities, when the prone or supine hold is used, an observer, who is trained to identify the risks associated with positional, compression, or restraint asphyxiation and with prone and supine holds, and who is not involved in the restraint, shall ensure the client's breathing is not impaired.

➤ **Local Mental Health Authority**

Additionally, the LMHA shall comply with TAC §412.312 regarding restraint or seclusion.

The use of personal restraint must be documented as a critical incident by the Waiver Provider and LMHA and follow the procedures for Critical Incident Reporting. Unauthorized use of restraint and seclusion will be detected by record review and through complaints.

➤ **Waiver Provider**

The use of personal restraint must be documented as a critical incident by the Waiver Provider and LMHA and follow the procedures for Critical Incident Reporting. Unauthorized use of restraint and seclusion will be detected by record review and through complaints.

Direct service staff shall be trained in the safe use of personal restraint by the Waiver provider agencies. Waiver Providers shall not use personal restraint unless it is necessary to intervene to prevent imminent probable death or substantial bodily harm to the Waiver participant or imminent physical harm to another, and less restrictive methods have been tried and failed. Waiver Providers shall not use more force than is necessary to prevent imminent harm and shall ensure the safety, well-being, and dignity of clients who are personally restrained, including attention for personal needs.

The Waiver Provider must take into consideration information that could contraindicate or otherwise affect the use of personal restraint, including information obtained during the initial assessment of each client at the time of admission or intake. This information includes, but is not limited to:

- a. techniques, methods, or tools that would help the client effectively cope with his or her environment;
- b. pre-existing medical conditions or any physical disabilities and limitations, including substance use disorders, that would place the client at greater risk during restraint;
- c. any history of sexual or physical abuse that would place the client at greater psychological risk during restraint; and
- d. any history that would contraindicate restraint.

A Waiver participant held in restraint shall be under continuous direct observation. The Waiver Provider shall ensure adequate breathing and circulation during restraint. An acceptable hold is one that engages one or more limbs close to the body to limit or prevent movement.

The Waiver Provider shall record the following information in the clinical record within 24 hours:

- the circumstances leading to the use of personal restraint;
- the specific behavior necessitating the restraint and the behavior required for release;
- less restrictive interventions that were tried before restraint began;
- the names of the direct service staff who implemented the restraint;
- the date and time the procedure began and ended; and
- the Waiver participant's response.

The family or LAR must be notified each time restraint is used. The use of restraint must be reported daily to Waiver Provider.

➤ **Department of State Health Services**

DSHS is responsible for overseeing the use of personal restraints by Waiver Providers. For residential treatment settings, DFPS is responsible for oversight of restraint and seclusion.

The oversight of personal restraint for Waiver Providers is accomplished through the quarterly risk assessment conducted by DSHS. Unauthorized use of restraint and seclusion will be detected by record review and through complaints.

U. Record Keeping

The LMHA and Waiver Providers must allow DSHS, HHSC, and/or CMS access to information or records related to Waiver participants, to the fullest extent permitted by applicable law, rule or regulation, and provide the information or records at no cost to the agency requesting such information or records.

The exchange or sharing of confidential information, particularly protected health information or other sensitive personal information shall be done in compliance with HIPAA. All parties involved with the YES Waiver (including DSHS staff, LMHA staff, and Waiver Provider direct service staff) shall maintain and protect the confidential information to the extent required by law.

1. Clinical Records / Progress Notes

Clinical Records

The LMHA is required to maintain a clinical record for each Waiver participant. The LMHA clinical record must contain the following (when applicable):

- Demographic and contact information for the Waiver Participant;
- Clinical Eligibility Determination Form;
- Offer Letter;
- Vacancy and Deadline Notification Form;
- Notification of Participant Rights Form;
- Consumer Choice Consent Form;
- Documentation of Provider Choice Form;
- Treatment Plans including:
 - Goals and Objectives;
 - Initial IPC, IPC Projection (if applicable), IPC 90 day Revisions;
 - Safety Plans and Crisis Plans;
- Denial Letter;
- Termination Letter;
- Inquiry List Removal Letter;
- Letter of Withdrawal;
- Progress Notes for all State Plan Services provided to the Waiver participant;
- Summaries from all meetings regarding the Waiver participant; and
- Critical Incident Reports;
- Participant Referral Form (to Waiver Provider if not the LMHA)
- Other YES Waiver documentation.

Waiver Providers are required to maintain a clinical record for each Waiver participant which covers the services provided both directly and those provided through arrangements with other agencies.

The Waiver Provider clinical record must contain the following (when applicable):

- Participant Referral Form (if the Waiver Provider is not the LMHA);
- Treatment Plans including:
 - Goals and Objectives;
 - IPC and IPC Projection; IPC 90 day Revisions
 - Safety Plans and Crisis Plans;
- Respite Relative Provider Form;
- Transportation Log;
- Progress Notes for all Waiver services provided to the Waiver participant;
- Progress Notes for all State Plan Services provided to the Waiver participant (if Waiver Provider is selected to provide these services);
- Summaries from all meetings regarding the Waiver participant; and
- Other YES Waiver documentation.

Progress Notes

Progress Notes are required for all services provided to a Waiver participant. General documentation requirements for Progress Notes include but are not limited to:

- The name of the individual receiving the service;
- The name of the service and a description of the service provided;
- The date of the contact;
- Start and Stop time of the contact;
- The location where the service was provided;
- The specific skills trained on and the method used to provide the training;
- The Waiver participant 's response to the services being provided;
- The progress or lack of progress in addressing the Waiver participant 's outcomes as identified in the Treatment Planning Process;
- Summary of activities, meals, behaviors which occurs during the provision of the service; and
- The direct service staff's signature and credentials.

TCM services must be documented in compliance with TAC 412 I. guidelines.

If the contact is not face-to-face with the Waiver participant (i.e. phone call), document:

- the date(s) of the contact;
- a description of the contact;
- the direct service staff's signature and credentials;

If the service involves face-to-face or telephone contact with someone other than the Waiver participant (i.e. LAR), document:

- the date of the contact;
- the person with whom the contact was made;
- a description of the contact;
- the outcome of the contact; and
- the direct service staff's signature and credentials

In addition to the general documentation requirements, the following services have the following requirements.

- Minor Home Modifications & Adaptive Aids and Supports:
 - Receipt of purchase; and
 - Good Faith Effort to obtain multiple bids of expenditures over \$500.00;
 - Documentation that home modifications repairs fall outside the scope of any existing warranty for time to be repaired;
 - Copy of warranty information;
 - Documentation that home modifications meet any applicable standards and/or codes; and
 - Documentation of how the item/service will meet a functional adaptive need of participant.
- Non-Medical Transportation:
 - Mileage log with Start and Stop Time

- Transitional Services:
 - Receipt of purchase

The Waiver Provider shall allow DSHS Staff access to all clinical records upon request.

The Waiver Provider must keep all records required by the Provider Agreement until one of the following occurs, whichever is the latest:

- Six years from the date the records were created;
- Any audit exception or litigation involving the records is resolved; or
- For records concerning an individual under 18 years of age, the individual becomes 21 years of age.

Records of Waiver participant evaluations and re-evaluations of level of care are maintained in the following locations: DSHS, LMHA, and with the Waiver Provider.

Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by HHSC, DSHS, and the Waiver Provider for a minimum period of 3 years as required in 45 CFR §92.42.

The provision of the Waiver Provider list and the final selection of a Waiver Provider must be documented and retained in the Waiver participant clinical record. DSHS will conduct periodic reviews to ensure that the LMHA objectively assists the Waiver participant and LAR in the process of selecting a Waiver Provider.

The Waiver participant's right to choose the service provider extends to the specific Waiver Provider personnel that will be providing YES Waiver services. The Waiver participant's and LAR's selection of Waiver Provider personnel will be documented and retained in the Waiver participant clinical record.

2. Personnel Records

The Waiver Provider is required to retain a confidential personnel record for each direct service staff person. The documentation process that Waiver Providers use to verify that subcontractor is in compliance with Subcontract agreement, including verifying staff qualifications, criminal history, and registry checks may vary depending on if subcontracting with an individual or an agency and should be specified in subcontract agreement. When subcontracting with an agency, it is typically the agency's responsibility to ensure staff providing services specified in the subcontract agreement meet stated qualifications, criminal history, and registry checks. When subcontracting with an individual, the Waiver Provider will want to conduct a source review of subcontractor qualifications since there is no agency to do so. Personnel records at minimum should include:

1. Current Criminal Background Check
2. Current copy of Professional Licensure, Certification or Registration with the state and federal government, as required by applicable state and federal Laws

3. Educational history;
4. Work history;
5. Prior or pending malpractice litigation;
6. Professional liability claims history;
7. Criminal convictions;
8. Client complaints received by facilities or state agency;
9. Any disciplinary action initiated against the provider by state board or other agency;
10. Any curtailing, suspension, or termination of staff privileges at any medical or treatment facility or program;
11. Any sanctions imposed by an insurance company or CMS, including sanctions relating to the provider's participation in Medicaid or Medicare programs;
12. Evidence of adequate malpractice or liability insurance;
13. For physicians, information on the practitioner from the National Practitioner's Data Bank and the following: current and valid license from the Texas Board of Medical Examiners; current and valid Drug Enforcement Administration (DEA) certificate, and evidence of graduation from medical school and completion of residency, or board eligibility/ certification, if applicable;
14. History, education, and ability to provide services to covered lives;
15. History or previous training in providing the covered services;
16. A statement by the applicant regarding:
 - a. Any physical or behavioral health problems that may affect the provider's ability to provide services;
 - b. History and current status of licensure and felony convictions.
 - c. History and current status of privileges, including limitations, or disciplinary actions by the appropriate licensing agency or facilities, and
 - d. An attestation to the correctness and completeness of the application.

The Waiver Provider shall allow DSHS Staff access to personnel records when conducting QM reviews, invoicing verifications and for other requests.

3. Operating Guidelines

Waiver Providers shall maintain policies and procedures which includes but is not limited to:

- a. Confidentiality and retention of client records;
- b. Provision of services / coordination of care;
- c. Quality and utilization management;
- d. Personnel recordkeeping / management;
- e. Critical incident reporting;
- f. Personnel and client safety (behavior management, seclusion and restraint);
- g. Personnel credentialing and training;
- h. Routine and emergency appointment availability; and
- i. Medication safety

Waiver Providers shall ensure availability of their policies and procedures to staff, Waiver participants, LAR or family members or any other interested parties. Waiver Provider policies and procedures may be subject to review by DSHS.

Waiver Providers shall be responsible for implementing a procedure which ensures the reporting of all critical incidences. Incidences may include, but are not limited to, the following:

1. Abuse, neglect, or exploitation of a Waiver participant;
2. Psychiatric hospitalizations;
3. Restraint of a Waiver participant;
4. A slip or fall, medication error, or medical complication; or
5. Incidents caused by the member such as verbal and/or physical abuse of staff or other members, destruction or damage of property, and member self abuse.

Waiver Providers shall be responsible for implementing a procedure which ensures the reporting of a complaint against an agency or its personnel by a member or interested party.

V. Clinical Management for Behavioral Health Services (CMBHS)

The LMHA shall utilize the Web-based Clinical Management for Behavioral Health Services to enter information from the Uniform Assessment that includes, but is not limited to the CA-TRAG and YES Waiver authorization (LOC-A = Y).

1. Uniform Assessments

Entering the Uniform Assessment

The LMHA completes the Uniform Assessment at intake and conducts CA-TRAG updates every 90 days. The LMHA must complete Uniform Assessment and CA-TRAG updates within the timeframes specified by CMBHS (120 days) or the client record will be auto-closed, which will also override the authorization for services. The 90 day CA-TRAG updates will not affect the level of care / clinical eligibility determination as the initial LOC-A = Y authorization is valid for 365 days. In the circumstance that a 90 day update is missed and the record is auto-closed, a new Uniform Assessment will need to occur and the system will require level of care / clinical eligibility criteria to be met.

Safeguards:

- Since Waiver participants will be receiving intensive case management, there should be ample opportunities to perform the update within the required timeframe (actually have up to 120 days).
- If the Waiver participant is hospitalized, it is very unlikely he/she will be there the entire duration of when the update is due.

- If the Waiver participant is absent for other reasons (missed appointments, cannot be located, etc.) and they are auto-closed, the LMHA will need to assess whether the individual is committed to the Waiver and if so, perform a new intake.
- If upon reassessment for a new intake the individual currently doesn't meet the eligibility criteria, thus not allowing for an LOC-A = Y then the LMHA and DSHS will coordinate an alternative workaround in the system, which may require entering initial intake Uniform Assessment information in CMBHS, and maintaining the current CA-TRAG assessment data offline to incorporate into the outcome measurements. DSHS would also monitor the original LOC-A = Y authorization date from the initial intake.

Question: When does the LMHA enter the initial Uniform Assessment into CMBHS

- This is at the discretion of the LMHA, within the parameters of the CMBHS guidelines and system.

2. LOC-A = Y Authorization

LOC-R and LOC-D

The Level of Care Recommended (LOC-R) will result in an existing TRR service package. There will not be an LOC-R = Y for YES Waiver.

The Level of Care Deviation (LOC-D) = Y will allow for an override into Level of Care Authorized (LOC-A) of Y. **EXCEPTION:** If the LOC-R = 0 (Crisis Services), then CMBHS will not allow an LOC-D or LOC-A = Y. The individual should be served under crises services and then re-assessed before being authorized for the YES Waiver.

LOC-A = Y (YES Waiver Authorization)

The authorization for YES Waiver services is valid for 365 days and eligibility for the YES Waiver is valid for 12 months based on the initial YES Waiver Authorization (LOC-A = Y) effective date in CMBHS. Prior to the original 365 day authorization period expiring, a Uniform Assessment update will be performed to determine if the Waiver participant currently meets eligibility criteria in order to be re-authorized for another 365 day period. The LMHA will submit a Clinical Eligibility Determination Form to DSHS for approval prior to re-authorizing for another 12 months. **Since it is an update, CMBHS will not check to make sure CA-TRAG eligibility criteria is met and will allow for LOC-A = Y to be selected for any TRAG scores so there will need to be diligence from both the LMHA's and DSHS to ensure all clinical and financial eligibility criteria are met before re-authorizing.**

Because the LMHA is required to perform 90 day CA-TRAG assessment updates, this activity will also update the LOC-A = Y Effective Date within CMBHS. This update to the LOC-A = Y Effective Date does not change the Waiver participant's 12 month enrollment period since the 12 months is based on the initial LOC-A = Y for that enrollment period.

YES Waiver Authorization Date

The YES Waiver Authorization Date is the date the LMHA initially authorizes the individual for YES Waiver (LOC-A = Y) within CMBHS. The initial YES Waiver authorization date is used to determine the start of the Waiver participant's 12-month eligibility period for the YES Waiver. Prior to the 12 month authorization end date, the Waiver participant should be re-evaluated to see if level of care criteria is met in order to re-authorize for an additional 12 months. The Annual IPC Begin Date will match the initial LOC-A = Y date.

Not at Capacity

Question: When does the LMHA authorize for the YES Waiver?

- If the individual is already determined Medicaid eligible for the YES Waiver:
Option 1: Authorize for YES Waiver (LOC-A = Y) and begin services.
- If an individual has pending financial eligibility for the YES Waiver (Not already in TRR):

Option 1: Authorize the individual for a TRR service package (if eligible) and provide TCM and other necessary services within the package. The IPC is not in effect at this time. Medicaid funding is not guaranteed for the provision of any State Plan services while authorized for a TRR service package.

Note: If the individual remains in the TRR service package for a full month they will be counted towards TRR Performance Measures. Partial months are not included in Performance Measure Calculations.

Option 2: Authorize the individual for the YES Waiver (LOC-A = Y) and provide services in accordance with an approved IPC.

Note: The LMHA and Waiver Provider are assuming any financial risk if financial eligibility is denied and the individual will not be able to continue in the YES Waiver.

- If an individual has pending financial eligibility for the YES Waiver (Already in TRR):

Option 1: Continue to serve the individual in the TRR service package. The IPC is not in effect at this time. Medicaid funding is not guaranteed for the provision of any State Plan services while authorized for a TRR service package.

Option 2: Authorize the individual for the YES Waiver (LOC-A = Y) and provide services in accordance with an approved IPC.

Note: The LMHA and Waiver Provider are assuming any financial risk if financial eligibility is denied and the individual will not be able to continue in the YES Waiver.

At Capacity

Question: When does the LMHA authorize for the Waiver services?

- When there is not a YES Waiver slot available. The individual remains on the Inquiry List.

Option 1: If the individual is already receiving TRR services, the LMHA should continue to serve the individual in a TRR service package until there is a YES Waiver slot available.

Option 2: If the individual is not already receiving TRR services, the LMHA should determine if the individual qualifies for TRR services and serve them in the appropriate service package until there is a YES Waiver slot available.

Option 3: Refer to other community services (if available) until there is a YES Waiver slot available.

Option 4: There may be circumstances in which the individual and/or LAR chooses not to receive any other services or does not qualify for other services while on the Inquiry List for Waiver services.

In the circumstance in which an individual must wait for an available YES Waiver slot and is not a current recipient of Medicaid benefits but may qualify for regular Medicaid (outside of the Waiver), the LMHA should assist the individual and/or LAR in completing a financial application for regular Medicaid, particularly if they are likely to be waiting more than 30-60 days for a YES Waiver slot to become available.

If the application is submitted to DSHS Waiver staff it can be forwarded on to the HHSC Medicaid Eligibility workers, marked as applying for regular Medicaid and on the Inquiry List for YES Waiver, and the workers may be able to expedite processing of a regular Medicaid determination.

Appendix

Files are located at <http://www.dshs.state.tx.us/mhsa/yes> by accessing the YES Webpage.

- A. YES Waiver Service Codes, Descriptions, and Provider Qualifications**
- B. Quality Management Plan**
- C. Waiver Provider Credentialing Process Flow**
- D. Eligibility and Enrollment Process Flow**
- E. Billing Guidelines**
- F. Question and Answer Documents**

Forms

Forms, templates and letters are located at <http://www.dshs.state.tx.us/mhsa/yes> by accessing the Youth Empowerment Services Webpage.

- **Clinical Eligibility Determination Form**
- **Consumer Choice Consent Form (English & Spanish)**
- **Co-Occurring Diagnoses Needs Assessment**
- **Critical Incident Reporting Form**
- **Denial of Eligibility Letter – Bexar County (English and Spanish)**
- **Denial of Eligibility Letter – Travis County (English and Spanish)**
- **Denial of Eligibility Letter-Tarrant County (English and Spanish)**
- **Documentation of Provider Choice Form (English & Spanish)**
- **Encounter and Invoicing Template**
- **Financial Eligibility Screening Tool**
- **Individual Plan of Care Form**
- **Inquiry List Removal Letter (English & Spanish)**
- **Letter of Withdrawal (English & Spanish)**
- **Notification of Participant Rights Form (English and Spanish)**
- **Offer Letter (English & Spanish)**
- **Optional Eligibility Screening Tool (LMHA)**
- **Optional Eligibility Screening Tool (Referral Source)**
- **Participant Handbook and Provider Directory (English and Spanish)**
- **Participant Referral Form**
- **Respite Relative Provider Form (English & Spanish)**
- **Signature Page**
- **Transportation Log Template**
- **Vacancy and Deadline Notification Form (English & Spanish)**