



**Youth Empowerment Services Waiver
(YES)
Policy and Procedure Manual**

March 2015

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YES WAIVER
PROGRAM OVERVIEW

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BACKGROUND AND
HISTORY

Texas strives to provide a continuum of appropriate services and supports for families with children and youth who have serious emotional disturbance (SED). There are instances in which parents have placed their child in state custody when they believe they have reached or exceeded their financial, emotional or health care resources and are unable to fully meet their child or youth's mental health care needs.

Under direction of the 78th and 79th Texas Legislatures, the Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS) developed the Youth Empowerment Services (YES) 1915(c) Waiver for three counties—Travis, Bexar, and Tarrant. The Centers for Medicare and Medicaid Services (CMS) approved the YES Waiver (“Waiver”) in February 2009. In 2013, the 83rd Legislature directed the YES Waiver to expand statewide.

The YES Waiver provides comprehensive home and community-based mental health services to children and youth ages three to 18 at risk of institutionalization and/or out-of-home placement due to their SED. The program provides flexibility in the funding of intensive community-based services and supports for children, youth, and their families.

OBJECTIVE AND
GOALS OF THE YES
WAIVER

The objective of the Waiver is to provide community-based services, in lieu of institutionalization, to eligible children and youth in accordance with the approved Waiver and program capacity.

The goals of the Waiver are to:

1. Reduce out-of-home placements by all child-serving agencies;
2. Reduce inpatient psychiatric treatment;
3. Provide a more complete continuum of community-based services and supports for children and youth with SED and their families;
4. Ensure families have access to parent partners and other flexible non-traditional support services identified in a family-centered planning process;
5. Prevent entry and recidivism into the foster care system and relinquishment of parental custody; and
6. Improve the clinical and functional outcomes of children and youth with SED.

- SERVICE ARRAY The service array available through the Waiver includes:
1. Respite (In-Home and Out-of-Home);
 2. Adaptive Aids and Supports;
 3. Community Living Supports (CLS);
 4. Employment Assistance;
 5. Family Supports;
 6. Minor Home Modifications;
 7. Non-Medical Transportation;
 8. Paraprofessional Services;
 9. Specialized Therapies:
 - a. Animal-Assisted Therapy;
 - b. Art Therapy;
 - c. Music Therapy;
 - d. Recreational Therapy; and
 - e. Nutritional Counseling;
 10. Supportive Employment;
 11. Supportive Family-Based Alternative;
 12. Transitional Services; and
 13. Pre-Engagement Service for non-Medicaid applicants.

It is possible for the types, locations, and/or availability of Respite and Specialized Therapies to vary depending upon which provider is selected.

MEDICAID SERVICES Children and youth enrolled in the Waiver are enrolled in Medicaid and therefore entitled to all Medicaid behavioral health services, as well as services specific to the Waiver. Children and youth participating in the Waiver are authorized into Level of Care-YES (LOC-YES) in the Texas Resilience and Recovery (TRR) mental health system, which is outlined in the TRR Utilization Management Guidelines. LOC-YES authorization is 365 days.

State Medicaid Plan behavioral health services include, but are not limited to:

1. Intensive Case Management (utilized for the coordination of Waiver services);

YES WAIVER
PROGRAM OVERVIEW

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2. Psychiatric Evaluation;
3. Psychological Services;
4. Counseling;
5. Crisis Services; and
6. Rehabilitation Services.

CONTACT
INFORMATION

Further information regarding the Waiver is available through DSHS:

1. E-mail address: YESWaiver@dshs.state.tx.us;
2. Web site: <http://www.dshs.state.tx.us/mhsa/yes/>;
3. Office: 512-206-4691;
4. Fax: 512-206-5019; or
5. Mailing address:

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

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PARTICIPANT ELIGIBILITY
GENERAL REQUIREMENTS

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In accordance with 25 TAC §419.3, to participate in the Waiver, a child or youth shall meet the following criteria:

1. Be eligible to receive Medicaid, under a Medicaid Eligibility Group included in the Waiver;
2. Live in a county included in the Waiver;
3. Be reasonably expected to qualify for inpatient care under the Texas Medicaid inpatient psychiatric admissions guidelines, in the absence of Waiver services;
4. Reside in:
 - a. A non-institutional setting with the child or youth's legally authorized representative (LAR); or
 - b. The child or youth's own home or apartment, if legally emancipated; and
5. Choose, or have the LAR choose, the Waiver as an alternative to care in an inpatient psychiatric facility.

AGE RANGE

The approved age range for a Waiver participant is three to 18 years of age, up to the youth's 19th birthday.

INELIGIBILITY

An individual in either of the programs below shall not be eligible to participate in the Waiver.

FOSTER CARE

An individual is not eligible to receive Waiver services if he or she is in the foster care system.

DUAL PROGRAM
ENROLLMENT

In order to participate in the Waiver, a child or youth shall not be dually enrolled in, nor receive services from, another 1915(c) or 1915(i) program, including, but not limited to the:

1. Department of Aging and Disability Services (DADS) Waiver programs:
 - a. Community Living Assistance and Support Services (CLASS);
 - b. Home and Community-Based Services (HCS);
 - c. Medically Dependent Children Program (MDCP);
 - d. Consolidated Waiver Program (CWP);
 - e. Deaf Blind with Multiple Disabilities (DBMD);
 - f. Community-Based Alternatives (CBA); or
 - g. Texas Home Living (TxHML).
2. DSHS 1915(i) programs, including Home and Community-Based Services—Adult Mental Health (HCBS-AMH).
3. Health and Human Service Commission (HHSC) STAR PLUS Community-Based Waiver.

PARTICIPANT ELIGIBILITY
MEDICAID CRITERIA

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	<p>A child or youth shall be required to obtain and/or maintain Medicaid to in order to receive Waiver services.</p>
FINANCIAL CRITERIA	<p>To participate in the Waiver, a child or youth must meet the applicable federal financial participation limits to obtain Medicaid benefits in one of the Medicaid Eligibility Groups, as follows:</p> <ol style="list-style-type: none">1. Low-income families with children, as provided in §1931 of the Social Security Act (“Act);2. Supplemental Security Income (SSI) recipients;3. Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act; and4. All state plan groups, EXCEPT:<ol style="list-style-type: none">a. Early Aged Widow(er) – §1634(b);b. Disabled Widow(er) – §1634 (d);c. Disabled Adult Children – §1634(c); andd. Foster Care Groups under §1902(a)(10)(A)(i)(I) and §1902(a)(10)(A)(ii)(XVII).
YES SERVICES UNDER EXISTING MEDICAID BENEFIT	<p>A child or youth who meets Waiver eligibility through an existing Medicaid benefit shall continue his or her enrollment in their current Medicaid program. An individual may be enrolled in either a fee-for-service plan or managed care plan.</p>
STATE OF TEXAS ACCESS REFORM (STAR)	<p>Following approval of participation in the Waiver, an individual who is receiving SSI/Medicaid and is enrolled in the State of Texas Access Reform (STAR) program shall continue to receive those services.</p>
TYPE OF ASSISTANCE (TA)10	<p>An individual who is approved to participate in the Waiver under Type of Assistance (TA)10 shall have a traditional, fee-for-service Medicaid plan rather than STAR.</p>
OBTAINING MEDICAID BENEFITS	<p>A child or youth who is otherwise not eligible to receive Medicaid shall obtain Medicaid to participate in the Waiver. The individual must meet the SSI disability requirements under the special income limit group.</p> <p>Parental income and resources shall not be included in determining a child or youth’s special income limit.</p> <p>Individuals eligible under the special income limit group are identified as TA10 (program code “ME waiver” in the Texas Integrated Eligibility Redesign System (TIERS)). The special income limit for Medicaid in institutions is equal to 300 percent of the SSI full Federal Benefit Rate (FBR).</p>

PARTICIPANT ELIGIBILITY
MEDICAID CRITERIA

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	<p>If a child or youth receives a Social Security or Railroad Retirement benefit, or previously received SSI benefits and was denied Medicaid for reasons other than not meeting disability requirements, the disability requirement for the special income limit group shall be considered met. For all others, the Health and Human Services Commission (HHSC) shall seek a disability determination.</p> <p>An individual who is applying for Medicaid benefits under the special income limit group cannot begin Waiver services prior to the submission of his or her Medicaid application to HHSC.</p>
DISABILITY DETERMINATION	<p>The community mental health center shall assist an individual or the LAR with completing and submitting forms and documents to HHSC when disability determination is required for an individual to apply for Medicaid.</p> <p>Failure to submit all applicable disability documentation to HHSC as required shall result in a delay in Medicaid eligibility determination.</p>
HHSC FORMS FORM H1200	<p>The Medical Assistance Only (MAO) application is for an individual who is likely to qualify for Medicaid based upon the special income limit group. This application is also used to determine whether the individual qualifies for additional Medicaid programs.</p> <p>English and Spanish versions of the MAO application are available at: http://www.dads.state.tx.us/forms/H1200/.</p>
FORM H3034	<p>The Socio-Economic Report is available at: http://www.dads.state.tx.us/forms/H3034/</p>
FORM H3035	<p>The Medical Information Release/Disability Determination is available at: http://www.dads.state.tx.us/forms/H3035/</p>
SUPPORTING DOCUMENTS	<p>The community mental health center shall:</p> <ol style="list-style-type: none">1. Ensure a completed application is submitted regarding income and available resources for the individual applying for Medicaid. A note shall be included in the application if parent or guardian income and/or resource information is included and not the child or youth's.2. Assist in obtaining and submitting required verification of documents, including, but not limited to:<ol style="list-style-type: none">a. Copy of individual's birth certificate;b. Copy of individual's private insurance card (front and back);c. Financial status: three consecutive monthly bank statements, showing account holder's name(s), the ending

PARTICIPANT ELIGIBILITY
MEDICAID CRITERIA

2000.1

account balance, and must be dated from the first month of the application date.

3. Assist in obtaining and submitting the most recent 12 months of healthcare records, including:
 - a. Diagnosis Review; and
 - b. Medical records which include the diagnosis and physician's signature.
4. Assist in gathering information from other sources to help show the extent to which the individual's impairment(s) affects his or her ability to function in an educational or work setting; or the ability of the child to function compared to that of children the same age who do not have impairment(s).

Examples of other non-medical sources to gather information from are: public and private agencies; schools; parents; caregivers; social workers; employers; and other practitioners such as naturopaths, chiropractors, and audiologists.

INTENSIVE CASE
MANAGEMENT

For an individual who is not currently eligible, but who is applying for Medicaid benefits, the Wraparound Facilitator ("Facilitator") shall schedule a meeting to:

1. Engage the family in the Wraparound process;
2. Develop a crisis and safety plan;
3. Complete an individual plan of care (IPC)–Projection;
4. Provide necessary documents for individual to apply for Medicaid benefits; and
5. Complete a Clinical Eligibility Determination (CED) as required. If 90 days elapses before Waiver services begin, the clinician shall submit an updated CED before the initial IPC will be approved by DSHS.

QUALIFIED INCOME
TRUST

If an individual is ineligible for Medicaid benefits because his or her income exceeds the special income limit, the individual or LAR has the option of establishing a Qualified Income Trust (QIT). Information on how to establish a QIT is available at:

<http://www.dads.state.tx.us/handbooks/mepd/appendix/XXXVI/index.htm>

An individual who is participating Waiver services and who also has a QIT shall be required to pay a co-pay, to be determined by HHSC. A Waiver provider shall collect the co-pay prior to billing DSHS for services.

PARTICIPANT ELIGIBILITY
DEMOGRAPHIC CRITERIA

2000.2

To be eligible to participate in the YES program available in the service area where the child or youth inquired, an individual shall:

1. Be three through 18 years of age, up to the youth's 19th birthday;
2. Reside in a county included in the community mental health center service area; and
3. Reside in a non-institutional setting with his or her legally authorized representative (LAR), or in his or her own home or apartment, if legally emancipated.

MEETING
DEMOGRAPHIC
CRITERIA

For an individual who meets the demographic criteria, the community mental health center shall:

1. Schedule an appointment for clinical eligibility assessment within seven business days of the demographic eligibility screening;
2. Formally offer Waiver services, in writing, to the individual meeting clinical eligibility or LAR; and
3. Send the individual or LAR information regarding acceptance of the Waiver slot and deadline notification.

OFFER LETTER

The offer letter provided to the individual or LAR is valid for 30 days from the date of the letter.

WITHDRAWAL

In the event the individual or LAR fail to respond to the offer letter within 30 days, the community mental health center shall provide notice, in writing, to the individual or LAR that the offer of Waiver services has been withdrawn.

OUTSIDE OF SERVICE
AREA

An individual who does not meet the demographic criteria due to living outside of the community mental health center's service area shall be referred to a community mental health center serving the individual's county of residence. This includes the provision of the correct inquiry line for the YES program in his or her county of residence.

PARTICIPANT ELIGIBILITY
CLINICAL CRITERIA

2000.3

	<p>Clinical eligibility for the Waiver requires an individual to have serious functional impairment or acute psychiatric symptomatology, as determined by the clinical interview, specific domain scores from the Child and Adolescent Needs and Strengths (CANS) Assessment, and the Clinical Eligibility Determination (CED) Form.</p> <p>In addition, there shall be a reasonable expectation that, without Waiver services, the individual would qualify for inpatient care under the Texas Medicaid inpatient psychiatric admission guidelines.</p>
APPROVED CLINICIANS	<p>The initial clinical interview and clinical eligibility assessment, as well as the annual clinical re-evaluation, shall be conducted only by an approved licensed master's level clinician: clinical social worker, marriage and family therapist, professional counselor, or psychologist.</p>
CANS ASSESSMENT CRITERIA	<p>An individual must meet the clinical level of care criteria in accordance with the CANS Assessment Criteria A through E.</p>
CRITERIA A	<p>The individual must score at the identified levels on the following domains:</p> <ol style="list-style-type: none">1. Score a 0 or 1 on Life Domain Functioning – Development; OR2. Score a 2 or 3 on Life Domain Functioning – Development; AND3. Score a 0, 1, or 2 on Developmental Disability Module: Cognitive; AND4. Score a 0 or 1 on Development Disability Module: Developmental.
CRITERIA B	<p>The individual must score at the identified levels on one or more of the following domains:</p> <ol style="list-style-type: none">1. Score a 3 on Child Risk Behaviors: Suicide Risk;2. Score a 3 on Child Risk Behaviors: Self-Mutilation;3. Score a 3 on Child Risk Behaviors: Self Harm;4. Score a 2 or 3 on Child Risk Behaviors: Danger to Others;5. Score a 2 or 3 on Child Risk Behaviors: Sexual Aggression;6. Score a 2 or 3 on Child Risk Behaviors: Fire Setting;7. Score a 2 or 3 on Child Risk Behaviors: Delinquency;8. Score a 2 or 3 on Caregiver Strengths and Needs: Involvement with Care;

PARTICIPANT ELIGIBILITY
CLINICAL CRITERIA

2000.3

9. Score a 2 or 3 on Caregiver Strengths and Needs: Family Stress;
10. Score a 2 or 3 on Caregiver Strengths and Needs: Safety;
11. Score a 2 or 3 on Life Domain Functioning: School; AND
12. Score a 2 or 3 on Life Domain Functioning: School Module – School Behavior; OR
13. Score a 2 or 3 on Life Domain Functioning: School Module – School Attendance;
14. Score a 1 on Psychiatric Hospitalization; AND
15. Score 1, 2, or 3 on Psychiatric Hospitalization: Psychiatric Hospitalization Module – Time Since Most Recent Discharge.

CRITERIA C

Outpatient therapy or partial hospitalization has been attempted and failed or a psychiatrist has documented reasons why an inpatient level of care is required.

CRITERIA D

A Medicaid-eligible child or youth shall meet at least one of the following Texas Medicaid Inpatient Psychiatric Admission criteria:

1. The child or youth is presently a danger to self, demonstrated by at least one of the following:
 - a. Recent suicide attempt or active suicidal threats with a deadly plan and an absence of appropriate supervision or structure to prevent suicide;
 - b. Recent self-mutilating 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, or the like;
 - c. 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
 - d. 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.
2. The child or youth 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. Danger is presented by:

PARTICIPANT ELIGIBILITY
CLINICAL CRITERIA

2000.3

- a. 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;
 - b. 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
 - c. Active hallucinations or delusions directly or likely to lead to serious harm of others.
3. The child or youth exhibits acute onset of psychosis or severe thought disorientation, or there is significant clinical deterioration in the condition of the child or youth with chronic psychosis, rendering him or her unmanageable and unable to cooperate in treatment. This child or youth is in need of assessment and treatment in a safe and therapeutic setting.
 4. The child or youth has a severe eating or substance abuse disorder, which requires 24-hour a day medical observation, supervision, and intervention.
 5. The proposed treatment or therapy requires 24-hour a day medical observation, supervision, and intervention.
 6. The child or youth exhibits severe disorientation to person, place, or time.
 7. The child or youth's evaluation and treatment cannot be carried out safely or effectively in other settings due to severely disruptive behaviors, including, but not limited to, physical, psychological, or sexual abuse.
 8. The child or youth requires medication therapy or complex diagnostic evaluation where his or her level of functioning precludes cooperation with the treatment regimen.

CRITERIA E The child or youth's admitting diagnosis must be an Axis I diagnosis.

EXCEPTION If an individual meets all criteria except criteria A and is thereby eligible for non-mental health specific programs, then the clinician must provide additional information to DSHS to verify that the individual can both actively participate and more appropriately benefit from YES Waiver services versus non-mental health specific programs targeting the child's clinical needs. DSHS shall evaluate additional information submitted to determine the child or youth's anticipated benefit from and eligibility for Waiver services.

PARTICIPANT ELIGIBILITY
FAILURE TO MEET CRITERIA AND RIGHT TO APPEAL

2000.4

An individual who does not meet clinical eligibility shall not be enrolled in the YES Waiver or be authorized into LOC-YES. The community mental health center shall not be required to conduct an intake of any individual because he or she fails to meet Waiver eligibility criteria. However, the LMHA must authorize the appropriate LOC for the individual with a denied CED within seven days of the CED denial to prevent a default authorization.

NOTICE OF APPEAL

The community mental health center shall provide written notice, within seven business days, to an individual or LAR of the right to appeal, in accordance with 25 TAC §419.8, available at:

[http://texreg.sos.state.tx.us/public/readtac\\$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=419&rl=8](http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=419&rl=8).

PARTICIPANT APPROVAL PROCESS
WAIVER APPLICATION

2100

SUBMITTING THE
APPLICATION

The community mental health center shall provide all forms, documents, and a scanned image of the Waiver application to the Department of State Health Services (DSHS) within 30 days of completing an individual's clinical eligibility assessment.

The application shall be submitted to DSHS via secure email at: YESWaiver@dshs.state.tx.us.

PARTICIPANT APPROVAL PROCESS
MEDICAID BENEFITS

2100.1

MEDICAID DETERMINATION	<p>Upon receipt of a completed Medicaid application, the Health and Human Services Commission (HHSC) makes a determination of Medicaid benefits within:</p> <ol style="list-style-type: none">1. 45 days, when disability determination is not required; or2. 90 days, when a disability determination is required.
NOTICE OF APPROVAL OR DENIAL	<p>The Department of State Health Services (DSHS) shall notify the community mental health center via email within 48 hours of receiving the notice of approval or denial of Medicaid from HHSC.</p>
APPROVAL	<p>Upon approval of Medicaid benefits, HHSC establishes the Medicaid Effective Date (MED) in the Texas Integrated Eligibility Redesign System (TIERS).</p>
MEDICAID EFFECTIVE DATE (MED)	<p>The (MED) under the special income limit group is based upon the date Medicaid benefits begin for Waiver services, and is consistent with the individual's approved Individual Plan of (IPC) Care. DSHS shall provide HHSC with the effective date of Waiver services.</p> <p>The MED shall be dated back to the first day of the month of the Medicaid application. Example: A Medicaid application signed on June 17 would have a MED of June 1, if it is determined that all eligibility requirements are met for the month of June.</p>
PROVISIONAL WAIVER ENROLLMENT	<p>The community mental health center shall be permitted to enroll an individual who is waiting for a Medicaid determination from HHSC in the Waiver, on a provisional basis. The individual or legally authorized representative (LAR) shall be notified, in writing, that if Medicaid is denied for any reason, the individual will no longer be eligible to receive Waiver services.</p> <p>The community mental health center and Waiver service providers shall not be guaranteed payment for services rendered in the event Medicaid is denied.</p> <p>The community mental health center and Waiver service providers shall not be guaranteed payment for services for which claims are submitted beyond 95 days of the provision of those services.</p>
DENIAL	<p>Denial of an individual's application for Medicaid benefits shall render him or her unable to participate in the Waiver.</p>
MAINTAINING MEDICAID	<p>An individual shall be required to maintain Medicaid benefits so long as he or she is participating in the Waiver.</p> <p>The community mental health center shall assist an individual or LAR in renewing Medicaid benefits in accordance with HHSC rules.</p>

PARTICIPANT APPROVAL PROCESS
ENROLLMENT

2100.2

	<p>Upon determining that the participant meets all demographic and clinical criteria, the clinician shall recommend LOC YES and complete the Clinical Eligibility Determination (CED) Form.</p> <p>The CED shall be entered into Clinical Management for Behavioral Health Services (CMBHS) within seven business days of completion of the CED.</p> <p>An individual with an approved CED is authorized in LOC-YES so that he or she may receive TRR services available in that LOC. An LOC-YES authorization is for 365 days.</p>
INDIVIDUAL PLAN OF CARE (IPC)	<p>The initial individual plan of care (IPC) or IPC–Projection (depending on the individuals’ Medicaid status) shall be completed within ten business days of completing the CED.</p>
CLINICAL ELIGIBILITY DETERMINATION (CED) DURATION	<p>Once approved, the CED is valid for 365 days from the Waiver start date in CMBHS.</p> <p>For individuals waiting to receive a Medicaid eligibility determination, if 90 days elapses before Waiver services begin (not inclusive of TRR services provided in LOC-YES), the clinician must submit an updated CED before the initial IPC will be approved by DSHS.</p>
WRAPAROUND FACILITATOR	<p>Within seven days of determining that the participant meets all demographic and clinical eligibility criteria:</p> <ol style="list-style-type: none">1. The community mental health center shall assign a Wrap-around Facilitator; and2. The Facilitator shall meet face-to-face with the participant and the legally authorized representative (LAR).

WAIVER PARTICIPATION
PARTICIPANT RIGHTS AND RESPONSIBILITIES

2200

NOTICE OF
PARTICIPANT RIGHTS

The community mental health center shall review a participant's rights with the participant or legally authorized representative (LAR). The community mental health center shall provide the participant or LAR with a Notification of Participant Rights Form. The participant or LAR shall sign the form and return it to the community mental health center within ten calendar days of receipt from the community mental health center.

Failure of a participant or LAR to submit the form within ten calendar days shall result in the withdrawal of the offer of Waiver services.

The community mental health center shall provide to the participant or LAR a copy of the Department of State Health Services (DSHS) Handbook of Consumer Rights: Mental Health Services, available at: <http://www.dshs.state.tx.us/mhsa-rights/>

PROVIDER CHOICE

A participant and/or LAR in the Waiver shall have the right to choose among approved comprehensive waiver provider (CWP) in his or her county of residence from which to receive Waiver services. A participant and/or LAR in the Waiver shall also have choice of individual service providers within the CWP.

The Local Mental Health Authority (LMHA) shall assist the participant and/or LAR in selecting a CWP by:

1. Providing a list of all approved CWPs serving the participant's county of residence, which shall include location, contact information, and phone number; and
2. Providing all available material and information on each CWP.

The participant's choice of CWP shall be documented on the Provider Choice Form within 30 calendar days after the LMHA provides the list of approved CWPs to the participant or LAR.

REFERRAL

When the community mental health center is not the CWP chosen by the participant and/or LAR, the LMHA shall coordinate the referral to the participant's choice of CWP by preparing and submitting the Participant Referral Form to the selected CWP.

PARTICIPANT
RESPONSIBILITIES

A participant in the waiver shall agree to the following:

1. Be an active member of the Child and Family Team;
2. Participate fully in the services identified in the individual plan of care (IPC);
3. Continuously meet Medicaid and demographic eligibility criteria;

WAIVER PARTICIPATION
PARTICIPANT RIGHTS AND RESPONSIBILITIES

2200

4. Notify the community mental health center and CWP of any changes to living arrangement or location of residence; and
5. Notify the community mental health center and CWP of any changes to financial status which may affect Medicaid eligibility or renewal. (See MEDICAID ELIGIBILITY, 3000.1)

CONSENT FORM

Each participant shall complete a Participant Consent Form, which outlines participant responsibilities. The form shall be signed by the participant or LAR and returned to the community mental health center within ten calendar days of receiving the form.

Failure of a participant or LAR to submit the form within ten calendar days shall result in the withdrawal of the offer of Waiver services.

RELEASE OF
INFORMATION

The participant, LAR, a community mental health center representative, and a CWP representative shall all sign a Release of Information Form to permit the community mental health center and the CWP to exchange information about the participant's services, progress, and other information deemed necessary by the Child and Family Team.

COMPLAINTS

To file a complaint, contact the DSHS Consumer Services and Rights Protection Unit Monday through Friday, from 8:00 a.m. to 5:00 p.m. at:

Toll Free: 1-800-252-8154
Local: 512-206-5760

Complaints can also be submitted in writing to:

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

ABUSE, NEGLECT, OR
EXPLOITATION

Complaints involving allegations of abuse, neglect, or exploitation shall be immediately referred to the Department of Family and Protective Services (DFPS) at 1-800-252-5400. See REPORTING ABUSE, NEGLECT, OR EXPLOITATION, policy 2300.3 of this manual.

COMMUNITY MENTAL HEALTH CENTER RESPONSIBILITIES
INQUIRY LIST

2300

INQUIRY LIST	<p>The community mental health center shall establish and maintain an inquiry list of individuals interested in YES Waiver (“Waiver”) program services in its service area.</p> <p>A copy of the community mental health center’s up-to-date inquiry list shall be submitted to the Department of State Health Services (DSHS) on the last business day of each month.</p> <p>DSHS shall approve the inquiry list management policy for each service area in the Waiver.</p>
CONTENTS	<p>The inquiry list shall be comprehensive and, at minimum, shall include the information in the DSHS Inquiry List sample.</p>
PHONE LINE	<p>The community mental health center shall establish and maintain a phone line in accordance with the following:</p> <ol style="list-style-type: none"><li data-bbox="560 798 1161 840">1. A direct Waiver Inquiry phone number; or<li data-bbox="560 850 1494 934">2. An agency-wide phone number equipped with an operating system which provides a Waiver Inquiry option for callers. <p>Phone messages received on the Waiver Inquiry phone line shall be returned within 48 hours or two business days.</p>
REGISTRATION	<p>Slots in the Waiver program shall be filled on a first-come, first-serve basis based upon the chronological date and time the phone call or voice message is received.</p> <p>An individual’s registration on the inquiry list shall be permitted only by the individual or the individual’s legally authorized representative (LAR) contacting the community mental health center directly.</p> <p>An individual shall not be placed on the inquiry list if contact to the community mental health center is from a referral agency acting on behalf of the individual or LAR.</p>
PROGRAM INFORMATION	<p>The community mental health center shall provide general information about the Waiver to an interested individual or LAR, including but not limited to:</p> <ol style="list-style-type: none"><li data-bbox="560 1533 1031 1575">1. Description of Waiver services;<li data-bbox="560 1585 1031 1627">2. Demographic eligibility criteria;<li data-bbox="560 1638 1006 1680">3. Clinical eligibility criteria; and<li data-bbox="560 1690 974 1732">4. Financial eligibility criteria. <p>An individual or LAR shall be informed that if the individual is enrolled in the Waiver, he or she shall not be eligible to participate in another Medicaid 1915(c) home and community-based or 1915(i) waiver at the same time.</p>

COMMUNITY MENTAL HEALTH CENTER RESPONSIBILITIES
INQUIRY LIST

2300

NOTIFICATION OF
SLOT AVAILABILITY

When a participant slot is available or is projected to be available within 30 days, the community mental health center shall notify the next individual or LAR on the list.

REMOVAL FROM
INQUIRY LIST

The community mental health center shall provide written notification to an individual or the individual's LAR of removal from the inquiry list.

COMMUNITY MENTAL HEALTH CENTER RESPONSIBILITIES
CO-OCCURRING DIAGNOSIS

2300.1

The community mental health center shall ensure that a Waiver participant with a co-occurring diagnosis is offered services which address both severe emotional disturbance (SED) and his or her intellectual or developmental disability (IDD) or Pervasive Developmental Disorder (PDD).

ASSESSMENT

Additional assessment and planning of appropriate services and service delivery shall be required for a participant with a co-occurring diagnosis of:

1. IDD – mental retardation (mild, moderate, severe, profound, or unspecified); or
2. PDD – Autistic disorder, Rett’s Disorder, Childhood Disintegrative Disorder, Asperger’s Disorder, and PDD Not Otherwise Specified.

WAIVER SERVICES

Community-based services and supports received through the Waiver shall address the participant’s needs that arise as a result of and are specific to his or her SED. YES Waiver services do not meet the participant’s needs that arise as a result of the diagnoses identified directly above.

INDIVIDUAL PLAN OF CARE (IPC)

The individual plan of care (IPC) for a participant with a co-occurring IDD diagnosis shall identify non-Waiver services the participant needs in relation to his or her IDD diagnosis. These shall be noted at Other Non-Waiver Medicaid State Plan Services or Non-Waiver Services—Services Provided by Other Funding Sources.

COMMUNITY MENTAL HEALTH CENTER RESPONSIBILITIES
REPORTING ABUSE, NEGLECT, OR EXPLOITATION

2300.2

REPORTING POLICY The community mental health center shall develop, implement, and enforce a written policy which trains all direct service staff members on requirements for reporting abuse, neglect, or exploitation (ANE).

At a minimum, the policy shall cover the Department of State Health Services (DSHS) Child Abuse Screening, Documenting, and Reporting Policy for Contractors/Providers, available at:

http://www.dshs.state.tx.us/childabuserreporting/gsc_pol.shtm.

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

1. The Texas Department of Family and Protective Services (DFPS) via:
 - a. Texas Abuse Hotline, 1-800-252-5400, 24 hours a day, seven days a week;
 - b. Fax at 1-800-647-7410; or
 - c. Web site at <https://www.txabusehotline.org/Login/>
2. Any local or state law enforcement agency;
3. The state agency that operates, licenses, certifies, or registers the facility in which the alleged abuse occurred; or
4. 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.

EMERGENCIES All emergency situations must be reported by calling 911 or contacting the local law enforcement agency.

The DFPS Web site is to be used only for reporting situations that do not require an emergency response, as it may take up to 24 hours for a report made through the Web site to be processed.

ALLEGATIONS OF ABUSE, NEGLECT, OR EXPLOITATION (ANE) Allegations of ANE shall be reported by the community mental health center to the appropriate investigative authority immediately.

Within one calendar day following an allegation of ANE, the community mental health center shall submit a Client Abuse Reporting Form to DFPS. The form is available at:

<http://www.dshs.state.tx.us/childabuserreporting/checklist.shtm>

INVESTIGATIVE AUTHORITY Investigative authority over allegations of ANE shall be in accordance with the following:

COMMUNITY MENTAL HEALTH CENTER RESPONSIBILITIES
REPORTING ABUSE, NEGLECT, OR EXPLOITATION

2300.2

DFPS

DFPS shall have investigative authority of ANE involving Waiver participants when the alleged perpetrator(s) is:

1. An employee of the community mental health center;
2. An employee of an agent of the community mental health center;
3. An employee of a subcontractor of the community mental health center; or
4. A parent or primary caregiver.

LAW
ENFORCEMENT

Law enforcement shall have investigative authority of allegations of ANE involving Waiver participants when the alleged perpetrator is any other entity or any other person not under DFPS investigative authority.

COMMUNITY MENTAL HEALTH CENTER RESPONSIBILITIES
CRITICAL INCIDENT REPORTING

2300.3

A community mental health center, comprehensive waiver provider (CWP), and direct service provider shall be required to report all critical incidents that result in substantial disruption of program operation involving or potentially affecting a Waiver participant.

The Department of State Health Services (DSHS) shall be responsible for overseeing the reporting of and response to critical incidents.

CRITICAL INCIDENT
REPORT

The first employee of the community mental health center, CWP, or direct service provider with knowledge of an incident shall complete the Critical Incident Report and submit it to the Wraparound Facilitator ("Facilitator") within 24 hours of finding out an incident occurred.

The Facilitator shall be responsible for submitting the Critical Incident Report to DSHS, within 72 hours of receiving the report.

Examples of incidents required to be reported include, but are not limited to:

1. Medical injuries;
2. Hospitalizations;
3. Behavioral or psychiatric emergencies;
4. Allegations of violation(s) of participant rights;
5. Criminal activity;
6. Conduct involving restraints;
7. Property loss or damage;
8. Vehicle loss or damage;
9. Medication errors;
10. Participant departure;
11. Legal/juvenile justice department involvement; or
12. Death.

FOLLOW UP

The Facilitator shall be responsible for following up on the incident within 72 hours and resubmitting the Critical Incident Report to DSHS with updated information and the outcome of the incident, if applicable.

TEMPORARY
INPATIENT SERVICES

In the event a Waiver participant must be placed in temporary inpatient services for a maximum of 90 days, the participant's Waiver eligibility shall not be affected, so long as the community mental

COMMUNITY MENTAL HEALTH CENTER RESPONSIBILITIES
CRITICAL INCIDENT REPORTING

2300.3

health center monitors the individual on a monthly basis, and concludes that he or she needs Waiver services.

Upon admission and discharge from a hospital, the community mental health center shall complete and submit the Critical Incident Report to DSHS within 72 hours of being notified of the hospitalization or discharge.

Within seven days of discharge from an inpatient psychiatric setting, the Facilitator shall meet with the participant and LAR to review and update the crisis/safety plan.

The Child and Family Team shall meet to update the individual plan of care (IPC) and submit the revised IPC to DSHS within 30 days of the participant's discharge from the hospital or institution.

CRITICAL INCIDENTS
RELATED TO ABUSE,
NEGLECT, OR
EXPLOITATION (ANE)

Critical incidents related to abuse, neglect, or exploitation (ANE) shall be handled in accordance with REPORTING ABUSE, NEGLECT, OR EXPLOITATION, policy 2300.3 of this manual.

RISK ASSESSMENT

DSHS shall conduct a risk assessment of community mental health centers and comprehensive waiver providers (CWP) on a quarterly basis. The assessment shall include a review of any reported critical incidents and/or events.

Data gathered from risk assessments shall be reported to the Texas Health and Human Services Commission (HHSC) annually.

COMMUNITY MENTAL HEALTH CENTER RESPONSIBILITIES
WRAPAROUND FACILITATOR

2300.4

	<p>The Waiver utilizes the National Wraparound Implementation Center (NWIC) model as the intensive case management delivery method for Waiver participants. See TRAINING, policy 3500.2 of this manual.</p>
WRAPAROUND FACILITATOR	<p>In accordance with NWIC requirements, the Wraparound Facilitator (“Facilitator”) shall be responsible for coordinating and leading the Child and Family Team meetings to:</p> <ol style="list-style-type: none">1. Develop goals and objectives;2. Crisis/safety planning;3. Develop the Individual Plan of Care (IPC);4. Conduct periodic review of the participant’s IPC; <p>See INDIVIDUAL PLAN OF CARE, policy 2300.6 of this manual.</p>
CHILD AND FAMILY TEAM MEETING	<p>Child and Family Team meeting to shall include the following members:</p> <ol style="list-style-type: none">1. Waiver participant;2. Legally Authorized Representative (LAR); and/or3. Family members;4. Identified informal supports;5. Identified formal supports; and6. Representation from the selected comprehensive waiver provider (CWP).
OVERSIGHT	<p>The community mental health center shall oversee the Facilitator’s efforts to ensure that:</p> <ol style="list-style-type: none">1. All required meetings and contact occur;2. Modifications to the individual plan of care (IPC) occur as necessary; and3. The Facilitator’s documentation demonstrates compliance with Waiver requirements.
DOCUMENTATION AND RECORD KEEPING REQUIREMENTS	<p>The Facilitator shall document Waiver services in accordance with TAC §414, Subchapter I, regarding Intensive Case Management. See RECORD KEEPING, policy 2700.3 of this manual.</p>

COMMUNITY MENTAL HEALTH CENTER RESPONSIBILITIES
INDIVIDUAL PLAN OF CARE

2300.5

INITIAL INDIVIDUAL PLAN OF CARE (IPC)	<p>An initial individual plan of care (IPC) is required to obtain authorization for Waiver services from DSHS. The initial IPC can be completed without every team member present or in the absence of the comprehensive waiver provider (CWP).</p> <p>The CWP, or designee, shall be required to be present at any and all revisions to the IPC after development of the initial IPC.</p>
DEVELOPMENT	<p>IPC development shall include:</p> <ol style="list-style-type: none">1. Identifying the types of Waiver services;2. Identifying annual quantity of Waiver services;3. Calculating annual cost of proposed services;4. State Plan Services;5. Non-Waiver services (i.e. Department of State Health Services (DSHS) general revenue flexible funds).
EFFECTIVE DATE	<p>The effective date is the date DSHS approves the IPC to be in effect, which defaults to the IPC Start Date.</p>
END DATE	<p>The end date is the end date of the CED.</p>
ANNUAL RENEWAL INDIVIDUAL PLAN OF CARE (IPC)	<p>An Annual Renewal IPC shall be completed prior to the end of the current IPC end date. Prior to completion of the Annual Renewal IPC, the clinician shall re-evaluate the participant to determine clinical eligibility to continue participation in the Waiver.</p> <p>Once the clinician determines that clinical eligibility is met, the Wraparound Facilitator (“Facilitator”) shall coordinate a Child and Family Team meeting to develop the Annual Renewal IPC, in accordance with the Wraparound model. See WRAPAROUND FACILITATOR, policy 2300.5 of this manual.</p>
EFFECTIVE DATE	<p>The effective date is the date DSHS authorizes the IPC.</p>
END DATE	<p>The end date is the end date of the CED.</p>
START DATE	<p>In the event the requested start date of the IPC is earlier than the date the IPC was submitted to DSHS, the community mental health center shall provide explanation for beginning services prior to receiving DSHS approval. Reasons to begin services prior to DSHS approval may include, but are not limited to: critical need existed to provide services in order to immediately prevent a crisis.</p>
BILLABLE ACTIVITIES	<p>Waiver services shall be provided and billed at the frequency and duration specified in the IPC, and in accordance with the billing policies for each specific Waiver service. See BILLING policies, beginning at 2800.4, of this manual.</p>

COMMUNITY MENTAL HEALTH CENTER RESPONSIBILITIES
INDIVIDUAL PLAN OF CARE

2300.5

OVERSIGHT	<p>The community mental health center shall oversee clinical eligibility determinations (CEDs) and IPCs to verify that:</p> <ol style="list-style-type: none">1. Medicaid, demographic, and clinical eligibility criteria are met; and2. Any applicable Waiver service and associated cost limitations are not exceeded.
DEPARTMENT OF STATE HEALTH SERVICES (DSHS) REVIEW	<p>The community mental health center shall enter the IPC into Clinical Management for Behavioral Health Services (CMBHS) and place in 'Ready for Review' status within seven business days of completing the IPC with the Child and Family Team.</p> <p>DSHS shall review the submitted IPC within five business days of the date the IPC was entered into CMBHS. Requests for clarification or questions regarding the IPC from the DSHS authorizer shall be placed in the 'Note' section and the IPC shall be placed into 'Draft' status.</p> <p>The community mental health center shall be responsible for monitoring the status of the IPC. Requests for changes must be communicated to DSHS prior to authorization of the IPC. Changes shall be made by the Facilitator and placed back in 'Ready for Review' status within five business days of the IPC being placed back into 'Draft' status by DSHS.</p>
COMPREHENSIVE WAIVER PROVIDER COPY	<p>The community mental health center shall provide a copy of the current IPC authorized by DSHS to the CWP within three business days of DSHS approval.</p>
PERIODIC REVIEW	<p>To ensure appropriate services are provided to assist the participant with achieving identified goals, the IPC shall be reviewed and revised in CMBHS every 90 days, at minimum. In accordance to fidelity to the Wraparound process changes are likely to occur at least every 30 days.</p> <p>A revised IPC shall be reviewed by DSHS as described in DSHS REVIEW, above.</p>
REASSESSMENT	<p>The participant shall be reassessed every 90 days using the Child and Adolescent Needs and Strengths (CANS) assessment. These assessments do not impact clinical eligibility.</p>
DENIAL	<p>If an IPC is denied for any reason, DSHS shall provide a reason for the denial in the 'Reviewer Notes' section of the denied IPC.</p>
APPEAL	<p>The community mental health center shall be permitted to appeal a denial of an IPC by submitting an Appeal IPC to DSHS within 14 business days of the date of denial.</p>

COMMUNITY MENTAL HEALTH CENTER RESPONSIBILITIES
INDIVIDUAL PLAN OF CARE–PROJECTION

2300.6

	<p>To document medical necessity for a Waiver participant who is waiting for Medicaid benefit approval, the community mental health center shall develop an individual plan of care (IPC)–Projection.</p> <p>The IPC–Projection is not an authorization for the participant to receive Waiver services.</p>
START DATE	<p>The IPC–Projection start date shall be the date the IPC was completed with the participant and family.</p>
INITIAL INDIVIDUAL PLAN OF CARE (IPC) UPON MEDICAID APPROVAL	<p>Upon approval of Medicaid benefits by HHSC, an initial IPC shall be completed in accordance with policy to enable the participant to begin receiving Waiver services. See INDIVIDUAL PLAN OF CARE, policy 2300.5 of this manual.</p>
EFFECTIVE_DATE	<p>The effective date of the initial IPC can be the date the IPC–Projection was completed; however, the actual date the initial IPC was completed shall be indicated in the ‘Notes’ section when the community mental health center enters the initial IPC into Clinical Management for Behavioral Health Services (CMBHS).</p>
PAYMENT NOT GUARANTEED	<p>The community mental health center and Waiver service providers shall not be guaranteed payment for services rendered in the event Medicaid is denied.</p> <p>The community mental health center and Waiver service providers shall not be guaranteed payment for services for which claims are submitted beyond 95 days of the provision of those services.</p>

COMMUNITY MENTAL HEALTH CENTER RESPONSIBILITIES
PARTICIPANT TRANSFER

2300.7

RELOCATION WITHIN TEXAS The community mental health center shall coordinate the transfer of Waiver services for a participant who moves to a different Waiver service area in the state.

RELOCATION OUTSIDE OF TEXAS A participant who moves out of the state shall no longer be eligible to participate in the Waiver and shall be terminated from the Waiver program. The community mental health center shall inform the participant and legally authorized representative (LAR) that Waiver services shall be terminated. See TERMINATION, policy 2400.10 of this manual.

The community mental health center shall complete and submit an individual plan of care (IPC)–Termination in the Clinical Management for Behavioral Health Services (CMBHS), documenting the reason for, and effective date of, termination.

INITIATING PARTICIPANT TRANSFER The community mental health center initiating the transfer of the participant's Waiver services shall:

1. Email the Department of State Health Services (DSHS) via encrypted email within 72 hours of being notified of the participant's relocation and include the following info:
 - a. Participant name;
 - b. Expected date of transfer; and
 - c. Receiving service area, if known;
2. Obtain a release of information from the participant or legally authorized representative (LAR) within five business days of receiving notice that the participant is transferring;
3. Contact the receiving community mental health center to inform staff of the pending transfer;
4. Prepare a transfer packet to send to the receiving community mental health center, which shall include:
 - a. A copy of the Clinical Eligibility form;
 - b. The valid individual plan of care (IPC);
 - c. A copy of the current Child and Youth Needs and Strengths (CANS) Assessment
5. Notify the comprehensive waiver provider (CWP) of the impending transfer.
6. Invite the receiving community mental health center to participate in the Wraparound termination meeting with the initiating community mental health center.

COMMUNITY MENTAL HEALTH CENTER RESPONSIBILITIES
PARTICIPANT TRANSFER

2300.7

RECEIVING
PARTICIPANT
TRANSFER

Once the transfer is completed, the community mental health center shall submit an IPC termination in CMBHS.

The community mental health center receiving the participant transfer shall:

1. Review the transfer packet.
2. Contact the participant or LAR to schedule a face-to-face meeting within seven business days of receiving the transfer.
3. Appoint a Wraparound Facilitator.
4. Identify the Child and Family Team.
5. Determine whether current IPC shall be adopted as written or revised, or whether a new IPC shall be developed.
6. Update the participant's CANS, if needed.
7. Submit a new IPC within ten calendar days in CMBHS.

COMMUNITY MENTAL HEALTH CENTER RESPONSIBILITIES
TRANSITION PLAN–LEVEL OF CARE

2300.8

When the Child and Family Team determines that it is in the best interest of a Waiver participant to transition out of Waiver services to a less-intensive service array, and/or can utilize natural and community supports to achieve his or her goals and objectives, the community mental health center and comprehensive waiver provider (CWP) shall develop a transition plan.

PLAN DEVELOPMENT

The transition plan shall be developed in consultation with the participant, legally authorized representative (LAR), current CWP, and future providers.

The transition plan shall include:

1. A summary of the mental health community services and treatment the youth received as a Waiver participant;
2. The participant's current status (e.g., diagnosis, medications, level of functioning) and unmet needs;
3. Information from the participant and the LAR regarding the participant's strengths, preferences for mental health community services, and responsiveness to past interventions;
4. A service plan that indicates the mental health and other community services the participant shall receive; and
5. Adequate time for both current and future providers to transition natural supports and/or community based services without a disruption in services.

NOTIFICATION OF
TRANSITION

The community mental health center shall notify the CWP of a participant's upcoming transition out of Waiver services.

TERMINATION OF
SERVICES

The community mental center shall submit a copy of the transition plan to DSHS at least 30 days prior to the participant's termination from the Waiver.

INDIVIDUAL PLAN
OF CARE (IPC)

An individual plan of care (IPC)–Termination shall be entered into Clinical Management for Behavioral Health Services (CMBHS) within ten business days of the participant's termination from the Waiver.

COMMUNITY MENTAL HEALTH CENTER RESPONSIBILITIES
TRANSITION PLAN—AGING OUT

2300.9

	<p>The community mental health center shall establish a plan for any participant who turns 19 years of age while receiving Waiver services to transition out of the Waiver.</p>
PLAN DEVELOPMENT	<p>At least six months prior to the participant's 19th birthday, development of the transition shall begin, in consultation with the participant, legally authorized representative (LAR), current comprehensive waiver provider (CWP), and future providers.</p> <p>The transition plan shall include:</p> <ol style="list-style-type: none">1. A summary of the mental health community services and treatment the youth received as a Waiver participant;2. The participant's current status (e.g., diagnosis, medications, level of functioning) and unmet needs;3. Information from the participant and the legally authorized representative (LAR) regarding the participant's strengths, preferences for mental health community services, and responsiveness to past interventions;4. A service plan that indicates the mental health and other community services the participant shall receive as an adult; and5. Adequate time for both current and future providers to transition the participant into adult services without a disruption in services.
NOTIFICATION OF TRANSITION	<p>The community mental health center shall notify the CWP and the Department of State Health Services (DSHS) at least six months prior to a participant's transition out of Waiver services.</p>
TERMINATION OF SERVICES	<p>The participant's transition out of, and termination from, the Waiver shall be completed on the last day of the month preceding the participant's 19th birthday.</p> <p>The community mental health center shall submit a copy of the transition plan to DSHS at least 30 days prior to the participant's date of termination from the Waiver.</p>
INDIVIDUAL PLAN OF CARE (IPC)	<p>An individual plan of care (IPC)—Termination shall be entered into Clinical Management for Behavioral Health Services (CMBHS) within ten business days of the participant's termination from the Waiver.</p>

COMMUNITY MENTAL HEALTH CENTER RESPONSIBILITIES
TERMINATION OF WAIVER SERVICES

2300.10

A Waiver participant shall be terminated from the Waiver in the event:

1. The participant meets treatment goals, completes the course of treatment, and no longer requires Waiver services;
2. The participant no longer meets Waiver eligibility criteria upon re-evaluation;
3. The participant no longer resides with the legally authorized representative (LAR);
4. The participant no longer resides in the state of Texas;
5. The cost of services and supports provided in the home or community exceeds the cost neutrality guidelines of the Waiver;
6. The participant is in and out of home placement for more than 90 days (psychiatric hospital, substance abuse treatment center, residential treatment center, or juvenile justice custody);
7. The participant reaches the last day of the month preceding his or her 19th birthday;
8. The participant and/or the LAR select hospital or institutional services rather than Waiver services;
9. The participant and/or the LAR choose to discontinue participation in the Waiver;
10. The participant and/or the LAR refuse Waiver services for 90 consecutive days;
11. The participant is placed in Child Protective Services (CPS) custody; or
12. The participant is deceased.

INDIVIDUAL PLAN OF
CARE (IPC)–
TERMINATION

An individual plan of care (IPC)–Termination shall be entered into Clinical Management for Behavioral Health Services (CMBHS) within ten business days of the participant’s termination from the Waiver.

If the participant or LAR refuses services, moves, is not engaged in Waiver services and the Wraparound process, is unable to sign the IPC–Termination, or is in a residential treatment facility for more than 90 days, the Wraparound Facilitator shall provide documentation in the ‘Notes on IPC Type’ section of the IPC–Termination.

COMMUNITY MENTAL HEALTH CENTER RESPONSIBILITIES
OUTREACH

2300.11

To increase awareness of home and community-based services available to children and youth with severe emotional disturbance (SED), ages three to 18, the community mental health center shall develop and implement a strategic outreach and marketing plan.

OUTREACH
STRATEGIES

Some strategies the community mental health center shall utilize for outreach and marketing shall include, but not be limited to:

1. Posting an overview of the Waiver on the community mental health center's Web site;
2. Utilizing marketing materials available through the Department of State Health Services (DSHS);
3. Establishing a Waiver Inquiry phone line (See INQUIRY LIST, policy 2300 of this manual);
4. Working with stakeholders in the community mental health center's service area to identify potential participants;
5. Presenting information about the Waiver at community events; and
6. Conducting presentations for staff of behavioral health centers, social service agencies, school districts, behavioral health consortia, private hospitals, juvenile justice centers, managed care organizations, and other potential referral sources.

OUTREACH MATERIAL
APPROVAL

Any tools or information developed by the community mental health center for use in its outreach and marketing plan shall be submitted to, and approved by, DSHS prior to dissemination.

COMPREHENSIVE WAIVER PROVIDER
CREDENTIALING AND ENROLLMENT

2400

NOTICE OF OPEN ENROLLMENT (NOE)	<p>The Department of State Health Services (DSHS) shall post a Notice of Open Enrollment (NOE) to request applications for entities interested in providing all services covered under the Waiver.</p> <p>The NOE shall describe the eligibility requirements for an entity to become a credentialed comprehensive waiver provider (CWP). An interested entity shall meet, and must maintain, the eligibility requirements contained in the NOE throughout the application and selection process.</p> <p>The interested entity shall submit the application in accordance with the instructions provided in the NOE.</p>
CREDENTIALING	<p>CWPs shall be credentialed by DSHS through a desk review and an on-site review. The community mental health center shall not be responsible for, nor have a role in, credentialing CWPs.</p>
DESK REVIEW	<p>Upon receiving the application and other required documents, DSHS shall complete a review of all submitted materials within ten business days.</p> <p>DSHS shall notify the entity via email that the desk review is complete and to schedule the on-site review.</p>
ON-SITE REVIEW	<p>DSHS shall conduct the on-site within four weeks of completing the desk review. The on-site review shall include, but is not limited to, a tour of the facility, interviews with pertinent staff, and the review and verification of:</p> <ol style="list-style-type: none">1. Facility and staff availability;2. Staff credentialing and privilege;3. Quality assurance/management;4. Clinical operations;5. Treatment records;6. Facility safety;7. Facility appearance;8. Record keeping;9. Confidentiality practices;10. Utilization program;11. Organization of administration;12. Staffing plan; and13. Medication safety.

COMPREHENSIVE WAIVER PROVIDER
CREDENTIALING AND ENROLLMENT

2400

APPROVAL

Following successful completion of the desk review and on-site review, DSHS shall enter into a Medicaid Provider Agreement with the approved CWP. The CWP shall also receive an approval letter from DSHS, to enable the CWP to apply for and obtain its YES Waiver-specific provider type.

Upon receipt of the approval letter from DSHS, the CWP shall contact Texas Medicaid Healthcare Partnership (TMHP) to enroll as a Waiver provider; however, Waiver services shall not be permitted to begin until the Waiver provider type has been determined by TMHP. See BILLING, policy 2800 of this manual.

TRAINING

The credentialing process shall not be complete until CWP staff receives all required training. See TRAINING, policy 2400.2 of this manual.

COMPREHENSIVE WAIVER PROVIDER
CRIMINAL HISTORY AND BACKGROUND CHECKS

2400.1

As part of the credentialing process with the Department of State Health Services (DSHS), an entity interested in providing Waiver services shall conduct a criminal history check and abuse registry check on persons who will have substantial contact or potentially substantial contact with a Waiver participant.

Criminal history and background checks shall be conducted in accordance with TAC §414, Subchapter K, available at:

[http://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=414&sch=K&rl=Y](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=414&sch=K&rl=Y)

DEPARTMENT OF
AGING AND
DISABILITY SERVICES
(DADS)

An entity interested in providing Waiver services shall conduct a check of the Nurse Aide Registry and the Employee Misconduct Registry in accordance with the Department of Aging and Disability Services (DADS).

Consolidated results for both the Nurse Aide Registry and the Employee Misconduct Registry are available at:

<https://emr.dads.state.tx.us/DadsEMRWeb/emrRegistrySearch.jsp>

NURSE AIDE
REGISTRY

DADS reviews and investigates allegations of abuse, neglect, or misappropriation of property by nurse aides. If there's a finding of an alleged act of abuse, neglect or misappropriation, the nurse aide shall not be employed by, or serve as a volunteer or intern at, the comprehensive waiver provider (CWP).

EMPLOYEE
MISCONDUCT
REGISTRY

The Employee Misconduct Registry shall be used to determine whether an individual has committed an act of abuse, neglect, exploitation, misappropriation, or misconduct and is, therefore, unemployable.

DOCUMENTATION

Upon becoming credentialed as a CWP by DSHS, and in accordance with TAC §414, Subchapter K, a CWP shall be required to maintain a documented process for keeping criminal history checks and abuse registry checks up to date on all individuals who are providing Waiver services, including subcontractors.

NOTIFICATION OF
CHANGE IN CRIMINAL
HISTORY

The CWP shall notify DSHS, in writing, of any changes to the criminal history and/or abuse registry check for any individual who has been involved in providing Waiver services.

Notification shall be provided to DSHS within three business days of the CWP discovering the change in the criminal history or abuse registry.

COMPREHENSIVE WAIVER PROVIDER
TRAINING REQUIREMENTS

2400.2

YES WAIVER
ORIENTATION

Prior to providing Waiver services and/or participating on a Child and Family Team, the comprehensive waiver provider (CWP) shall ensure that all CWP and direct service provider staff receive training on the Waiver.

The CWP shall receive Waiver training from the Department of State Health Services (DSHS) that shall consist of:

1. Waiver overview and background;
2. Waiver service array;
3. Provider qualifications;
4. Individual plan of care (IPC) development; and
5. Use of Clinical Management for Behavioral Health Services (CMBHS).

OTHER REQUIRED
TRAINING

Within the first three months of hire, and prior to providing Waiver services and/or participating on a Child and Family Team, each CWP and direct service provider staff member shall complete online training on the Introduction to Systems of Care and the Wraparound Initiative service delivery method.

Information is available at: <http://www.txsystemofcare.org/>

POLICIES AND
PROCEDURES

The CWP shall be responsible for training all direct service provider staff, volunteers, and interns on the CWP's policies and procedures, including, but not limited to: reporting of abuse, neglect or exploitation (ANE), behavior management, critical incident reporting, and first aid and CPR.

CREDENTIALING

Once all training requirements are met, the CWP credentialing process shall be considered complete by DSHS and the CWP shall be permitted to begin Waiver services.

COMPREHENSIVE WAIVER PROVIDER
GENERAL RESPONSIBILITIES

2400.3

OVERVIEW

A comprehensive waiver provider (CWP) shall ensure staffing, service delivery, training, documentation, billing, and operation practices promote quality care and high fidelity Wraparound for Waiver participants, as required by this manual and the contract entered into with the Department of State Health Services (DSHS).

STAFFING

The CWP shall be responsible for:

1. Recruiting an adequate number of qualified staff and/or sub-contractors for the provision of services, access to services that is convenient for the family, and choice of individual service providers.
2. Ensuring adequate back-up staffing is available when the lack of immediate care would pose a serious threat to the participant's health or welfare.
3. Maintaining current information regarding staff qualifications and training records and direct service employee attendance/time records for DSHS review, in accordance with law.

SERVICE DELIVERY

The CWP shall be responsible for:

1. Training and supervising all staff and/or subcontractors in the provision of Waiver services.
2. Providing services and supports, by staff or subcontractors, in appropriate locations that are in the best interest of the participant.
3. Appropriately matching the skill set of a direct service staff member with the most recent assessment of a participant.
4. Implementing services that are approved in the participant's valid Individual Plan of Care (IPC).
5. Monitoring authorized services for consistency with the participant's IPC and verifying authorization prior to the provision of services.
6. Monitoring proper implementation and provision of Waiver services in accordance with the participant's valid IPC.
7. Training staff and/or subcontractors on the Wraparound process.
8. Notifying the Wraparound Facilitator of significant changes in the participant's situation or needs.

TRAINING

The CWP shall be responsible for:

COMPREHENSIVE WAIVER PROVIDER
GENERAL RESPONSIBILITIES

2400.3

1. Training all direct service staff on the CWP's policies and procedures.
2. Developing training interventions and/or strategies for achieving objectives with the Child and Family Team.

DOCUMENTATION

The CWP shall be responsible for:

1. Monitoring service notes entered into CMBHS.
2. Reviewing and maintaining adequate documentation of services.
3. Making documentation of services available to participating entities and/or others, as needed.

BILLING

The CWP shall be responsible for:

1. Monitoring billing to ensure integrity of all claims submitted to TMHP for payment.
2. Refunding to TMHP any overpayment, as defined by 42 CFR §433.304, within 60 days, following the CWP's discovery of the overpayment.

OPERATIONS

The CWP shall be responsible for:

1. Complying with all rules and regulations of the DSHS.
2. Complying with all licensure rules and regulations and maintaining current licenses.
3. Reporting suspected fraudulent practices in accordance with DSHS rules.
4. Completing and submitting critical incident reports.
5. Reporting allegations of abuse, neglect, and exploitation (ANE).
6. Implementing a procedure for reporting a complaint against the CWP or its staff and/or subcontractors.

COMPREHENSIVE WAIVER PROVIDER
COMPLIANCE AND LICENSING

2400.4

LICENSING

The Department of State Health Services (DSHS) monitors comprehensive waiver providers (CWP) for compliance with licensing requirements.

At any time that harmful or non-compliant practices are identified, corrective action shall be taken to bring the CWP back into compliance.

COMPREHENSIVE WAIVER PROVIDER
SUBCONTRACTED SERVICES

2400.5

AGREEMENT

A comprehensive waiver provider (CWP) shall be permitted to enter into an agreement with individuals or agencies to subcontract for Waiver services. A separate agreement shall be required for each individual or agency providing Waiver services.

The agreement shall include, but not be limited to, the following:

1. Role and responsibilities of the CWP;
2. Role and responsibilities of the subcontractor;
3. Staff qualifications;
4. Criminal history and abuse registry checks; and
5. Rate and payment information.

The CWP shall provide a copy of its standard agreement to the Department of State Health Services (DSHS).

VERIFICATION OF
QUALIFICATIONS

The CWP shall verify the qualifications of an individual or agency interested in providing subcontracted Waiver services. The CWP shall verify that a subcontractor:

1. Is in good standing with all federal and state funding and regulatory agencies;
2. Is not debarred, suspended, or otherwise excluded from participation in any federal grant program;
3. Is not delinquent on any repayment agreement associated with the business;
4. Has not had a required license or certification revoked;
5. Has not voluntarily surrendered any license issued by DSHS within the previous three years of the date of the agreement; and
6. Has not had a contract terminated by DSHS.

DOCUMENT
RETENTION

The CWP shall retain a copy of all current subcontractor agreements. The CWP shall also retain a copy of a subcontractor agreement that has been amended or changed.

SUBCONTRACTOR
RESPONSIBILITIES

An individual or agency entering into a subcontractor agreement to provide Waiver services shall be responsible for, but not limited to, the following:

1. Maintaining a list of current personnel providing Waiver services or performing related activities;
2. Maintaining a list of the service(s) provided by personnel;

COMPREHENSIVE WAIVER PROVIDER
SUBCONTRACTED SERVICES

2400.5

3. Identifying staff performing dual roles; and
4. Providing documentation to the CWP of the procedures for:
 - a. Record keeping;
 - b. Verifying staff qualifications; and
 - c. Criminal history and abuse registry checks.

COMPREHENSIVE WAIVER PROVIDER
MEDICATION MANAGEMENT

2400.6

SCOPE	<p>The comprehensive waiver provider (CWP) shall ensure that medications are administered only by individuals with authority to do so by the nature and scope of their license, certification, and/or practice.</p> <p>This policy shall also apply to a community mental health center that administers medication.</p>
PRESCRIPTION MEDICATION ADMINISTRATION	<p>The CWP shall be responsible for administering prescription medication to Waiver participants who are unable to self-administer medication. To administer prescription medication to a Waiver participant, the CWP shall:</p> <ol style="list-style-type: none">1. Obtain a signed authorization from the participant's legally authorized representative (LAR);2. Ensure medication is in its closed, original container, and includes the:<ol style="list-style-type: none">a. Waiver participant's full name;b. Waiver participant's date of birth;c. Name of the prescribing doctor or other licensed health professional; andd. Expiration date.3. Ensure medication is administered in accordance with a physician or other licensed health professional's instructions and label directions.4. Ensure expired medications are not administered to the participant;5. Administer the medication only to the participant for whom it is intended; and6. Notify the LAR of any expired prescription medication.
SELF- ADMINISTRATION	<p>A Waiver participant shall be permitted to self-administer prescription medication under the supervision of a CWP direct service staff member. To permit a participant to self-administer medication, the CWP shall:</p> <ol style="list-style-type: none">1. Obtain a signed authorization from the participant's legally authorized representative (LAR);2. Ensure medication is in its closed, original container, and includes the:<ol style="list-style-type: none">a. Waiver participant's full name;

COMPREHENSIVE WAIVER PROVIDER
MEDICATION MANAGEMENT

2400.6

- b. Waiver participant's date of birth;
 - c. Name of the prescribing doctor or other licensed health professional; and
 - d. Expiration date.
3. Ensure medication is administered in accordance with a physician or other licensed health professional's instructions and label directions;
 4. Ensure the participant is not self-administering expired medication;
 5. Ensure the participant is administering only to him or herself; and
 6. Notify the LAR of any expired prescription medication.

DOCUMENTATION

When prescription medication is administered to or self-administered by a participant, the CWP shall document the:

1. Full name of Waiver participant taking the medication;
2. Name of the medication;
3. Date, time, and amount of medication given or taken; and
4. Full name of the direct service staff member administering the medication or supervising the participant's self-administration.

The CWP shall retain records of medication administration for three months following the date of the administration.

UNUSED
MEDICATION

Any unused medication shall be returned to the participant's LAR. The CWP shall note the name of the medication returned and the date the medication was returned to the LAR in the participant's clinical record.

NONPRESCRIPTION
MEDICATION

The CWP shall be permitted to administer nonprescription medication after obtaining permission from the LAR and in accordance with the CWP's policies and procedures.

ADMINISTRATION
ERRORS

The CWP shall be required to report any medication administration error to DSHS as a critical incident. Medication errors that shall be reported to DSHS include, but are not limited to:

1. Administering medication to the wrong person;
2. Administering the wrong medication;
3. Administering the wrong dosage;
4. Failing to administer medication at the prescribed time;

COMPREHENSIVE WAIVER PROVIDER
MEDICATION MANAGEMENT

2400.6

5. Failing to follow administration instructions properly; or
6. Failing to accurately document the administration.

STORAGE

Medication shall be kept out of the reach of children and stored in a locked storage container. Medication that requires refrigeration shall be stored separately from and in a manner that does not contaminate food.

COMPREHENSIVE WAIVER PROVIDER
INVOLUNTARY RESTRAINT

2400.7

PHYSICAL
RESTRAINTS

The limited use of physical restraints shall be permitted in the delivery of Waiver services only when:

LIMITED USE

1. Necessary to prevent imminent death or substantial physical harm to the Waiver participant; or
2. Necessary to prevent imminent death or substantial physical harm to another; and
3. Less restrictive methods have been attempted and failed.

Use of restraints shall be used in accordance with TAC §415, Subchapter F, available at:

[http://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=415&sch=F&rl=Y](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=415&sch=F&rl=Y)

Restraints shall be used for the shortest period of time necessary and terminated upon the participant demonstrating release behaviors specified by the ordering physician.

TRAINING

The CWP shall train direct service staff in the safe use of physical restraints. Training shall focus on maintaining the safety, well-being, and dignity of participants who are physically restrained.

In addition, the CWP shall take into consideration information that could contraindicate or otherwise affect the use of physical restraint, including, but not limited to:

1. Techniques, methods, or tools that would help the client effectively cope with his or her environment;
2. Pre-existing medical conditions or any physical disabilities or limitations, including substance abuse disorders, that would place the participant at greater risk during restraint;
3. Any history of sexual or physical abuse that would place the participant at greater psychological risk during restraint; and
4. Any history that would contraindicate restraint.

REPORTING

The CWP shall report the use of physical restraints on a Waiver participant to DSHS as a critical incident.

OTHER RESTRAINTS

In accordance with TAC §415.254 and §415.256, the use of chemical and mechanical restraints and seclusion are prohibited.

COMPREHENSIVE WAIVER PROVIDER
TEMPORARY OUT-OF-HOME LIVING ARRANGEMENT

2400.8

DEFINITION	<p>Temporary out-of-home living arrangement shall be defined as a temporary living arrangement, not funded through the Waiver Respite or Supportive Family-Based Alternative services, in which the participant is residing on a daily basis, away from the legally authorized representative (LAR), or outside of his or her own apartment or home, if legally emancipated.</p> <p>Examples of temporary out-of-home living arrangements include, but are not limited to: shelter, group home, residential treatment center, or other facility-based setting.</p>
DURATION	<p>A temporary out-of-home living arrangement shall be permitted to last up to 90 consecutive or cumulative days per individual plan of care (IPC) year.</p>
WAIVER STATUS	<p>During the time a participant is in a temporary out-of-home living arrangement, he or she shall remain enrolled in the Waiver, but shall not receive Waiver services.</p>
CASE MANAGEMENT	<p>Case management shall continue on a monthly basis in order to coordinate and document the participant's plan to transition back to residing with the LAR or back to the participant's home or apartment, if legally emancipated.</p>
REPORTING TO DSHS	<p>Monthly status updates on the transition plan shall be provided to the Department of State Health Services (DSHS).</p> <p>The community mental health center shall contact DSHS when the participant is no longer in the temporary out-of-home living arrangement. If the participant has not received Waiver services for at least 90 days, the community mental health center shall provide DSHS with an updated IPC within 30 calendar days of the participant no longer being in the temporary out-of-home living arrangement.</p> <p>The community mental health center and DSHS shall coordinate the date for Waiver services to resume.</p>

COMPREHENSIVE WAIVER PROVIDER
OUTREACH

2400.9

To recruit and maintain a competent workforce and develop a comprehensive network of direct service providers, the comprehensive waiver provider (CWP) shall develop and implement a strategic outreach and marketing plan.

OUTREACH
STRATEGIES

Some strategies the CWP shall utilize for outreach and marketing shall include, but not be limited to:

1. Posting an overview of the Waiver on the CWP's Web site;
2. Utilizing marketing materials available through the Department of State Health Services (DSHS); and
3. Collaborating with the community mental health center to present information about the Waiver at community events.

OUTREACH MATERIAL
APPROVAL

Any tools or information developed by the CWP for use in its outreach and marketing plan shall be submitted to, and approved by, DSHS prior to dissemination.

COMPREHENSIVE WAIVER PROVIDER
TERMINATION OF AGREEMENT

2400.10

When the agreement between the Department of State Health Services (DSHS) and a comprehensive waiver provider (CWP) is terminated, all Waiver participants served by the CWP shall choose another CWP. Participants shall be transitioned to the CWP of their choice prior to the termination.

COMMUNITY MENTAL
HEALTH CENTER
RESPONSIBILITIES

At least 30 days prior to the termination, the community mental health center shall provide notice to the participant and/or legally authorized representative (LAR) that the CWP agreement with DSHS is being terminated.

The community mental health center shall assist the participant and LAR with selecting another CWP. After a new CWP is chosen, the Wraparound Facilitator shall revise the participant's individual plan of care (IPC) to reflect the participant's transfer to a new CWP.

See PARTICIPANT TRANSFER, policy 2300.8 of this manual.

COMPREHENSIVE
WAIVER PROVIDER
RESPONSIBILITIES

The CWP shall inform the participant and/or LAR that its provider agreement with DSHS is being terminated.

SERVICE DOCUMENTATION
PROGRESS NOTES

2500

PROGRESS NOTES	<p>Progress notes shall be required for all services provided to a participant. Progress notes shall include, but not be limited to, the following:</p> <ol style="list-style-type: none">1. Participant name;2. Date of contact with the participant;3. Start and stop time of contact with the participant;4. Service name and description;5. Service location;6. Specific skills received and method used to train participant in skill(s);7. Participant response to service being provided;8. Participant progress or lack of progress;9. Summary of activities, meals, and behaviors during the service; and10. Direct service staff member's signature and credentials.
NON FACE-TO-FACE CONTACT WITH PARTICIPANT	<p>When contact with a participant is not face-to-face, the provider shall document in the progress notes:</p> <ol style="list-style-type: none">1. Date of the contact;2. Description of the contact; and3. Direct service staff member's signature and credentials.
FACE-TO-FACE CONTACT WITH OTHER PARTIES	<p>When a service involves face-to-face or telephone contact with someone other than the participant, such as, but not limited to, the legally authorized representative (LAR), the provider shall document in the progress notes:</p> <ol style="list-style-type: none">1. Date of the contact;2. Person with whom the contact was made;3. Description of the contact;4. Outcome(s) of the contact; and5. Direct service staff member's signature and credentials.

SERVICE DOCUMENTATION
MINOR HOME MODIFICATIONS

2500.1

MINOR HOME
MODIFICATIONS

Requesting the use of minor home modifications shall require documentation of:

1. The receipt of purchase;
2. Soliciting bids for expenditures over \$500.00;
3. Home modification repairs falling outside of the scope of any existing warranty;
4. Copy of warranty information for the modification, if available;
5. Requested home modifications meeting any applicable standards and/or codes; and
6. How the item or service shall meet a functional adaptive need of the participant.

SERVICE DOCUMENTATION
NON-MEDICAL TRANSPORTATION

2500.2

NON-MEDICAL
TRANSPORTATION

Documentation of non-medical transportation shall require a Transportation Log or alternative mileage log that includes:

1. Date of contact;
2. Start and stop time of contact;
3. Name of service provider; and
4. Direct service staff member's signature and credentials.

A sample Transportation Log is available on the Department of State Health Services (DSHS) Web site at:

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

ADAPTIVE AIDS AND SUPPORTS
HEALTH AND SAFETY REQUIREMENTS

2600

PARTICIPANT HEALTH AND SAFETY	<p>Ensuring the health and safety of a Waiver participant is a top priority. The comprehensive waiver provider (CWP) shall take reasonable measures to protect a participant from abuse, neglect, and exploitation (ANE) and to ensure the safety of the physical location of adaptive aids and supports (AA&S), as applicable.</p> <p>Decisions regarding the participant's activities shall be based on a reasonable and prudent parent standard, in accordance with the Department of Family and Protective Services' (DFPS) Minimum Standards for Child-Placing Agencies.</p>
PLACES OF PUBLIC USE	<p>Locations for AA&S that are public places shall be safe for human use. A legally authorized representative (LAR), LAR's designee, or a community mental health center or CWP staff member shall be held to the reasonable and prudent parent standard when accompanying the participant to places of public use, including, but not limited to: museums, parks, and zoos.</p>
SHORT-TERM ACTIVITIES	<p>A participant engaging in a short-term activity or one-time event shall be accompanied by, and under the constant supervision of, the LAR, LAR's designee, a community mental health center staff member, or a CWP staff member.</p>
ONGOING ACTIVITIES	<p>When a participant is engaging in an ongoing activity for a specific service, lesson, or encounter, for a limited number of hours per week or month, the CWP shall:</p> <ol style="list-style-type: none"><li data-bbox="560 1144 1438 1291">1. Complete a criminal history and background check, in accordance with TAC §414, Subchapter K, of any person who will have substantial, or potentially substantial, contact with the participant; and<li data-bbox="560 1312 1438 1522">2. Conduct a check of the Nurse Aide Registry and the Employee Misconduct Registry, in accordance with the Department of Aging and Disability Services (DADS), of any person who will have substantial, or potentially substantial, contact with the participant. Consolidated results for the Nurse Aide Registry and the Employee Misconduct Registry are available at: https://emr.dads.state.tx.us/DadsEMRWeb/emrRegistrySearch.jsp
BUSINESSES WITHIN CITY LIMITS	<p>The CWP shall obtain a copy of the certificate of occupancy of a business providing a Waiver service that is located within city limits.</p> <p>If for any reason a business within city limits does not have a certificate of occupancy, the CWP shall provide justification to DSHS in the individual plan of care (IPC) for choosing that particular service provider and why the business does not have a certificate of occu-</p>

ADAPTIVE AIDS AND SUPPORTS
HEALTH AND SAFETY REQUIREMENTS

2600

	<p>pany. The CWP shall also need to complete the Building Safety and Environmental Health Checklist.</p>
<p>BUSINESSES OUTSIDE OF CITY LIMITS</p>	<p>The CWP shall complete the Building Safety and Environmental Health Checklist when a business located outside of city limits is chosen as a Waiver service provider.</p>
<p>NOTIFICATION OF CHANGE IN CRIMINAL HISTORY</p>	<p>The CWP shall notify the Department of State Health Services (DSHS), in writing, of any changes to the criminal history and/or abuse registry check for any individual involved in providing AAS Waiver services.</p> <p>Notification shall be provided to DSHS within three business days of the CWP discovering the change in the criminal history or abuse registry.</p>

ADAPTIVE AIDS AND SUPPORTS
TYPES AND REQUIREMENTS

2600.1

SERVICE
AUTHORIZATION
DOCUMENTATION

To justify the use of Adaptive Aids and Supports (AA&S), a comprehensive waiver provider (CWP) shall describe in the Service Authorization the participant's need for the requested AA&S arising as result of his or her serious emotional disturbance (SED). AA&S requests shall include:

1. AA&S being requested;
2. The identified treatment need for the AA&S;
3. A description of how the AA&S may positively impact the identified treatment need;
4. Length of time of AA&S, not to exceed 90 days; and
5. Verification that health and safety inspections and background checks on the AA&S provider are completed prior to the provision of service(s), if applicable.

TYPES OF ADAPTIVE
AIDS AND SUPPORTS

There are four types of AA&S:

1. Consumable goods;
2. Durable goods;
3. Lessons, classes, and seasonal activities; and
4. Memberships.

CONSUMABLE
GOODS

Consumable goods include, but shall not be limited to: educational materials, workbooks, reading books, and art supplies. An AA&S request for a consumable good shall include an estimated maximum dollar cost for the purchase of the requested good, and any applicable taxes and shipping and handling costs.

DURABLE GOODS

Durable goods include, but shall not be limited to: exercise equipment, sports equipment, and musical instruments. An AA&S request for a durable good shall include:

1. An estimated maximum dollar cost for the purchase of the requested good, and any applicable taxes and shipping and handling costs; and
2. A brief explanation of why the good is being purchased by the payer of last resort, rather than rented or borrowed, if the AA&S request is for purchase.

LESSONS,
CLASSES, AND
SEASONAL
ACTIVITIES

Lessons, classes, and seasonal activities include, but shall not be limited to: karate classes, guitar lessons, and playing team sports. An AA&S request for lessons, classes, and seasonal activities shall include:

ADAPTIVE AIDS AND SUPPORTS
TYPES AND REQUIREMENTS

2600.1

1. An estimated maximum dollar cost that pays for participation in the requested activity;
2. A brief explanation of why equipment is being purchased by the payer of last resort, rather than rented or borrowed, if the AA&S request is for purchase of equipment; and
3. The date range of the requested AA&S, not to exceed 90 days.

MEMBERSHIPS

Memberships include, but shall not be limited to: Young Men's Christian Association (YMCA), Girl Scouts, Boys and Girls Clubs. An AA&S request for a membership shall include:

1. An estimated maximum dollar cost that adequately pays for participation in the requested activity;
2. A brief explanation of why equipment is being purchased by the payer of last resort, rather than rented or borrowed, if equipment is necessary for participation in the activity;
3. Justification for selection of adult chosen to accompany participant to activity, if applicable; and
4. The date range of the requested AA&S, not to exceed 90 days.

INDIVIDUAL PLANS OF
CARE (IPC) REVISIONS
AND ANNUAL
RENEWALS

When completing a 90-day individual plan of care (IPC) revision or an Annual Renewal IPC, the community mental health center shall include continued use of a previously approved AA&S, with a description of the benefits of continuing the AA&S in meeting participant need(s) and outcome(s).

QUALITY MANAGEMENT
DEPARTMENT OF STATE HEALTH SERVICES RESPONSIBILITIES

2700

OVERSIGHT The Department of State Health Services (DSHS) shall develop, implement, and monitor compliance activities of community mental health centers and comprehensive waiver providers (CWP), through policies, procedures, and other guidance governing the Waiver.

ACTIVITIES To ensure compliance with the Waiver, DSHS shall:

1. Use reports and data to guide performance improvement activities and assessment of:
 - a. Unmet needs of individuals;
 - b. Service delivery issues; and
 - c. Effectiveness of Waiver services for the local service area;
2. Oversee compliance with, and quality of, service delivery of the National Wraparound Implementation Center (NWIC) principles;
3. Oversee a direct service provider's efforts to ensure required meetings and contact occur and that documentation demonstrates compliance with Waiver requirements;
4. Utilize mechanisms to measure, assess, and reduce incidents of client abuse, neglect, and exploitation (ANE) and improve participant rights processes;
5. Coordinate activities and communication of information on:
 - a. Participant enrollment;
 - b. The individual plan of care (IPC);
 - c. Provider assignments;
 - d. Provider recruitment efforts;
 - e. Reporting critical incidents;
 - f. Resolution of participant complaints and grievances; and
 - g. Service utilization data; and
6. Oversee systems intended to prevent fraud and abuse of Medicaid funds.

MEASURES DSHS shall utilize desk and on-site reviews to provide oversight to community mental health centers and CWPs.

DESK AND ON-SITE
REVIEWS DSHS shall compare a sample of service claims and/or encounter data to the participant's valid IPC to ensure the services the CWP

provides are consistent with the participant's valid IPC in scope, frequency, and duration.

Reviews of provider employee and training records shall be reviewed by DSHS to verify staff member credentials, current criminal history and background checks, and completion of Waiver training requirements. See TRAINING REQUIREMENTS, policy 2400.2 of this manual.

PLAN OF
CORRECTION

The community mental health center or CWP shall receive an official report of DSHS's findings following a desk or on-site review, identifying strengths, areas needing improvement, and non-compliance issues.

A Plan of Correction shall be required to address areas needing improvement and noncompliance issues. The community mental health center or CWP shall submit a Plan of Correction to DSHS no later than 30 days after the issuance of the DSHS official report.

The Plan of Correction shall:

1. Detail the specific action(s) being taken or that will be taken to ensure correction of the issues and to come back into compliance;
2. Identify staff member(s) responsible for implementing and monitoring the plan; and
3. Note the expected date(s) the corrections shall be completed.

Upon approval of the Plan of Correction by DSHS, the community mental health center or CWP shall submit any requested documentation to DSHS to demonstrate progress of the corrective action(s).

A participating entity providing Waiver services shall ensure adequate quality management by collecting data and measuring, assessing, and improving performance dimensions in:

1. Providing timely access to Waiver services;
2. Providing timely enrollment of participants;
3. Providing at least one billable service per month (or monthly monitoring if the need for service(s) is less than monthly);
4. Basing plans of care and services on underlying needs and outcome statements;
5. Providing services according to the participant's valid individual plan of care (IPC);
6. Participating in Child and Family Team meetings;
7. Assuring development and revision of the IPC;
8. Identifying and updating health and safety risk factors;
9. Collecting and analyzing critical incident data;
10. Credentialing and training providers;
11. Adhering to policies and procedures; and
12. Maintaining continuity of care.

QUALITY MANAGEMENT
CONFIDENTIALITY

2700.2

PROTECTED HEALTH
INFORMATION

A participating entity ("entity") shall exchange or share protected health information (PHI), sensitive personal information (SPI), and/or medical records in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and any other applicable federal or state laws.

The entity shall have a policy addressing federal and state confidentiality requirements and the procedure(s) the entity utilizes to comply with these requirements.

SHARING OR
EXCHANGING
CONFIDENTIAL
INFORMATION

To comply with the Department of State Health Services (DSHS) quality management review in protecting confidential information, an entity shall:

1. Establish and implement appropriate administrative, technical, and physical safeguards to protect the privacy, and prevent unauthorized disclosure of, PHI or SPI;
2. Take necessary precautions when transmitting PHI or SPI so that a participant could not be identified (e.g., remove the name(s) of relatives, household members, and/or employers);
3. Secure and encrypt email when transmitting PHI or SPI;
4. Transmit all PHI or SPI via a HIPAA-compliant method
5. Include a cover sheet when faxing items that include PHI or SPI;
6. Report violations of privacy or privacy concerns to a supervisor and DSHS;
7. Take immediate and corrective action following the discovery of a privacy violation; and
8. Refer complaints or allegations of breaches of confidentiality to DSHS.

INFORMATION
MANAGEMENT
SYSTEM

An entity shall maintain a secure information management system to protect information such as:

1. Who the participant wishes to be informed about his or her services, supports, and treatment;
2. Collateral information provided by someone about the participant;
3. Protected health information;
4. Sensitive personal information;
5. Billing information; and

QUALITY MANAGEMENT
CONFIDENTIALITY

2700.2

	<p>6. All service-related information.</p>
RELEASE OF CONFIDENTIAL INFORMATION RELATED TO THE WAIVER	<p>The Wraparound Facilitator (“Facilitator”) shall inform the participant and/or legally authorized representative (LAR) of the participant’s confidentiality rights and the reasons associated with the Waiver requiring release of confidential information.</p> <p>The Facilitator shall obtain permission, through a signed release, from the participant or LAR in order to release personal or program information for administrative purposes.</p>
RELEASE FORM	<p>The release form shall grant permission to the entity to release participant information, billing and claims information, information needed for quality assurance and Waiver claims monitoring, and audits.</p> <p>The release form shall:</p> <ol style="list-style-type: none">1. Be signed by the participant and the participant’s LAR, if the participant is under the age of 18;2. Be signed by the participant if the participant is legally emancipated or is 18 years of age;3. Include the date of signature;4. Include a specific termination date, which shall be no longer than one year from the date of signature; and5. Be renewed as necessary.
RELEASE OF CONFIDENTIAL INFORMATION NOT RELATED TO THE WAIVER	<p>In the event an entity must disclose confidential information for purposes other than those related to Waiver administration, the entity or direct service provider shall obtain separate permission from the participant or LAR prior to the release of any information.</p> <p>A release granting permission to disclose information for a non-Waiver related purpose shall not be considered a blanket release of information. The entity shall be required to obtain a release for each separate non-Waiver related purpose.</p>
CONFIDENTIALITY IN SERVICE DELIVERY	<p>Staff shall consider the participant’s privacy and confidentiality rights and preferences to the greatest extent possible when determining locations for services.</p> <p>To accommodate service delivery in various environments such as homes, schools, homeless shelters, or street locations, the entity shall have policies and procedures addressing confidentiality considerations when services are provided in a community based setting.</p>

QUALITY MANAGEMENT
CONFIDENTIALITY

2700.2

OFFICIAL AGENCIES	<p>Acting in their official capacity, staff of DSHS, the Health and Human Services Commission (HHSC), and/or the Centers for Medicare and Medicaid Services (CMS) shall be permitted to access information or records related to participants, in accordance with applicable law, rule, or regulation.</p> <p>Staff of official agencies shall be required to follow all applicable confidentiality laws, rules, and regulations regarding the transmission, sharing, or exchange of confidential information.</p>
TRANSFER OF RECORDS	<p>DSHS shall have authority to require an entity to transfer original and/or copies of participant records to another entity without consent from the participant or LAR:</p> <ol style="list-style-type: none"><li data-bbox="552 724 1437 798">1. Upon termination of the contract between the entity and DSHS; or<li data-bbox="552 819 1437 892">2. When the care and treatment of the participant is transferred to another entity.
FEES	<p>An entity shall not be permitted to charge fees to any official agency requesting information or records.</p>

QUALITY MANAGEMENT
RECORD KEEPING

2700.3

A participating entity (“entity”) shall ensure the security of participant records in retention and destruction, in accordance with all applicable federal and state laws, rules, and regulations by establishing an effective and efficient record keeping system.

An effective and efficient record keeping system shall:

1. Protect against unauthorized access, disclosure, modification, or destruction of medical records;
2. Ensure availability, integrity, utility, authenticity, and confidentiality of information with a participant’s clinical record;
3. Adhere to good professional practice;
4. Permit clinical review and audit activities; and
5. Facilitate prompt and systematic retrieval of information.

SECURITY OF
RECORDS

All active records shall be maintained in an organized system located in a secure, locked area. The filing system shall be in accordance with accepted practice.

DISASTER
RECOVERY PLAN

The entity shall develop and maintain a written disaster recovery plan for information resources to ensure continuity of services.

PARTICIPANT RECORD
RETENTION

All records, reports, and source documentation related to service data for Waiver participants shall be retained by the entity for six years following either the date of expiration or termination of the entity’s contract with the Department of State Health Services (DSHS) or termination of services, whichever is later.

Records retention practices shall remain in compliance with current federal or state law, rule, or regulation.

RETENTION OF
OTHER INFORMATION

The entity shall retain all records pertaining to:

1. The contract with DSHS;
2. Documents associated with pending litigation; and
3. Documents associated with a pending audit.

Documents pertaining to pending litigation or a pending audit shall be retained until all inquiries and/or actions of the litigation or audit are resolved.

CONTRACT
RETENTION

The entity shall retain the following documents, as required by its contract with DSHS, for a period of six years:

1. Internal monitoring records of the quality and appropriateness of Medicaid program participation and compliance;
2. All plans required by the contract;

QUALITY MANAGEMENT
RECORD KEEPING

2700.3

3. All accounting and other financial records;
4. Real and personal property leases;
5. Policies, manuals, and standard operating procedures;
6. Provider credentialing records;
7. Records relating to insurance policies;
8. Employee records;
9. Licenses and certifications;
10. Any records required by DSHS;
11. Subcontracts;
12. Audit records and working papers; and
13. Claim payments.

TYPES OF RECORDS

All clinical, administrative, and service records shall be current and meaningful and maintained in an organized, concise, and complete manner.

PARTICIPANT
CLINICAL RECORD

A community mental health center shall maintain a clinical record for each participant. A participant's clinical record shall:

1. Include participant name and contact information;
2. Identify an emergency contact with contact information;
3. Include participant diagnosis;
4. Include detail regarding any medication(s) used by participant;
5. Include information regarding previously received services, if applicable;
6. Note any precautions to be taken;
7. Identify whether the participant has allergies, and if so, the specific allergies;
8. Be written in black or blue ink, except to denote allergies or precautions, which shall be permitted to be written in red ink;
9. Demonstrate medical necessity of the service(s);
10. Financial and insurance information;
11. Identify the participant's selection of a CWP;

QUALITY MANAGEMENT
RECORD KEEPING

2700.3

12. Include documentation of service provision for each invoice amount; and
13. Rights, consent, and legally pertinent information, including, but not limited to:
 - a. Consent for service(s);
 - b. Release of information form; and
 - c. Documentation that participant rights and responsibilities are reviewed annually.

COMMUNITY
MENTAL HEALTH
CENTER CASE
RECORD

A community mental health center shall maintain a case record for each participant which shall include:

1. Clinical Eligibility Determination Form;
2. Offer Letter;
3. Vacancy and Deadline Notification Form;
4. Notification of Participant Rights Form;
5. Participant Consent Form;
6. Release of Information Form;
7. Consumer Choice Consent Form;
8. Provider Choice Form;
9. All individual plans of care (IPCS)
10. Denial Letter;
11. Termination Letter;
12. Inquiry List Removal Letter;
13. Letter of Withdrawal;
14. Progress Notes for all State Plan services provided to participant;
15. Summaries of all meetings regarding the participant;
16. Critical Incident Reports;
17. Participant Referral Form, if applicable; and
18. Other Waiver documentation.

COMPREHENSIVE
WAIVER PROVIDER
CASE RECORD

A comprehensive waiver provider (CWP) shall maintain a case record for each participant which documents services provided

QUALITY MANAGEMENT
RECORD KEEPING

2700.3

both directly and through businesses subcontracted with the CWP. The service record shall:

1. Include participant name and contact information;
2. Identify an emergency contact with contact information;
3. Note any precautions to be taken;
4. Identify whether the participant has allergies, and if so, the specific allergies;
5. Be written in black or blue ink, except to denote allergies or precautions, which shall be permitted to be written in red ink;
6. Include all individual plans of care (IPCS);
7. Include rights, consent, and legally pertinent information, including, but not limited to:
 - a. Consent for service(s);
 - b. Release of information form; and
 - c. Documentation that participant rights and responsibilities are reviewed annually;
8. Include Critical Incident Reports;
9. Include a transportation log;
10. Include Progress Notes for all Waiver services provided to participant;
11. Include summaries of all meetings regarding the participant; and
12. Include other Waiver documentation.

PARTICIPANT
EVALUATIONS

Participant evaluations and re-evaluations of level of care shall be maintained by: the community mental health center, CWP, and DSHS.

AUDITS OF CLAIMS

In accordance with 45 CFR §92.42, all documents associated with an audit of claims shall be maintained by: the Health and Human Services Commission (HHSC), DSHS, and the CWP for at least three years.

Information regarding retention and access requirements of records are available at:

<http://www.hhs.gov/opa/grants-and-funding/grant-forms-and-references/45-cfr-92.html#92.42>

The Department of State Health Services is responsible for credentialing each prospective comprehensive waiver provider (CWP) and determining eligibility to enroll as a Waiver provider with the Texas Medicaid Healthcare Partnership (TMHP).

During the credentialing process, DSHS shall issue a letter to the applicant entity verifying that enrollment with TMHP is approved by DSHS. See CREDENTIALING AND ENROLLMENT, policy 2400 of this manual.

ENROLLMENT
PROCESS

A CWP shall enroll with TMHP as a YES Waiver-specific service provider. To enroll in TMHP, a CWP shall:

1. Submit a copy of the DSHS credentialing letter to TMHP (See Appendix ____);
2. Go to www.tmhp.com;
3. Click 'Providers' at the top of the home page;
4. On the Providers page, click 'Enroll Today!' at the top of the page;
5. On the Provider Enrollment page, go to the "How do I enroll in Texas Medicaid?" section at the bottom of the page;
6. Click the 'Click here to activate your account' link;
7. Follow the instructions on the Account Activation page to complete the portal account set up; and
8. Use the Provider Enrollment Portal (PEP) to submit a Waiver enrollment application.

For assistance in the online enrollment process, contact the TMHP Contact Center at 1-800-925-9126.

BILLING
COMMUNITY MENTAL HEALTH CENTER

2800.1

PRE-ENGAGEMENT SERVICES	<p>A community mental health center shall be permitted to request reimbursement for pre-engagement staff time spent enrolling individuals in the Waiver who are not Medicaid eligible or who become Medicaid eligible in accordance with Title 42 of the Code of Federal Regulations (CFR).</p> <p>Claims for pre-engagement services shall be submitted in Clinical Management for Behavioral Health Services (CMBHS).</p>
ACTING AS COMPREHENSIVE WAIVER PROVIDER	<p>A community mental health center that has entered into a comprehensive waiver provider (CWP) agreement with the Department of State Health Services (DSHS) shall enter service notes into CMBHS for Waiver services.</p>
REIMBURSEMENT RATE	<p>In accordance with the CWP agreement with DSHS, the current Waiver service reimbursement rate(s), or any amendment to the rate(s), shall be payment in full for the provision of Waiver services.</p> <p>Current rates for all Waiver services, effective September 1, 2013, are found in Appendix B at the end of this manual.</p>
ADDITIONAL CHARGES PROHIBITED	<p>The community mental health center, acting as CWP, shall be prohibited from assessing additional charges to a participant, any member of a participant's family, or any other party, including a third-party payer, except as permitted by federal and/or state law, rule, regulation, or the Medicaid State Plan.</p>
NON-REIMBURSED SERVICES	<p>Services that shall not be reimbursed include those:</p> <ol style="list-style-type: none">1. Not approved on the participant's IPC;2. Exceeding the limits approved by DSHS;3. Provided on a date in which a current IPC was not in place; or4. Provided outside of Waiver eligibility.
STATE PLAN SERVICES	<p>Medicaid providers of State Plan Services shall submit claims for payment to Texas Medicaid Healthcare Partnership (TMHP), the appropriate Managed Care Organization, or private insurance, as applicable. DSHS shall not pay claims for State Plan Services or for other non-Waiver services.</p>
PAYER OF LAST RESORT	<p>Medicaid shall be the payer of last resort. Any claims that may be covered by a private insurance benefit shall be submitted for payment to the private insurance provider prior to submitting the claim to Medicaid; i.e. TMHP or a Managed Care Organization.</p>

BILLING
COMPREHENSIVE WAIVER PROVIDER

2800.2

	<p>A comprehensive waiver provider (CWP) shall enter service notes into CMBHS for Waiver services. The CWP shall maintain documentation of service provision for each invoiced amount in the participant's service record.</p>
REIMBURSEMENT RATE	<p>In accordance with the CWP agreement with DSHS, the current Waiver service reimbursement rate(s), or any amendment to the rate(s), shall be payment in full for the provision of Waiver services.</p> <p>Current rates for all Waiver services, effective September 1, 2013, are found in Appendix B at the end of this manual.</p>
ADDITIONAL CHARGES PROHIBITED	<p>The CWP, shall be prohibited from assessing additional charges to a participant, any member of a participant's family, or any other party, including a third-party payer, except as permitted by federal and/or state law, rule, regulation, or the Medicaid State Plan.</p>
NON-REIMBURSED SERVICES	<p>Services that shall not be reimbursed include those:</p> <ol style="list-style-type: none">1. Not previously approved on the participant's IPC;2. Exceeding the limits approved by DSHS;3. Provided on a date in which a current IPC was not in place; or4. Provided outside of Waiver eligibility.
STATE PLAN SERVICES	<p>Medicaid providers of State Plan Services shall submit claims for payment to Texas Medicaid Healthcare Partnership (TMHP), the appropriate Managed Care Organization, or private insurance, as applicable. DSHS shall not pay claims for State Plan Services or for other non-Waiver services.</p>
PAYER OF LAST RESORT	<p>Medicaid shall be the payer of last resort. Any claims that may be covered by a private insurance benefit shall be submitted for payment to the private insurance provider prior to submitting the claim to Medicaid; i.e. TMHP or a Managed Care Organization.</p>

BILLING
 ADAPTIVE AIDS AND SUPPORTS

2800.3

PAYMENT RATE The payment rate for an adaptive aid and support (AA&S) shall be dependent upon the direct and associated costs for the type of aid or support chosen: consumable good; durable good; lessons, classes, and seasonal activities; or memberships.

The Department of State Health Services (DSHS) shall not reimburse costs for, or associated with, room and board, normal household expenses, and items not related to amelioration of the participant's disability.

ANNUAL LIMIT There shall be a collective limit of \$5,000 per year for AA&S.

The availability of annual AA&S shall vary, depending upon the recommendations of the Child and Family Team and the Wrap-around Plan, in consideration of the annual cost limit.

BIDS DSHS shall require a comprehensive waiver provider (CWP) to obtain three bids for any AA&S costing more than \$500.

REQUIRED DOCUMENTATION In order to properly bill for the provision of AA&S, a provider shall provide:

1. A receipt of purchase; and
2. Documentation of a good faith effort to obtain multiple bids, when applicable.

REQUISITION FEE DSHS shall directly reimburse the CWP for the requisition fee associated with the total cost of securing each identified support purchased, in accordance with the following:

Cost of Service	Payment Rate
Under \$500	10% of cost
\$500–\$999.99	\$54.03
\$1,000–\$1,499.99	\$92.85
\$1,500–\$1,999.99	\$105.66
\$2,000–\$2,499.99	\$118.86
\$2,500–\$2,999.99	\$134.21
\$3,000–\$3,499.99	\$140.81
\$3,500–\$3,999.99	\$147.02
\$4,000–\$4,499.99	\$153.62
\$4,500–\$4,999.99	\$160.22
\$5,000	\$168.96

BILLING
ADAPTIVE AIDS AND SUPPORTS

2800.3

REIMBURSEMENT OF SERVICE RATE DSHS shall directly reimburse the CWP for the total cost, per identified support. If the AA&S was subcontracted, the CWP shall reimburse the subcontractor the total cost.

BILLING
COMMUNITY LIVING SUPPORTS

2800.4

UNIT DESIGNATION AND PAYMENT RATE	<p>The unit designation for community living supports (CLS) is 15-minutes. One 15-minute increment shall be billed as one unit. In order to bill for a unit, the entire unit shall be provided to the participant, face-to-face.</p> <p>Bachelor's degree and Master's degree level CLS clinicians shall be paid at the rate of \$25.02 per unit.</p>
AVAILABILITY OF ANNUAL UNITS	<p>The availability of annual units shall vary, depending upon the recommendations of the Child and Family Team and the Wraparound Plan.</p>
GROUP SETTING SERVICE(S)	<p>Waiver services that are permitted to be provided in a group setting shall be billed using the following formula:</p> $\text{Number of providers} \times \text{Time spent delivering service(s)} \div \text{Number of participants served} = \text{Billable Time.}$
REQUIRED DOCUMENTATION	<p>In order to properly bill for the provision of CLS service(s), a provider shall document:</p> <ol style="list-style-type: none">1. Date of Contact;2. Start and Stop Time;3. Progress towards goals set forth in the individual plan of care (IPC); and4. Information about the service provider, including:<ol style="list-style-type: none">a. Printed name;b. Signature (electronic signature is acceptable); andc. Credentials.
REIMBURSEMENT AND NEGOTIATION OF SERVICE RATE	<p>The Department of State Health Services (DSHS) shall directly reimburse the comprehensive waiver provider (CWP) for the entire, per unit, rate.</p> <p>The CWP is permitted to negotiate payment to its employees or subcontractors.</p>

BILLING
FAMILY SUPPORTS

2800.5

UNIT DESIGNATION
AND PAYMENT RATE

The unit designation for family supports is 15-minutes. One 15-minute increment shall be billed as one unit. In order to bill for a unit, the entire unit shall be provided to the participant, face-to-face.

Family support services shall be paid at the rate of \$6.25 per unit.

AVAILABILITY OF
ANNUAL UNITS

The availability of annual units shall vary, depending upon the recommendations of the Child and Family Team and the Wraparound Plan.

GROUP SETTING
SERVICE(S)

Waiver services that are permitted to be provided in a group setting shall be billed using the following formula:

Number of providers × Time spent delivering service(s) ÷ Number of participants served = Billable Time.

REQUIRED
DOCUMENTATION

In order to properly bill for the provision of family support services, a provider shall document:

1. Date of Contact;
2. Start and Stop Time;
3. Progress towards goals set forth in the individual plan of care (IPC); and
4. Information about the service provider, including:
 - a. Printed name;
 - b. Signature (electronic signature is acceptable); and
 - c. Credentials.

REIMBURSEMENT AND
NEGOTIATION OF
SERVICE RATE

The Department of State Health Services (DSHS) shall directly reimburse the comprehensive waiver provider (CWP) for the entire, per unit, rate.

The CWP is permitted to negotiate payment to its employees or subcontractors.

BILLING
 MINOR HOME MODIFICATIONS

2800.6

PAYMENT RATE The payment rate for minor home modifications shall be dependent upon the direct and associated costs for the type of modification chosen.

ANNUAL LIMIT There shall be a collective limit of \$5,000 per year for minor home modifications.

The availability of minor home modifications shall vary, depending upon the recommendations of the Child and Family Team and the Wraparound Plan, in consideration of the annual cost limit.

BIDS DSHS shall require a comprehensive waiver provider (CWP) to obtain three bids for any modification costing more than \$500.

REQUIRED DOCUMENTATION In order to properly bill for minor home modifications, a provider shall provide:

1. A receipt of purchase; and
2. Documentation of a good faith effort to obtain multiple bids, when applicable.

REQUISITION FEE DSHS shall directly reimburse the CWP for the requisition fee associated with the total cost of each identified modification, in accordance with the following:

Cost of Service	Payment Rate
Under \$500	10% of cost
\$500–\$999.99	\$80.04
\$1,000–\$1,499.99	\$118.86
\$1,500–\$1,999.99	\$131.67
\$2,000–\$2,499.99	\$163.89
\$2,500–\$2,999.99	\$196.50
\$3,000–\$3,499.99	\$227.19
\$3,500–\$3,999.99	\$258.27
\$4,000–\$4,499.99	\$284.28
\$4,500–\$4,999.99	\$309.90
\$5,000	\$335.91

BILLING
MINOR HOME MODIFICATIONS

2800.6

REIMBURSEMENT OF
SERVICE RATE

DSHS shall directly reimburse the CWP for the total cost, per identified modification. If the modification was subcontracted, the CWP shall reimburse the subcontractor the total cost.

BILLING
 NON-MEDICAL TRANSPORTATION

2800.7

UNIT DESIGNATION AND PAYMENT RATE The unit designation for non-medical transportation is one mile. One mile shall be billed as one unit. In order to bill for a unit, it shall be provided to the participant, face-to-face.

Non-medical transportation shall be paid at the rate of \$0.55 per unit.

LIMITATIONS Payment for non-medical transportation shall be limited to the costs of transporting a participant to Waiver services included in the individual plan of care (IPC), or to access other activities and/or resources identified in the IPC.

Whenever possible, members of the participant's family, neighbors, friends, or community agencies which can provide non-medical transportation at no cost shall be utilized prior to requesting it through the Waiver.

When costs for transportation are included in the provider rate for another Waiver service the participant is receiving at the same time, non-medical transportation shall not be reimbursed separately as a Waiver service.

AVAILABILITY OF ANNUAL UNITS The availability of annual units shall vary, depending upon the recommendations of the Child and Family Team and the Wraparound Plan.

REQUIRED DOCUMENTATION In order to properly bill for the provision of non-medical transportation, a provider shall document:

1. Date of Contact;
2. Mileage, including Start and Stop Time; and
3. Information about the service provider, including:
 - a. Printed name;
 - b. Signature (electronic signature is acceptable); and
 - c. Credentials.

ROUNDING MILEAGE Mileage shall be rounded to the nearest whole mile, in accordance with the following:

Mileage	Round
.01-.49	Down
.50-.99	Up

BILLING
NON-MEDICAL TRANSPORTATION

2800.7

REIMBURSEMENT AND
NEGOTIATION OF
SERVICE RATE

The Department of State Health Services (DSHS) shall directly reimburse the comprehensive waiver provider (CWP) for the entire, per unit rate.

The CWP is permitted to negotiate payment to its employees or subcontractors.

BILLING
PARAPROFESSIONAL SERVICES

2800.8

UNIT DESIGNATION AND PAYMENT RATE	<p>The unit designation for paraprofessional services is 15-minutes. One 15-minute increment shall be billed as one unit. In order to bill for a unit, the entire unit shall be provided to the participant, face-to-face.</p> <p>Paraprofessional services shall be paid at the rate of \$6.15 per unit.</p>
AVAILABILITY OF ANNUAL UNITS	<p>The availability of annual units shall vary, depending upon the recommendations of the Child and Family Team and the Wraparound Plan.</p>
GROUP SETTING SERVICE(S)	<p>Waiver services that are permitted to be provided in a group setting shall be billed using the following formula:</p> $\text{Number of providers} \times \text{Time spent delivering service(s)} \div \text{Number of participants served} = \text{Billable Time.}$
REQUIRED DOCUMENTATION	<p>In order to properly bill for the provision of paraprofessional services, a provider shall document:</p> <ol style="list-style-type: none">1. Date of Contact;2. Start and Stop Time;3. Progress towards goals set forth in the individual plan of care (IPC); and4. Information about the service provider, including:<ol style="list-style-type: none">a. Printed name;b. Signature (electronic signature is acceptable); andc. Credentials.
REIMBURSEMENT AND NEGOTIATION OF SERVICE RATE	<p>The Department of State Health Services (DSHS) shall directly reimburse the comprehensive waiver provider (CWP) for the entire, per unit rate.</p> <p>The CWP is permitted to negotiate payment to its employees or subcontractors.</p>

BILLING
PRE-ENGAGEMENT SERVICES

2800.9

UNIT DESIGNATION
AND PAYMENT RATE

The unit designation for pre-engagement services is hourly. One hour shall be billed as one unit. The maximum number of hours permitted to be billed for pre-engagement services is 16.

Pre-engagement services shall be paid at the rate of \$15.85 per unit.

NON-BILLABLE
HOURS AND
ACTIVITIES

Billing for pre-engagement services is not permitted when:

1. The individual does not enroll in the Waiver; or
2. The individual was receiving Medicaid benefits prior to seeking Waiver eligibility.

Texas Department of State Health Services
YES Waiver

BILLING
RESPITE
IN-HOME

2800.10

UNIT DESIGNATION
AND PAYMENT RATE

The unit designation for in-home respite services is hourly. One hour shall be billed as one unit. In order to bill for a unit, the unit shall be provided to the participant, face-to-face.

In-home respite services shall be paid at the rate of \$20.88 per unit.

UNIT LIMITATION

Up to 720 consecutive or cumulative hours, or 30 days, of any respite service, or combination of respite services, shall be permitted to be provided per participant service plan year.

REQUIRED
DOCUMENTATION

In order to properly bill for the provision of in-home respite services, a provider shall document:

1. Date of Contact;
2. Start and Stop Time;
3. Progress towards goals set forth in the individual plan of care (IPC); and
4. Information about the service provider, including:
 - a. Printed name;
 - b. Signature (electronic signature is acceptable); and
 - c. Credentials.

REIMBURSEMENT AND
NEGOTIATION OF
SERVICE RATE

The Department of State Health Services (DSHS) shall directly reimburse the comprehensive waiver provider (CWP) for the entire, per unit rate or the amount up to the annual service maximum.

The CWP is permitted to negotiate payment to its employees or subcontractors.

BILLING
 RESPITE
 OUT-OF-HOME: CAMP

2800.11

UNIT DESIGNATION
 AND PAYMENT RATE

The unit designation for out-of-home camp respite services is hourly. One hour shall be billed as one unit. In order to bill for a unit, the unit shall be provided to the participant face-to-face.

Out-of-home camp respite services shall be paid at the rate of \$9.84 per unit.

INCREMENTAL
 BILLING

The Department of State Health Services (DSHS) shall permit out-of-home camp respite services to be billed in ¼, or 15-minute, increments; however, when billed incrementally, the entire 15-minute increment shall be provided to the participant.

Incremental billing shall be in accordance with the following:

Minutes	Unit
15	.25
30	.5
45	.75
60	1.0

UNIT LIMITATION

Up to 720 consecutive or cumulative hours, or 30 days, of any respite service, or combination of respite services, shall be permitted to be provided per participant service plan year.

REQUIRED
 DOCUMENTATION

In order to properly bill for the provision of out-of-home camp respite services, a provider shall document:

1. Date of Contact;
2. Start and Stop Time;
3. Progress towards goals set forth in the individual plan of care (IPC);
4. A summary of activities, meals, and behaviors; and
5. Information about the service provider, including:
 - a. Printed name;
 - b. Signature (electronic signature is acceptable); and
 - c. Credentials.

REIMBURSEMENT AND
 NEGOTIATION OF
 SERVICE RATE

DSHS shall directly reimburse the comprehensive waiver provider (CWP) for the entire, per unit rate or the amount up to the annual service maximum.

The CWP is permitted to negotiate payment to its employees or subcontractors.

**BILLING
 RESPITE**

OUT-OF-HOME: LICENSED CHILD CARE CENTER

2800.12

UNIT DESIGNATION AND PAYMENT RATE The unit designation for out-of-home licensed child care center (LCCC) respite services is hourly. One hour shall be billed as one unit. In order to bill for a unit, the unit shall be provided to the participant face-to-face.

PRESCHOOL AGE LCCC respite services for preschool children, ages three to five years old, shall be paid at the rate of \$5.32 per unit.

SCHOOL AGE LCCC respite services for school age children, ages six to 18 years old, shall be paid at the rate of \$5.17 per unit.

INCREMENTAL BILLING The Department of State Health Services (DSHS) shall permit LCCC respite services to be billed in ¼, or 15-minute, increments; however, when billed incrementally, the entire 15-minute increment shall be provided to the participant.

Incremental billing shall be in accordance with the following:

Minutes	Unit
15	.25
30	.5
45	.75
60	1.0

UNIT LIMITATION Up to 720 consecutive or cumulative hours, or 30 days, of any respite service, or combination of respite services, shall be permitted to be provided per participant service plan year.

REQUIRED DOCUMENTATION In order to properly bill for the provision of LCCC respite services, a provider shall document:

1. Date of Contact;
2. Start and Stop Time;
3. Progress towards goals set forth in the individual plan of care (IPC);
4. A summary of activities, meals, and behaviors; and
5. Information about the service provider, including:
 - a. Printed name;
 - b. Signature (electronic signature is acceptable); and
 - c. Credentials.

Texas Department of State Health Services
YES Waiver

BILLING
RESPITE

OUT-OF-HOME: LICENSED CHILD CARE CENTER

2800.12

REIMBURSEMENT AND
NEGOTIATION OF
SERVICE RATE

DSHS shall directly reimburse the comprehensive waiver provider (CWP) for the entire, per unit rate or the amount up to the annual service maximum.

The CWP is permitted to negotiate payment to its employees or subcontractors.

**BILLING
 RESPITE
 OUT-OF-HOME: LICENSED CHILD CARE CENTER,
 TEXAS RISING STAR PROVIDER**

2800.13

UNIT DESIGNATION AND PAYMENT RATE The unit designation for out-of-home, licensed child care center, Texas Rising Star (TRS) Provider respite services is hourly. One hour shall be billed as one unit. In order to bill for a unit, the unit shall be provided to the participant face-to-face.

PRESCHOOL AGE TRS Provider respite services for preschool children, ages three to five years old, shall be paid at the rate of \$5.61 per unit.

SCHOOL AGE TRS Provider respite services for school age children, ages six to 18 years old, shall be paid at the rate of \$5.54 per unit.

INCREMENTAL BILLING The Department of State Health Services (DSHS) shall permit TRS Provider respite services to be billed in ¼, or 15-minute, increments; however, when billed incrementally, the entire 15-minute increment shall be provided to the participant.

Incremental billing shall be in accordance with the following:

Minutes	Unit
15	.25
30	.5
45	.75
60	1.0

UNIT LIMITATION Up to 720 consecutive or cumulative hours, or 30 days, of any respite service, or combination of respite services, shall be permitted to be provided per participant service plan year.

REQUIRED DOCUMENTATION In order to properly bill for the provision of TRS Provider respite services, a provider shall document:

1. Date of Contact;
2. Start and Stop Time;
3. Progress towards goals set forth in the individual plan of care (IPC);
4. A summary of activities, meals, and behaviors; and
5. Information about the service provider, including:
 - a. Printed name;
 - b. Signature (electronic signature is acceptable); and
 - c. Credentials.

Texas Department of State Health Services
YES Waiver

BILLING
RESPITE
OUT-OF-HOME: LICENSED CHILD CARE CENTER,
TEXAS RISING STAR PROVIDER

2800.13

REIMBURSEMENT AND NEGOTIATION OF SERVICE RATE DSHS shall directly reimburse the comprehensive waiver provider (CWP) for the entire, per unit rate or the amount up to the annual service maximum.

The CWP is permitted to negotiate payment to its employees or subcontractors.

BILLING
 RESPITE

OUT-OF-HOME: LICENSED CHILD CARE HOME

2800.14

UNIT DESIGNATION AND PAYMENT RATE The unit designation for out-of-home licensed child care home (LCCH) respite services is hourly. One hour shall be billed as one unit. In order to bill for a unit, the unit shall be provided to the participant face-to-face.

PRESCHOOL AGE LCCH respite services for preschool children, ages three to five years old, shall be paid at the rate of \$4.90 per unit.

SCHOOL AGE LCCC respite services for school age children, ages six to 18 years old, shall be paid at the rate of \$4.86 per unit.

INCREMENTAL BILLING The Department of State Health Services (DSHS) shall permit LCCH respite services to be billed in ¼, or 15-minute, increments; however, when billed incrementally, the entire 15-minute increment shall be provided to the participant.

Incremental billing shall be in accordance with the following:

Minutes	Unit
15	.25
30	.5
45	.75
60	1.0

UNIT LIMITATION Up to 720 consecutive or cumulative hours, or 30 days, of any respite service, or combination of respite services, shall be permitted to be provided per participant service plan year.

REQUIRED DOCUMENTATION In order to properly bill for the provision of LCCH respite services, a provider shall document:

1. Date of Contact;
2. Start and Stop Time;
3. Progress towards goals set forth in the individual plan of care (IPC);
4. A summary of activities, meals, and behaviors; and
5. Information about the service provider, including:
 - a. Printed name;
 - b. Signature (electronic signature is acceptable); and
 - c. Credentials.

Texas Department of State Health Services
YES Waiver

BILLING
RESPITE

OUT-OF-HOME: LICENSED CHILD CARE HOME

2800.14

REIMBURSEMENT AND
NEGOTIATION OF
SERVICE RATE

DSHS shall directly reimburse the comprehensive waiver provider (CWP) for the entire, per unit rate or the amount up to the annual service maximum.

The CWP is permitted to negotiate payment to its employees or subcontractors.

**BILLING
 RESPITE
 OUT-OF-HOME: LICENSED CHILD CARE HOME
 TEXAS RISING STAR PROVIDER**

2800.15

UNIT DESIGNATION AND PAYMENT RATE The unit designation for out-of-home, licensed child care home, Texas Rising Star (TRS) Provider respite services is hourly. One hour shall be billed as one unit. In order to bill for a unit, the unit shall be provided to the participant face-to-face.

PRESCHOOL AGE TRS Provider respite services for preschool children, ages three to five years old, shall be paid at the rate of \$5.17 per unit.

SCHOOL AGE TRS Provider respite services for school age children, ages six to 18 years old, shall be paid at the rate of \$5.62 per unit.

INCREMENTAL BILLING The Department of State Health Services (DSHS) shall permit TRS Provider respite services to be billed in ¼, or 15-minute, increments; however, when billed incrementally, the entire 15-minute increment shall be provided to the participant.

Incremental billing shall be in accordance with the following:

Minutes	Unit
15	.25
30	.5
45	.75
60	1.0

UNIT LIMITATION Up to 720 consecutive or cumulative hours, or 30 days, of any respite service, or combination of respite services, shall be permitted to be provided per participant service plan year.

REQUIRED DOCUMENTATION In order to properly bill for the provision of TRS Provider respite services, a provider shall document:

1. Date of Contact;
2. Start and Stop Time;
3. Progress towards goals set forth in the individual plan of care (IPC);
4. A summary of activities, meals, and behaviors; and
5. Information about the service provider, including:
 - a. Printed name;
 - b. Signature (electronic signature is acceptable); and
 - c. Credentials.

Texas Department of State Health Services
YES Waiver

BILLING
RESPITE
OUT-OF-HOME: LICENSED CHILD CARE HOME
TEXAS RISING STAR PROVIDER

2800.15

REIMBURSEMENT AND NEGOTIATION OF SERVICE RATE DSHS shall directly reimburse the comprehensive waiver provider (CWP) for the entire, per unit rate or the amount up to the annual service maximum.

The CWP is permitted to negotiate payment to its employees or subcontractors.

**BILLING
 RESPITE**

OUT-OF-HOME: REGISTERED CHILD CARE HOME

2800.16

UNIT DESIGNATION AND PAYMENT RATE The unit designation for out-of-home, registered child care home (RCCH) respite services is hourly. One hour shall be billed as one unit. In order to bill for a unit, the unit shall be provided to the participant face-to-face.

PRESCHOOL AGE RCCH respite services for preschool children, ages three to five years old, shall be paid at the rate of \$4.75 per unit.

SCHOOL AGE RCCH respite services for school age children, ages six to 18 years old, shall be paid at the rate of \$3.83 per unit.

INCREMENTAL BILLING The Department of State Health Services (DSHS) shall permit RCCH respite services to be billed in ¼, or 15-minute, increments; however, when billed incrementally, the entire 15-minute increment shall be provided to the participant.

Incremental billing shall be in accordance with the following:

Minutes	Unit
15	.25
30	.5
45	.75
60	1.0

UNIT LIMITATION Up to 720 consecutive or cumulative hours, or 30 days, of any respite service, or combination of respite services, shall be permitted to be provided per participant service plan year.

REQUIRED DOCUMENTATION In order to properly bill for the provision of RCCH respite services, a provider shall document:

1. Date of Contact;
2. Start and Stop Time;
3. Progress towards goals set forth in the individual plan of care (IPC);
4. A summary of activities, meals, and behaviors; and
5. Information about the service provider, including:
 - a. Printed name;
 - b. Signature (electronic signature is acceptable); and
 - c. Credentials.

Texas Department of State Health Services
YES Waiver

BILLING
RESPITE

OUT-OF-HOME: REGISTERED CHILD CARE HOME

2800.16

REIMBURSEMENT AND
NEGOTIATION OF
SERVICE RATE

DSHS shall directly reimburse the comprehensive waiver provider (CWP) for the entire, per unit rate or the amount up to the annual service maximum.

The CWP is permitted to negotiate payment to its employees or subcontractors.

BILLING
 RESPITE
 OUT-OF-HOME: REGISTERED CHILD CARE HOME
 TEXAS RISING STAR PROVIDER

2800.17

UNIT DESIGNATION AND PAYMENT RATE The unit designation for out-of-home, registered child care home, Texas Rising Star (TRS) Provider respite services is hourly. One hour shall be billed as one unit. In order to bill for a unit, the unit shall be provided to the participant face-to-face.

PRESCHOOL AGE TRS Provider respite services for preschool children, ages three to five years old, shall be paid at the rate of \$4.99 per unit.

SCHOOL AGE TRS Provider respite services for school age children, ages six to 18 years old, shall be paid at the rate of \$4.08 per unit.

INCREMENTAL BILLING The Department of State Health Services (DSHS) shall permit TRS Provider respite services to be billed in ¼, or 15-minute, increments; however, when billed incrementally, the entire 15-minute increment shall be provided to the participant.

Incremental billing shall be in accordance with the following:

Minutes	Unit
15	.25
30	.5
45	.75
60	1.0

UNIT LIMITATION Up to 720 consecutive or cumulative hours, or 30 days, of any respite service, or combination of respite services, shall be permitted to be provided per participant service plan year.

REQUIRED DOCUMENTATION In order to properly bill for the provision of TRS Provider respite services, a provider shall document:

1. Date of Contact;
2. Start and Stop Time;
3. Progress towards goals set forth in the individual plan of care (IPC);
4. A summary of activities, meals, and behaviors; and
5. Information about the service provider, including:
 - a. Printed name;
 - b. Signature (electronic signature is acceptable); and
 - c. Credentials.

Texas Department of State Health Services
YES Waiver

BILLING
RESPITE
OUT-OF-HOME: REGISTERED CHILD CARE HOME
TEXAS RISING STAR PROVIDER

2800.17

REIMBURSEMENT AND NEGOTIATION OF SERVICE RATE DSHS shall directly reimburse the comprehensive waiver provider (CWP) for the entire, per unit rate or the amount up to the annual service maximum.

The CWP is permitted to negotiate payment to its employees or subcontractors.

BILLING
RESPITE

OUT-OF-HOME: RESIDENTIAL CHILD CARE
DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

2800.18

UNIT DESIGNATION
AND PAYMENT RATE

The unit designation for out-of-home, residential child care, Department of Family and Protective Services (DFPS) respite services is daily. Any portion of a 24-hour period shall be permitted to be billed as one unit.

FOSTER FAMILY

DFPS residential child care respite services provided by a foster family shall be paid at the rate of \$88.62 per unit, the mandated maximum.

CHILD PLACING
AGENCY

DFPS residential child care respite services provided by a child placing agency shall be paid at the rate of \$67.98 per unit.

GENERAL
RESIDENTIAL
OPERATION (GRO)

DFPS residential child care respite services provided by a general residential operation (GRO), which provides emergency care services, shall be paid at the rate of \$115.44 per unit.

BILLING
SPECIALIZED THERAPIES

2800.19

TYPES OF SPECIALIZED THERAPIES	<p>There are five types of specialized therapies:</p> <ol style="list-style-type: none">1. Animal-Assisted Therapy;2. Art Therapy;3. Licensed Nutritional Counseling;4. Music Therapy; and5. Recreational Therapy.
UNIT DESIGNATION	<p>The unit designation for each specialized therapy is 15-minutes. One 15-minute increment shall be billed as one unit. In order to bill for a unit, the entire unit shall be provided to the participant, face-to-face.</p>
PAYMENT RATE	<p>The payment rate for each specialized therapy shall be:</p> <ol style="list-style-type: none">1. Animal-Assisted Therapy – \$19.36;2. Art Therapy – \$19.36;3. Licensed Nutritional Counseling – \$13.82;4. Music Therapy – \$19.36; and5. Recreational Therapy – \$19.36.
AVAILABILITY OF ANNUAL UNITS	<p>The availability of annual units shall vary, depending upon the recommendations of the Child and Family Team and the Wraparound Plan.</p>
GROUP SETTING SERVICE(S)	<p>Waiver services that are permitted to be provided in a group setting shall be billed using the following formula:</p> $\text{Number of providers} \times \text{Time spent delivering service(s)} \div \text{Number of participants served} = \text{Billable Time.}$
REQUIRED DOCUMENTATION	<p>In order to properly bill for the provision of specialized therapy, a provider shall document:</p> <ol style="list-style-type: none">1. Date of Contact;2. Start and Stop Time;3. Progress towards goals set forth in the individual plan of care (IPC); and4. Information about the service provider, including:<ol style="list-style-type: none">a. Printed name;b. Signature (electronic signature is acceptable); andc. Credentials.

REQUISITION FEE The Department of State Health Services (DSHS) shall directly reimburse the provider for the requisition fee associated with the total per encounter cost, in accordance with the following:

Cost of Service	Payment Rate
Under \$500	10% of cost
\$500–\$999.99	\$54.03
\$1,000–\$1,499.99	\$92.85
\$1,500–\$1,999.99	\$105.66
\$2,000–\$2,499.99	\$118.86
\$2,500–\$2,999.99	\$134.21
\$3,000–\$3,499.99	\$140.81
\$3,500–\$3,999.99	\$147.02
\$4,000–\$4,499.99	\$153.62
\$4,500–\$4,999.99	\$160.22
\$5,000	\$168.96

EXCEPTION Licensed nutritional counseling does not have an associated requisition fee.

REIMBURSEMENT AND NEGOTIATION OF SERVICE RATE DSHS shall directly reimburse the comprehensive waiver provider (CWP) for the actual direct service cost, up to the per unit maximum. The amount billed shall reflect the payment amount to employees or subcontractors.

The CWP is permitted to negotiate payment to its employees or subcontractors.

BILLING
SUPPORTIVE FAMILY-BASED ALTERNATIVES

2800.20

UNIT DESIGNATION AND PAYMENT RATE	The unit designation for supportive family-based alternatives (SFA) is daily. Any portion of a 24-hour period shall be permitted to be billed as one unit.
SUPPORT FAMILY	SFA services provided by a support family shall be paid at the rate of \$69.25 per unit, the mandated maximum.
CHILD PLACING AGENCY	SFA services provided by a child placing agency shall be paid at the rate of \$67.98 per unit.
UNIT LIMITATION	Up to 90 consecutive or cumulative days of SFA shall be permitted to be provided, per participant service plan year.
REQUIRED DOCUMENTATION	<p>In order to properly bill for the provision of SFA service(s), a provider shall document:</p> <ol style="list-style-type: none">1. Date of Contact;2. Start and Stop Time;3. Progress towards goals set forth in the individual plan of care (IPC); and4. Information about the service provider, including:<ol style="list-style-type: none">a. Printed name;b. Signature (electronic signature is acceptable); andc. Credentials.
REIMBURSEMENT AND NEGOTIATION OF SERVICE RATE	<p>The Department of State Health Services (DSHS) shall directly reimburse the comprehensive waiver provider (CWP) for the entire, per unit rate.</p> <p>The CWP is permitted to negotiate payment to its employees or subcontractors; however, a support family shall be paid the entire mandated maximum rate.</p>

BILLING
TRANSITIONAL SERVICES

2800.21

PAYMENT	Transitional services shall be paid as a one-time, non-recurring expense, to a maximum of \$2,500, per participant. Failure to use the full \$2,500 at one time shall result in a loss of the remainder amount.
REQUIRED DOCUMENTATION	In order to properly bill for transitional services, a provider shall provide receipt(s) of purchase.
REQUISITION FEE	The Department of State Health Services (DSHS) shall reimburse the CWP for transitional services coordination in the amount of \$158.28.
REIMBURSEMENT OF SERVICE RATE	<p>The Department of State Health Services (DSHS) shall directly reimburse the comprehensive waiver provider (CWP) for the total amount of assistance, to the allowed maximum, plus the requisition fee.</p> <p>If transitional services were subcontracted, the CWP shall reimburse the subcontractor for the total amount of assistance; however, the CWP shall retain the requisition fee.</p>

BILLING
PAYMENT OF CLAIMS

2800.22

A claim for Waiver services shall be paid by the Texas Medicaid Healthcare Partnership (TMHP). In order to receive payment for performing the service(s), a comprehensive waiver provider (CWP) shall enter and manage claims through Clinical Management for Behavioral Health Services (CMBHS) as a service note. See SERVICE NOTES, policy 3800.4 of this manual.

To ensure accuracy during claim processing, TMHP shall verify that all required information is included in the claim.

PAYMENT

A claim that is ready for disposition at the end of each week shall be paid via an electronic funds transfer (EFT) or by a single check. The EFT shall include an explanation of each payment or denial of payment.

Additional information regarding TMHP's claims filing and reimbursement process is available at:

http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx

APPEAL OF DENIED
PAYMENT

A provider is permitted to appeal a denial of payment of a claim to TMHP. All appeals of denied claims and/or adjustments on paid claims shall be submitted to TMHP within 120 days from the date of disposition of the Remittance and Status (R&S) Report on which the claim(s) appears.

Additional information regarding TMHP's appeal process is available at:

http://www.tmhp.com/TMPPM/2008/06_TMPPM08_Appeals.pdf

In order to receive payment for Waiver services provided, a comprehensive waiver provider (CWP) shall enter and manage claims through Clinical Management for Behavioral Health Services (CMBHS) as a service note.

ENTERING A SERVICE
NOTE

To enter a service note:

1. There shall be a client profile and valid individual plan of care (IPC) in CMBHS;
2. In Special Services Documentation, select the 'Client Services Toolbar, YES Waiver Services';
3. The 'Progress Note Type' field automatically populates;
4. The 'Progress Note Type' displays 'YES Waiver Service Note' for each Waiver participant;
5. The number of authorized units for each service, billing units, and the Texas Medicaid Healthcare Partnership (TMHP) authorization automatically populate;
6. The CWP shall enter data in the following fields:
 - a. Service location;
 - b. Service date;
 - c. Start time and end time;
 - d. Service type; and
 - e. Service description;
7. The following fields are calculated by CMBHS:
 - a. Number of service units used; and
 - b. Number of remaining units; and
8. The CWP updates the document status as 'Draft' or 'Ready for Review'; and

CMBHS validates all of the required fields and creates a pending claim when the document is saved in 'Ready for Review' status.

DELETING A SERVICE
NOTE

A service note can be deleted from CMBHS before or after submission to TMHP by:

1. Finding the service note in the Client Workspace;
2. Highlighting the service note and selecting 'View'; and
3. Clicking 'Delete' at the top right corner of the page.

A 'Canceled Claim' shall be created in CMBHS, and once the claim is canceled, the service units from the canceled claim shall be re-added to the individual plan of care (IPC).

To submit a pending claim in Clinical Management for Behavioral Health Services (CMBHS), a comprehensive waiver provider (CWP) shall:

1. Hover over the 'Business Office' tab at the top of the page for the dropdown list;
2. Select 'Search Claims';
3. Select 'Pending Claims';
4. Select 'YES Waiver' as the funding source;
5. Select 'YES Waiver' as the 'Supporting Document (SD) Type';
6. Enter 'Service Begin Date';
7. Enter 'Service End Date';
8. Select 'Search' (limited to a 92-day date range);
9. Search the Pending Claims screen for the billable claim needing to be submitted;
10. Select 'YES Waiver Medicaid' as the 'Contract';
11. Verify accuracy of the information on the claim(s);
12. Select the claims to submit by checking the corresponding box;
13. Click the 'Submit Claims' button to submit claims to Texas Medicaid Healthcare Partnership (TMHP) for payment.

APPENDIX A

DEFINITIONS

Administrator – The individual providing authorization for Waiver services and/or overseeing the contract of a participating entity with the Department of State Health Services.

Billable Service – A Waiver service which a provider can bill for payment.

Billable Time – The billable units, per participant.

Capacity – The total number of Waiver participant slots available for a comprehensive waiver provider to enroll.

Child and Youth Strengths and Needs (CANS) Assessment – A multipurpose tool used to determine clinical eligibility, identify needs and strengths, support development of the individual plan of care, facilitate quality improvement initiatives, and monitor the outcome(s) of Waiver services.

Child and Family Team – The team identified by, and connected to, the family through natural, community, and formal support relationships. In partnership with the family, develops and implements the family's plan, addresses unmet needs, and works toward a collective team mission reflective of the family's vision. Also known as the Wraparound Team.

Child and Family Team Meeting – The meeting(s) during which the Child and Family Team members develop and monitor the participant's individual plan of care.

Clinical Interview – A face-to-face assessment with an interested individual and/or legally authorized representative to obtain information in order to complete the CANS Assessment and determine clinical eligibility.

Clinical Management for Behavioral Health Services (CMBHS) – An electronic health record system created and maintained by the Department of State Health Services for the use of contracted Mental Health and Substance Abuse services.

Community Mental Health Center – An entity established, as a community mental health center or community mental health and mental retardation center, in accordance with the Texas Health and Safety Code, §534.001, available at: <http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.534.htm#534.001>

Comprehensive Waiver Provider (CWP) – An agency, organization, or corporation contracted with the Department of State Health Services for the provision of Waiver services.

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Critical Incident – An incident which creates a significant risk of serious harm to the physical or mental health and/or the safety or well-being of a participant, as well as the risk of self-harm or harm to others by a participant.

Direct Service Provider – An employee or subcontractor of a participating entity, who, after meeting credentialing standards, provides Waiver services directly to a participant.

Eligible – A designation given to an interested individual once it is determined that all applicable Medicaid, demographic, and clinical eligibility are met.

Encounter Data – Details related to the treatment or services provided to a participant by a participating entity.

Enrolled – A designation given to an interested individual once his or her individual plan of care is approved by the Department of State Health Services.

Enrolled and Receiving Services – A designation given to a participant after receipt of the first Waiver service.

Fair Hearing – An informal proceeding requested by a participant or legally authorized representative to appeal an agency action before a Health and Human Services Commission hearings officer.

Individual Plan of Care (IPC) – Documentation of Waiver services, non-Waiver services, and State Plan services necessary to support a participant. Also known as the Wraparound Plan.

Intensive Case Management (ICM) – The Medicaid State Plan service that coordinates all services and supports a participant receives.

Interested Individual – An individual who has registered on the Inquiry List and who is awaiting assessment to determine eligibility for Waiver services.

Inquiry Line – A dedicated phone line or voicemail used to receive contact information from individuals interested in obtaining Waiver services.

Inquiry List – A list used to establish priority of assessment of interested individuals.

Legally Authorized Representative – A person authorized by law to act on behalf of a child or youth, including, but not limited to, a parent, guardian, or managing conservator, in accordance with Texas Administrative Code §414.403, Subchapter I, available at:

[http://texreg.sos.state.tx.us/public/readtac\\$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=414&rl=403](http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=414&rl=403)

APPENDIX A

Level of Care (LOC) – A designation given by the Department of State Health Services to the group of behavioral health services authorized for an individual based on the clinical needs identified by the Texas Resilience and Recovery (TRR) uniform assessment and any other applicable program standards.

Licensed Practitioner of the Healing Arts (LPHA) – A person who is licensed by the State of Texas to provide certain mental health services. This person may be a: Physician; Licensed Professional Counselor (LPC); Licensed Clinical Social Worker (LCSW); Licensed Marriage and Family Therapist (LMFT); Licensed Psychologist; or an Advanced Practice Nurse (APN).

Non-Waiver Services – Services provided by any funding source other than the Waiver, including, but not limited to, State Plan Services such as case management, rehabilitation, counseling, medication management, Temporary Assistance for Needy Families (TANF), and personal care services (PCS).

Participant – A child or youth currently enrolled in the Waiver and receiving Waiver services.

Participating Entity – A person, organization, agency, or corporation that participates in the provision of Waiver services by virtue of a contract with the Department of State Health Services.

Protected Health Information (PHI) – Individually identifiable health information transmitted by electronic media or maintained in any medium, in accordance with TAC §1.501, Subchapter W, available at:

[http://texreg.sos.state.tx.us/public/readtac\\$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=1&rl=501](http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=1&rl=501)

PHI excludes education records or information protected by the Family Educational Rights and Privacy Act (FERPA), employment records, and records of a person deceased for more than 50 years.

Qualified Mental Health Professional-Community Services (QMHP-CS) – A person who:

- 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 community mental health center or Managed Care Organization (MCO), in accordance with TAC §412.316(d), Subchapter G, available at:
[http://texreg.sos.state.tx.us/public/readtac\\$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=412&rl=316](http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=412&rl=316). Major course work must be in one of the following: 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;
- Is a registered nurse (RN); or

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- Completes an alternative credentialing process approved by the Department of State Health Services.

Sensitive Personal Information (SPI) – An individual's non-encrypted first name or first initial and last name, in combination with any one of the following: Social Security number; driver's license or government-issued identification number; or account number or credit or debit card number in combination with any required security or access code or password that would permit access to the individual's financial account(s). Any information that identifies an individual and relates to his or her: physical or mental health or other condition; provision of any health care service(s); or payment for the provision of any health care service(s).

Serious Emotional Disturbance (SED) – A diagnosable mental, behavioral, or emotional disorder which results in functional impairment(s).

Service Authorization – The process by which Waiver services documented in the individual plan of care (IPC) are authorized by the Department of State Health Services.

Service Note – Detailed documentation of Waiver service(s) provided to a participant used to process claims for payment for the provision of service(s).

State Plan Services – Services offered under the Medicaid State Plan service array, which can be provided by a community mental health center or any other credentialed Medicaid State Plan service provider.

Subcontractor – A single person, organization, or agency that enters into an agreement with a comprehensive waiver provider (CWP) to provide one or more Waiver services.

Texas Resilience and Recovery (TRR) – The State of Texas publically funded mental health service delivery system.

Uniform Assessment – The standardized tool used to gather information on individuals to determine Waiver eligibility, which includes: the Child and Youth Strengths and Needs (CANS) Assessment; community data; the Recommended Level of Care (LOC-R); and Authorized Level of Care (LOC-A).

Unit – a set period of time used to determine how Waiver services are provided and billed.

Utilization Management Guidelines – The utilization guidelines for behavioral health service provided through Texas Resilience and Recovery, available at: <http://www.dshs.state.tx.us/mhsa/trr/um/>

APPENDIX A

Wait-Listed Individual – An interested individual who is registered on the Inquiry List, but who may not be Medicaid eligible or demographically or clinically eligible and therefore, is awaiting an open Waiver slot.

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

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

Waiver Services Area – The geographical area covered by Waiver participating entities.

Waiver Slot – One of the total number of individuals enrolled in the Waiver in accordance with program capacity.

Wraparound Facilitator – The primary contact person for the participant's family and Wraparound Team who is trained to coordinate the Wraparound process.

