Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Texas** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.
B. **Program Title:**
Youth Empowerment Services (YES)
C. **Waiver Number:TX.0657**
D. **Amendment Number:TX.0657.R01.04**
E. **Proposed Effective Date:** *(mm/dd/yy)*
09/01/14
Approved Effective Date of Waiver being Amended: 04/01/13

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
This amendment:
1) Adds two new services to the current waiver service array: Supported Employment and Employment Assistance. The addition of these services will expand and enhance the YES service array to help meet the needs of individuals regarding employment services.

2) Adds the Home and Community Based Settings (HCBS) Transition Plan in Attachment #2. The transition plan was posted in the August 8, 2014 edition of the Texas Register (39 TexReg 6083). The YES waiver specific settings transition plan was also posted to the DSHS website in November 2014 with a notice to receive email updates posted as well.

3. Nature of the Amendment

A. **Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☑ **Waiver Application**	2; 3 a,b; Main 6,I; At
☐ **Appendix A – Waiver Administration and Operation**	

Component of the Approved Waiver	Subsection(s)
☐ Appendix B – Participant Access and Eligibility	
☑ Appendix C – Participant Services	C-1.a
☐ Appendix D – Participant Centered Service Planning and Delivery	
☐ Appendix E – Participant Direction of Services	
☐ Appendix F – Participant Rights	
☐ Appendix G – Participant Safeguards	
☐ Appendix H	
☑ Appendix I – Financial Accountability	I-2,a, I-5 b
☑ Appendix J – Cost-Neutrality Demonstration	J-2.d

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☑ **Add/delete services**
- ☐ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☐ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☑ **Other**

Specify:
Submit YES Transition Plan for HCBS settings.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Texas** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Youth Empowerment Services (YES)

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Waiver Number:TX.0657.R01.04
Draft ID: TX.017.01.07

D. Type of Waiver *(select only one):*
Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 04/01/13
Approved Effective Date of Waiver being Amended: 04/01/13

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

- ☑ **Hospital**

Select applicable level of care

- ○ **Hospital as defined in 42 CFR §440.10**
  If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
- ◉ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

- ○ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**
  If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
- ○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

- ◉ **Not applicable**
- ○ **Applicable**

Check the applicable authority or authorities:

- ☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
- ☐ **Waiver(s) authorized under §1915(b) of the Act.**

  Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

  Specify the §1915(b) authorities under which this program operates *(check each that applies):*
  - ☐ **§1915(b)(1) (mandated enrollment to managed care)**
  - ☐ **§1915(b)(2) (central broker)**
  - ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
  - ☐ **§1915(b)(4) (selective contracting/limit number of providers)**
- ☐ **A program operated under §1932(a) of the Act.**

  Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:
- ☐ **A program authorized under §1915(i) of the Act.**
- ☐ **A program authorized under §1915(j) of the Act.**
- ☐ **A program authorized under §1115 of the Act.**

  Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:
☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less,* briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The Health and Human Service Commission (HHSC) is the single state agency for Medicaid in Texas and has final authority in the State for Medicaid policies and operations. The Department of State Health Services (DSHS) is the operating agency for the YES waiver.

HHSC was authorized by the Texas Legislature to develop and implement a plan to prevent custody relinquishment of youth with serious emotional disturbances. To this end, HHSC was authorized to seek any necessary waivers or authorizations from the federal government. After review of various options, HHSC and DSHS, in collaboration with stakeholders, decided to request Youth Empowerment Services (YES) 1915(c) Medicaid waiver to improve access to services and allow more flexibility in providing intensive community-based services and supports for youth with serious emotional disturbances (SED) and their families.

The goals of the waiver include:

- Reducing out-of-home placements and inpatient psychiatric treatment by all child-serving agencies,

- Providing a more complete continuum of community-based services and supports for waiver participants with SED and their families, ensuring families have access to parent partners and other flexible non-traditional support services as identified in a family-centered planning process, preventing entry and recidivism into the foster care system and relinquishment of parental custody, and improving the clinical and functional outcomes of children and adolescents.

The objective of the YES waiver is to provide community-based services in lieu of institutionalization to a maximum of 400 waiver participants at any given time.

The HHSC Medicaid/CHIP Division provides oversight of the waiver. DSHS operates the waiver on a day-to-day basis. DSHS recruits waiver providers, processes provider applications, contracts with waiver providers, and provides quality and financial oversight of waiver administration and operations, including approval of level of care and service plans.

DSHS has designated local mental health authorities within each of the geographic service areas of the state (for local coordination of waiver services). Local mental health authorities are charged with the responsibility of screening people seeking admission to psychiatric facilities in their area to determine the least restrictive treatment environment and ensuring continuity of community-based services. DSHS contracts with the local mental health authorities to perform some administrative functions at the local level. Local mental health authorities: recruit and accept referrals of potential waiver participants, evaluate waiver applicants and recommend a level of care, provide potential participants with a choice of waiver or institutional services, provide information regarding all providers of waiver services, and perform utilization management functions and transition planning.

Case management for waiver participants is provided via Medicaid State Plan targeted case management. The local community mental health authorities provide case management functions as stipulated in the Texas Medicaid State Plan. The case manager develops the waiver participant's service plan using the wraparound planning process. The service plan will identify needed waiver and non-waiver services. All waiver services are provided in accordance with the waiver participant's service plan.

HHSC and DSHS also contract with waiver provider agencies in an open enrollment process. Waiver provider agencies are required to provide and arrange for all waiver services. Waiver participants have a choice of waiver provider agencies, if available, and of individual providers within these waiver provider agencies.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. **Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.

B. **Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. **Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. **Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. **Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. **Participant Rights. Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. **Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. **Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

I. **Financial Accountability. Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. **Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. **Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. **Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

C. **Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ○ **No**
- ◉ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

- ☑ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:
The waiver will be limited to waiver participants residing in Bexar, Brazoria, Cameron, Galveston, Fort Bend, Harris, Hidalgo, Tarrant, Travis and Willacy Counties. Bexar and Travis Counties began enrollment April 01, 2010; Tarrant County began enrollment July 1, 2012; Brazoria, Galveston, Fort Bend, and Harris Counties will begin enrollment February 1, 2014. Cameron, Hidalgo, and Willacy Counties will begin enrollment June 1, 2014.

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would

have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. **Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. **Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. **Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. **Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. **Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. **Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. **Inpatients**. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. **Room and Board**. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. **Access to Services**. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. **Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. **FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or

as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
The Public Notice of Intent was published in the Texas Register on April 25, 2014. Tribal Notification was emailed to the tribes on March 25, 2014, allowing a comment period. The comment period expired on April 24, 2014, and there were no comments received. In addition, Tribal notification specific to the HCBS transition plan was emailed to the tribes on July 9, 2014. The comment period expired on August 8, 2014, and there were no comments received.

The HCBS Transition Plan was posted in the August 8, 2014 edition of the Texas Register (39 TexReg 6083). The YES waiver specific settings transition plan was also posted to the DSHS website in November 2014. Comments received are addressed in Attachment #2: Home and Community-Based Settings Waiver Transition Plan.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Brownlee

First Name:

Becky

Title:

Director of Policy Development Support

Agency:

Texas Health and Human Services Commission

Address: 4900 North Lamar Blvd., Mail Code H-600

Address 2:

City: Austin

State: **Texas**

Zip: 78751

Phone: (512) 462-6281 **Ext:** **TTY**

Fax: (512) 730-7472

E-mail: becky.brownlee@hhsc.state.tx.us

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Robinson

First Name: Ross

Title: Director, Program Services Section

Agency: Department of State Health Services

Address: Mail Code 2018

Address 2: 909 W. 45th St.

City: Austin

State: **Texas**

Zip: 78751

Phone: (512) 467-5541 **Ext:** **TTY**

Fax: (512) 467-5547

E-mail: ross.robinson@dshs.state.tx.us

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: Sara McGhee

State Medicaid Director or Designee

Submission Date: Dec 30, 2014

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Ghahremani

First Name: Kay

Title: State Medicaid Director

Agency: Texas Health and Human Services Commission

Address: 4900 North Lamar Blvd.

Address 2: Mail Code H-620

City: Austin

State: **Texas**

Zip: 78751

Phone: (512) 462-6205 **Ext:** ☐ ☐ **TTY**

Fax: (512) 730-7472

E-mail: Kay.Ghahremani@hhsc.state.tx.us

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**

- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Not applicable

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301 (c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

YES Settings Transition Plan

Rule Overview

The Centers for Medicare & Medicaid Services (CMS) issued a final rule for home and community-based settings, effective March 17, 2014. Under 42 CFR §441.301, states must meet new requirements for home and community-based services and supports. The new rule defines requirements for the person-centered planning process; person-centered service plan; review of the person-centered service plan; qualities for home and community-based settings; assurances of compliance with the requirements; and transition plans to achieve compliance with the requirements. The rule also identifies settings that are not home and community-based.

Each state that operates a waiver under 1915(c) or a State Plan Amendment (SPA) under 1915(i) of the Social Security Act that was in effect on or before March 17, 2014, is required to file a Transition Plan, hereinafter referred to as the Settings Transition Plan. The Settings Transition Plan must be filed within 120 days of the first waiver renewal or amendment that is submitted to CMS after the effective date of the rule (March 17, 2014), but not later than March 17, 2015. The Settings Transition Plan must either provide assurances of compliance with 42 CFR §441.301 or set forth the actions that the State will take to bring each 1915(c) Home and Community-Based Service (HCBS) waiver and 1915(i) State Plan Amendment into compliance, and detail how the State will continue to operate all 1915(c) HCBS waivers and 1915(i) SPAs in accordance with the new requirements.

The Youth Empowerment Services (YES) waiver provides home and community-based services to children and youth age three through age 18 with serious emotional disturbance who reside in a non-institutional setting with the individual's legally authorized representative (LAR) or in the youth's own home, if legally emancipated.

Settings Transition Plan: The Settings Transition Plan is composed of the following three main components: (1) Assessment Process, (2) Remedial Strategy, and (3) Public Input. The Settings Transition Plan includes a timeframe and milestones for State actions, such as the various assessment and remedial actions.

Assessment Process:

The Assessment process may involve a (1) systemic (internal) review, (2) site specific assessments, (3) provider assessments and (4) identification of any settings presumed not to be home and community-based.

Systemic review: The State first determines its current level of compliance with the settings requirements. The State assesses the extent to which its rules, regulations, standards, policies, licensing requirements, and other provider requirements ensure settings comport with the HCBS settings requirements. In addition, the State assesses and describes the State's oversight process to ensure continuous compliance. The State may also assess individual settings/types of settings to further document compliance. Upon conducting the compliance assessment, if the State determines that existing standards meet the federal settings requirements and the State's oversight process is adequate to ensure ongoing compliance, the State will describe the process that it used for conducting the compliance assessment and the outcomes of that assessment. However, if the State determines that its standards may not meet the federal settings requirements, the State will include the following in its Settings Transition Plan: (1) remedial action(s) to come into compliance, such as proposing new state regulations or revising existing ones, revising provider requirements, or conducting provider training on the new state standards; (2) a timeframe for completing these actions; and (3) an estimate of the number of settings that likely do not meet the federal settings requirements.

Site specific assessments: States may conduct specific site evaluations through standard processes, such as licensing reviews, provider qualifications reviews, or support coordination visit reports. States may also choose to engage individuals receiving services and representatives of consumer advocacy entities in the assessment process. Evaluations may be conducted by entities such as state personnel, case managers that are not associated with the operating agency, licensing entities, managed care organizations, individuals receiving services, and/or representatives of consumer advocacy entities such as long-term care ombudsman programs and/or protections and advocacy systems. States may perform on-site assessments of a statistically significant sample of settings.

Provider assessments: The State may administer surveys of providers and include a validity check against self-evaluations.

Settings presumed not to be home and community-based: Where the State bases its assessment on state standards, the State will provide its best estimate of the number of settings that (1) fully align with the federal requirements, (2) do not comply with the federal requirements and will require modifications, (3) cannot meet the federal requirements and require removal from the program and/or relocation of the individuals, and (4) are presumptively non-home and community-based but for which the State will provide evidence to show that those settings do not have the characteristics of an institution and do have the qualities of home and community-based settings.

State Activity
First Phase of Assessment [March 2014-September 2014] (System/Internal Review):

In the first phase of the assessment process, Texas conducted a systemic/internal review of current waiver program rules and policies identifying areas that were in compliance with the new regulation, non-compliant, or silent. In addition, the State reviewed oversight processes to determine if revisions were needed to ensure ongoing compliance with new HCBS rules. The results of the systemic/internal review of rules and policies yielded an assessment document for the 1915(c) waivers operated by the Texas Department of State Health Services (DSHS) for the YES program, outlining areas of compliance and non-compliance across all of the waiver programs. The documents indicated whether the rules and policies were silent, non-compliant or partially compliant. The assessment document is posted the DSHS website, allowing ongoing input on the assessment process. The Texas Health & Human Services Commission (HHSC) website links to the DSHS website to support access to the assessment documents.

In July and August 2014 the State gave public notice for preliminary settings transition plans for CBA, CLASS, HCS, MDCP, and YES. Comments received were considered for incorporation into the assessment. Some suggestions were already underway, for example, the State was already in the process of adding supported employment and employment assistance to the waivers.

In addition to the systemic/internal review, the State sought additional public input on the waiver specific preliminary settings transition plans, for all of the 1915(c) waivers (CBA, CLASS, HCS, MDCP, and YES). For example, the State held an open meeting for stakeholders and the general public, on October 13, 2014. The meeting was also webcast to allow for greater participation across the State. The State accepted public testimony on waiver specific preliminary settings transition plans and additional recommendations for improving the assessment process for all of the 1915(c) waivers, and the 1115

demonstration waiver.

Second Phase of Assessment [September 2014-December 2015] (External Review):

Public input received during the first phase of the assessment indicated the need for an external assessment phase. As a result, additional external assessment activities were identified to include the following. The State may conduct additional assessments as deemed necessary:

• Provider self-assessment surveys: In order to validate the results of the first assessment phase, DSHS is releasing a provider self-assessment survey to a representative sample of providers. The survey will be based on the exploratory questions provided by CMS with input from external stakeholders. The provider self-assessment survey will be developed in conjunction with providers, provider associations and advocacy organizations to ensure a comprehensive approach. Providers who are not a part of the sample can still obtain and complete a self-assessment survey on the agency websites and provide data that will be considered as the State moves forward. Based on the results of the survey, ongoing remediation strategies and the assessment document will be updated.
• Participant surveys: In order to validate the provider self-assessment surveys, DSHS is releasing a participant survey to a representative sample of individuals receiving services. The survey will be based on the questions asked in the provider self-assessment. Participants who are not a part of the sample can still obtain and complete a participant survey on the agency websites and provide data that will be considered as the State moves forward. Based on the results of the survey, ongoing remediation strategies and the DSHS assessment document will be updated.
• Site specific assessments: DSHS already conducts at least annual site reviews of all providers and reviews 100% of charts. DSHS plans to conduct an additional assessment specifically to assess settings.
• Stakeholder meetings: The State is developing a plan for holding meetings around the state to allow providers, advocates, individuals receiving services, legally authorized representatives and other interested parties the opportunity to comment on all 1915(c) waiver programs and any concerns regarding compliance with the new regulations.
• National Core Indicators (NCI) Data: The State is in the process of analyzing NCI data and will consider using it in the assessment process.

Texas does not have any settings in the current 1915(c) Medicaid waivers that are presumed not to be community-based settings according to the regulations. The only possible exception may be day habilitation sites.

Third Phase of Assessment [June 2015-May 2016]

Texas will send provider self-assessment surveys to a representative sample of non-residential service providers the state identifies based on the internal assessment, public input, and additional CMS guidance, for example, day habilitation and pre-vocational service providers. Provider self-assessments will be verified by a representative sample of participant surveys.

Remedial Strategy:

The Remedial Strategy describes the actions the State proposes to assure initial and on-going compliance with the HCBS settings requirements, including timelines, milestones, and monitoring processes. State level remedial actions may include new requirements promulgated in statute, licensing standards or provider qualifications; revised service definitions and standards; revised training requirements or programs; or plans to relocate individuals to settings that are compliant with the regulations. Provider level remediation actions might include changes to the facility or program operation to assure that the Medicaid beneficiary has greater control over critical activities like access to meals, engagement with friends and family, choice of roommate, or access to activities of his/her choosing in the larger community, including the opportunity to seek and maintain competitive employment.

If the State determines the need to submit evidence to CMS for the application of heightened scrutiny for settings that are presumed not to be home and community-based, the Settings Transition Plan will include information that demonstrates that the setting does not have the characteristics of an institution and meets the HCB settings requirements. The State does not anticipate encountering this situation, but should it occur, the State will update the Settings Transition Plan and timeline accordingly.

If relocation of beneficiaries is required as part of the remediation strategy, the Settings Transition Plan will assure that the State provides reasonable notice and due process to those individuals; addresses the timeline for relocation; provides the number of beneficiaries impacted; and provides a description of the State's process to ensure that beneficiaries, through the person-centered planning process, are given the opportunity, information, and supports to make an informed choice of

alternate setting that aligns, or will align with, the requirements and that critical services or supports are in place in advance of the individual's transition. The State does not anticipate encountering this situation, but should it occur, the State will update the Settings Transition Plan and timeline accordingly.

State Activity
Texas has identified a number of remediation strategies to address issues of potential non-compliance:

• Rule and policy revisions: State rule revisions require extensive input from stakeholders including providers, advocates, individuals receiving services, legally authorized representatives and other interested parties. Stakeholders are allowed two opportunities to review draft rule language and provide comments prior to rules becoming effective. The first opportunity is through email announcing rule drafts are available for public comment on agency websites. Based on written comments, stakeholders may be contacted by agency staff for additional dialogue regarding proposed rule language. The second opportunity for input is through the formal 30-day public comment process outlined in statute. Policy manual revisions are also shared externally and stakeholders are asked to provide comments on drafts of the policy before it becomes effective.
• Revisions to processes used for provider oversight: All waiver programs have oversight processes administered by regulatory (Waiver, Survey and Certification) or contract monitoring staff. Applicable tools will be revised to reflect changes in rule and policy to ensure ongoing provider assessment will include compliance with HCBS regulations to the greatest extent possible. Written guidance concerning rights and responsibilities will be revised to ensure individuals receiving services understand their rights and know how to file a complaint with the appropriate state agency if there are restrictions being imposed on rights without adequate discussion and documentation through the person centered planning process.
• Provider education: Providers will have multiple opportunities to learn about the new regulations and understand rule and policy changes. DSHS conducts bi-weekly conference calls with providers.

Texas does not have any settings in the current 1915(c) Medicaid waivers that are presumed not to be community-based settings according to the regulations. The only possible exception may be day habilitation sites. However, if the State determines the need to submit evidence to CMS for the application of heightened scrutiny for settings that are presumed not to be home and community-based, the Settings Transition Plan will be amended to include information that demonstrates that the setting does not have the characteristics of an institution and meets the HCB settings requirements.

The State does not anticipate that relocation of beneficiaries will be required as part of the remediation strategy, however, if it is, then the State will provide reasonable notice and due process to those individuals, and ensure that beneficiaries, through the person-centered planning process, are given the opportunity, information, and supports to make an informed choice of alternate setting that aligns, or will align with, the requirements and that critical services or supports are in place in advance of the individual's transition and the Transition Plan will be amended if necessary to provide additional information.

Public Input and Notice:

Prior to filing with CMS, the State must seek input from the public for the proposed Settings Transition Plan, preferably from a wide range of stakeholders representing consumers, providers, advocates, families and others.

The public input process requires the State to provide at least a 30-day public notice and comment period regarding the Settings Transition Plan that the State intends to submit to CMS for review and consideration. The State must provide a minimum of two statements of public notice and public input procedures. The State must ensure that the Settings Transition Plan is available to the public for public comment. The State must consider and modify the Settings Transition Plan, as the State deems appropriate, to account for public comment. Upon submission of the Settings Transition Plan to CMS, the State must include evidence of compliance with the public notice requirements and a summary of the comments received during the public notice period, why comments were not adopted, and any modifications to the Settings Transition Plan based upon those comments.

The process for submitting public comment must be convenient and accessible. The Settings Transition Plan must be posted on the State's website and include a website address for comments. In addition, the State must have at least one additional option for public input, such as a public forum. The Settings Transition Plan must include a description of the public input process.

The State intends to reach out throughout the transition to State staff, providers, advocates, and individuals receiving services and their families. Through various venues, the State plans to educate providers about their responsibilities, help individuals understand their rights under the new HCBS requirements, and solicit input.

Based on public input in all phases of the transition process, HHSC and DSHS are committed to using feedback to guide remediation and assessment strategies until the transition is complete. HHSC and DSHS continue to work with internal and external stakeholders through existing statutorily mandated committees, workgroups and stakeholder meetings. The State continues to refine remediation activities in response to public input where possible.

The public had at least two 30-day public notice opportunities to make formal comments, as a result of July and August 2014 public notices of the preliminary settings transition plans, and a November 2014 public notice of the Statewide Settings Transition Plan, which included the YES waiver specific Settings Transition Plan. HHSC provides notice of the Statewide Settings Transition Plan through the Texas Register, and on the HHSC and DSHS websites. The notices provide information about the Statewide Settings Transition Plans, the comment period, a link to the Statewide Settings Transition Plan and locations and addresses where comments may be submitted. The State also provides notice to the Federally Recognized tribes in accordance with the Texas Medicaid State Plan. The State considered and modified the Settings Transition Plan, as the State deemed appropriate, to account for public comment, prior to submission of the plan to CMS.

In addition, the State has implemented the following public input strategy, aimed at achieving optimum public input:

• Bi-weekly conference calls: DSHS will review HCBS requirements and any necessary policy and rules changes, with providers during bi-weekly conference calls. These calls are held in lieu of webinars, and the same educational content of a webinar will be provided.
• Stakeholder meetings: On October 13, 2014, the State held an open stakeholder meeting in Austin providing all stakeholders the opportunity to provide input on the new regulations. In addition, a meeting specifically for YES stakeholders was held by the Hogg Foundation for Mental Health in Austin on December 2, 2014. Included as topics of discussion were the settings assessment and the new HCBS rules impact on the YES waiver.
• Electronic notices: The State posted the Settings Transition Plan on agency websites and in the Texas Register in November 2014. The DSHS assessment was also posted on the agency website. The preliminary transition plans for several of the waivers were posted in the Texas Register and on the agency websites.
• Feedback mechanism: Dedicated electronic mail boxes and websites for HHSC and DSHS are available to provide information about the new rules and accept feedback. The websites and the option to make comments will remain active throughout the transition and the State will take any comments received into consideration, until the State completes the transition. State websites are located at the following hyperlinks:
o http://www.hhsc.state.tx.us/medicaid/hcbs/index.shtml
o http://www.dshs.state.tx.us/mhsa/yes/

For more information or to obtain free copies of the YES Settings Transition Plan, you may contact Kathleen Cordova by mail at Texas Health and Human Services Commission, P.O. Box 13247, Mail Code H-600, Austin, Texas 78711-3247, phone (512) 487-3402, fax (512) 730-7472, or by email at TX_Medicaid_Waivers@hhsc.state.tx.us.

Timeline of YES Settings Transition Planning

*Represents milestone activities

ASSESSMENT - ALL PROGRAMS
Action Items

*Phase I: March 2014 - September 2014

• State (HHSC and DSHS) staff system/internal review of rules and policies and oversight processes governing the waivers.
• State staff identification of areas in which policy and rules appeared to be silent or in contradiction with new HCBS rules.
• State staff review of the assessment results and finalizing the internal assessment.
• Consider and modify assessment based upon ongoing public input (e.g., stakeholder groups.)

*Phase II: September 2014 - December 2015

• Recommendations from stakeholders provided at the October 13, 2014, meeting and webcast will be considered and appropriate changes made. Proposed initiation: October 2014
• System internal assessment results posted on DSHS websites for public input. HHSC website is linked to the DSHS website. Proposed initiation: November 2014
• Public notice and comment period for the Settings Transition Plan. Proposed initiation: November 2014; Proposed

Completion: December 2014
• *Submission of Settings Transition Plan to CMS - December 2014
• *Survey representative sample of providers using a self-assessment tool based on the new HCBS requirements. Provider self-assessments will be verified by a representative sample of participant surveys. Proposed initiation: July 2015; Proposed completion: December 2015
• *Hold additional stakeholder meetings providing individuals receiving services and providers an opportunity to provide input on the assessment and Settings Transition Plan. Proposed initiation: July 2015; Proposed completion: December 2015
• The State will continue to refine the Settings Transition Plan and settings assessment based on public input.
• The State will update the assessment after completion of the entire assessment phase. The update to the assessment will be posted on the agency websites. If as a result of the assessment, there was a change in assessment findings, or the State has added additional remedial action and milestones, the State will submit an amendment or modification to the transition plan, after the required public notice and comment period.

Phase III: January 2015 - May 2016

• If applicable, DSHS will survey a representative sample of any non-residential providers to ascertain whether providers are in compliance with CMS guidance. Proposed initiation: January 2015; Proposed completion: May 2016
• A representative sample of provider self-assessments will be verified by a representative sample of participant surveys. Proposed initiation: July 2015; Proposed completion: December 2015

PUBLIC INPUT
Action Items

• *Preliminary Settings Transition Plan for YES available for public comment through posting in the Texas Register. Proposed initiation: August 2014; Proposed completion: September 2014
• HHSC HCBS website and electronic mailbox is available to collect stakeholder input and allow public comment on the State's activities toward compliance with the settings requirements. Proposed initiation: September 2014 and continuing through the end of the transition period.
• *A public stakeholder meeting provided individuals with an opportunity to contribute feedback on the assessment process, the Preliminary Settings Transition Plans posted thus far, and implementation of the settings transition plans to all of the 1915(c) waivers and the 1115 demonstration waiver. Proposed initiation: October 2014; Proposed completion: October 2014
• *Preliminary Settings Transition Plan for YES available for public comment through posting on DSHS website. Proposed initiation: October 2014; Proposed completion: November 2014
• DSHS HCBS website is available to collect stakeholder input and allow public comment on the State's activities toward compliance with the settings requirements. Proposed initiation: October 2014 and continuing through the end of the transition period.
• *Internal assessment document outlining compliant and non-compliant settings requirements for YES waiver posted for public input. Proposed initiation: November 2014 and continuing through the end of the transition period.
• *The Statewide Settings Transition Plan posted for public comment, which included the YES waiver specific Settings Transition Plan. Two forms of public notice were utilized: notice in the Texas Register and on the HHSC, DADS, and DSHS websites. Proposed initiation: November 2014; Proposed completion: December 2014
• The State may implement additional stakeholder communications as such opportunities are identified. Proposed initiation: Ongoing and continuing through the end of the transition period.
• Once the assessment phase is completed, if the assessment has resulted in a change in the findings or added specific remedial action and milestones to a waiver, the State will incorporate the public notice and input process into the appropriate submissions to CMS.

YES REMEDIATION
Action Items

• *If determined necessary based on assessment and public input, amend YES program rules and other necessary rules and policies to ensure the services comply with the new HCBS guidelines. Proposed initiation: November 2014; Proposed completion: November 2015
• If determined necessary based on assessment, revise the YES policy manual, including rights and responsibilities forms/publications and billing guidelines to further outline HCBS requirements. Proposed initiation: April 2015; Proposed completion: January 2016
• If determined necessary based on assessment, revise the YES policy manual, including rights and responsibilities

forms/publications and billing guidelines to further outline HCBS requirements for non-residential settings. Proposed initiation: April 2015; Proposed completion: January 2016
• If determined necessary based on assessment and public input, amend YES program rules and other necessary rules and policies to ensure the services comply with the new HCBS guidelines. Proposed initiation: April 2015; Proposed completion: January 2016
• Review HCBS requirements, policy changes and rules changes, if necessary, with providers during bi-weekly conference calls. Proposed initiation: Ongoing and continuing through the end of the transition period.
• Conduct ongoing monitoring of HCBS requirements and any related policy or rules changes. Proposed initiation: Ongoing and continuing through the end of the transition period
The following action items represent amendments to the settings transition plan and related public notices during the remediation phase.
• Review and include appropriate revisions to the YES Settings Transition Plan. Proposed initiation: January 2016; Proposed completion: August 2016
• Public notice and public comment period for review of the revised YES Settings Transition Plan. Proposed initiation: September 2016; Proposed completion: October 2016
• *Submit YES amendment updating the Settings Transition Plan with appropriate changes based on public input after the required public notice. Proposed initiation: November 2016; Proposed completion: November 2016

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ○ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

   ○ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

   (Complete item A-2-a).

   ◉ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

   Specify the division/unit name:
   Texas Department of State Health Services

   In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The

interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   In 2004, the Texas Legislature reorganized its health and human services system to an organizational umbrella with an oversight agency, the Health and Human Services Commission (HHSC) that also functions as State Medicaid Agency. In accordance with 42 CFR Sec. 431.10 (e), the HHSC is the single State Medicaid Agency and retains administrative authority over the waiver program. The Texas Legislature gave HHSC plenary authority to supervise and operate the Medicaid program, including monitoring and ensuring the effective use of all federal funds received by the StateÃ¢Â€Â™s health and human services agencies. The financial management and accounting services of each of the agencies receiving Medicaid funds are the responsibility of HHSC.

   The designation of HHSC as the single State Medicaid Agency with authority to specifically direct the workings of the Medicaid program in each agency is echoed in Texas Government Code Sec. 531.021:
   (a) The commission is the state agency designated to administer federal medical assistance funds.
   (b) The commission shall:
   (1) plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program.

   The State Medicaid Agency has delegated to the Department of State Health Services (DSHS), an agency under the health and human services authority, responsibility for administration of waiver services, ensuring compliance with requirements, ensuring confidentiality, and maintaining records. HHSC directly determines waiver payment amounts or rates. DSHS will report to HHSC no less than quarterly regarding administrative activities for which DSHS has responsibility.

   HHSC and the operating agency executed an operating agreement that delineates the roles and responsibilities of each agency with regard to home and community-based services waivers in October of 2008. The agreement also outlines the State Medicaid Agency's monitoring and oversight functions. HHSC's Long-Term Supports and Services Policy Unit of the State Medicaid DirectorÃ¢Â€Â™s office is directly responsible for monitoring and oversight.

   The Long-Term Supports and Services Policy Unit is responsible for approving all waiver amendments and renewals and the CMS-372(S) reports. In addition, the Long-Term Supports and Services Policy Unit reviews all waiver program policies and operations and may require DSHS to modify, clarify, or provide additional information in considering approval or disapproval of proposed changes.

   HHSC and DSHS developed a Quality Improvement Strategy for this new waiver in late 2010. HHSC's involvement and oversight in the development of enhanced waiver quality assurance mechanisms under the

new CMS guidelines will ensure continued development of HHSC oversight of all areas of waiver operations, as outlined below.

HHSC monitors to ensure that DSHS:

Ã¢Â€Â¢ Disseminates and oversees dissemination of information concerning the waiver to potential enrollees and assists waiver participants in waiver enrollment by reviewing DSHS consumer education and outreach materials;
Ã¢Â€Â¢ Manages waiver enrollment against approved limits and monitors waiver expenditures against approved levels by reviewing DSHS inquiry list, slot allocation, and client count reports. Enrollment limits are approved by HHSC during the initial, renewal, and waiver amendment processes as cost neutrality calculations are adjusted;
Ã¢Â€Â¢ Approves level of care evaluations;
Ã¢Â€Â¢ Reviews participant plan of care to ensure that waiver requirements are met; and
Ã¢Â€Â¢ Performs prior authorization of waiver services and conducts utilization management functions.

HHSC also reviews and approves DSHSÃ¢Â€Â™ entries on CMS Form 372(S) prior to its submission to CMS.

HHSC plans to participate in at least one site visit each year to enhance knowledge of the program operations and DSHSÃ¢Â€Â™ monitoring procedures.

HHSC additionally ensures that DSHS:

Ã¢Â€Â¢ Conducts utilization management functions which are reported to HHSC under the new quality indicators;
Ã¢Â€Â¢ Recruits providers. HHSC approves and adopts policies governing the recruitment and enrollment of providers;
Ã¢Â€Â¢ Executes the Medicaid provider agreement. The requirements in the Medicaid provider agreement used by DSHS meets or exceeds Medicaid requirements. DSHS executes the provider agreement on behalf of HHSC, the Texas single State Medicaid Agency; and
Ã¢Â€Â¢ Conducts training and technical assistance concerning waiver requirements. The need for training and technical assistance is identified through results of DSHS' provider monitoring, technical assistance contacts, and the use of newly developed quality indicators. HHSC monitors DSHS' training using the quality indicators and reserves the right to discuss, review, or suggest additional training topics for DSHS providers.

The Executive Commissioner of HHSC is charged by state law with supervising, directing, and managing the activities and operations of health and human service agencies, including DSHS. On July 1, 2012, an Executive Directive was signed by the Commissioner of HHSC to replace the operating agreement with DSHS which set forth the duties and responsibilities of HHSC and DSHS relating to the operation of the YES waiver program. Major components of the Directive are summarized below.

Under this Directive, HHSC's responsibilities include:

Ã¢Â€Â¢ retaining authority to exercise administrative discretion and to issue rules, policies and procedures;
Ã¢Â€Â¢ planning and managing the use of all federal funds;
Ã¢Â€Â¢ conducting/arranging for periodic assessments of DSHS' performance in carrying out delegated functions related to program administration and operational activities;
Ã¢Â€Â¢ monitoring DSHS' clinical, administrative, and technical assistance to the local mental health authorities;
Ã¢Â€Â¢ credentialing of waiver providers;
Ã¢Â€Â¢ convening regular meetings with DSHS;
Ã¢Â€Â¢ reviewing reports that DSHS submits to HHSC on at least an annual basis;
Ã¢Â€Â¢ monitoring the quality improvement strategy and adherence to all six assurances through quarterly waiver strategic planning/quarterly report; and
Ã¢Â€Â¢ performing other activities as necessary to verify performance of functions listed in the Directive.

In addition to the quarterly oversight meetings, HHSC approves all CMS 372 reports and addresses any

issues identified in the reports. HHSC and DSHS communicate regularly regarding waiver program policies and operations.

HHSC directly performs Medicaid financial eligibility determinations for applicants applying to the program, and redeterminations for enrolled program participants, and conducts Medicaid fair hearings in accordance with federal and state laws, rules, and regulations.

Upon developing waivers, waiver amendments, waiver documents, waiver communications, rules, policies, procedures, Medicaid State Plan amendments, or directions that affect DSHS' duties and responsibilities under the program, HHSC notifies DSHS to ensure that DSHS can continue to perform its functions in an efficient manner.

HHSC develops the reimbursement rate methodology and sets reimbursement rates paid to providers in the program.

HHSC designated a representative of the agency who is authorized to address issues relating to the program or otherwise participate in a DSHS workgroup or policy group.

Under this Directive, the DSHS responsibilities include:
Ã¢Â€Â¢ dissemination of information concerning the program to potential enrollees;
Ã¢Â€Â¢ approving program eligibility;
Ã¢Â€Â¢ enrolling waiver participants;
Ã¢Â€Â¢ managing waiver enrollment against approved limits;
Ã¢Â€Â¢ managing waiver expenditures against approved levels;
Ã¢Â€Â¢ assuring services are approved in accordance with assigned level of care;
Ã¢Â€Â¢ reviewing participant service plans;
Ã¢Â€Â¢ providing prior authorization of waiver services;
Ã¢Â€Â¢ performing utilization management reviews;
Ã¢Â€Â¢ enrolling qualified providers;
Ã¢Â€Â¢ executing Medicaid provider agreements;
Ã¢Â€Â¢ developing rules, policies, procedures, and information governing the program;
Ã¢Â€Â¢ performing quality assurance and quality improvement activities;
Ã¢Â€Â¢ monitoring providers and local mental health authorities and addressing noncompliance as appropriate; and
Ã¢Â€Â¢ preparing reports required under the terms of the waiver.

DSHS complies with all assurances, representations, and requirements contained in the program waivers, Medicaid State Plan, federal and state laws, rules, regulations, and court orders related to the Medicaid program.

DSHS maintains confidentiality of information related to applicants and waiver participants as required by federal and state laws, rules, and regulations.

Upon request of HHSC, DSHS designated a representative of the agency who is authorized to address groups relating to the program or otherwise participate in an HHSC workgroup or policy group.

DSHS reporting to HHSC on waiver quality includes:
Ã¢Â€Â¢ a quarterly dashboard report to provide evidence of compliance with functions listed;
Ã¢Â€Â¢ a quarterly update of the most recent CMS 372 data report;
Ã¢Â€Â¢ within six months after the end of each waiver year, an evidence report updated to include waiver performance measures, and needed changes to the narrative, and other measures to ensure compliance with waiver assurances; and
Ã¢Â€Â¢ within six months after the end of each waiver year, a CMS 372 data report, which includes a preliminary financial report and final quality report.

Remedies are directed to DSHS' timely and responsive performance of functions described in the Directive. In its discretion, HHSC may conduct a performance review at any time and in relation to any responsibility and/or requirement.

HHSC and DSHS held two stakeholder meetings in coordination with the University of Texas Hogg Foundation for Mental Health in order to solicit comments for the waiver renewal. The stakeholder meetings will continue and be on-going.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

   ○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

   ◉ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

   ◉ **Not applicable**

   ○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

   ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

   Specify the nature of these agencies and complete items A-5 and A-6:

   ☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

   Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.
Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

Function	Medicaid Agency	Other State Operating Agency
Participant waiver enrollment	☑	☑
Waiver enrollment managed against approved limits	☑	☑
Waiver expenditures managed against approved levels	☑	☑
Level of care evaluation	☑	☑
Review of Participant service plans	☑	☑
Prior authorization of waiver services	☑	☑
Utilization management	☑	☑
Qualified provider enrollment	☑	☑
Execution of Medicaid provider agreements	☑	☑
Establishment of a statewide rate methodology	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☑
Quality assurance and quality improvement activities	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Administrative Authority**
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

   i. **Performance Measures**

   For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures

found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
A.a.1. Number and percent of applicants on the YES waiver inquiry list offered an assessment for eligibility on a first-come first-served basis by local mental health authorities. N: Number of applicants on the YES waiver inquiry list offered an assessment for eligibility on a first-come first-served basis by local mental health authorities. D: Number of waiver applicants assessed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.a.2. Number and percent of waiver participants enrolled at or below CMS approved level. N: Number of waiver participants enrolled at or below CMS approved level. D: Number of waiver participants.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

Performance Measure:
A.a.3. Number and percent of service plans at or below the approved cost limits of the waiver N: Number of service plans at or below the approved cost limits of the waiver. D: Number of service plans.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually

Performance Measure:
A.a.4. Number and percent of levels of care reviewed by DSHS within five business days of receipt of clinical eligibility form. N: Number of levels of care reviewed by DSHS within five business days of receipt of clinical eligibility form. D: Number of levels of care submitted.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.a.5. Number and percent of reviews of service plans conducted by DSHS in accordance with HHSC DSHS Executive Directive. N: Number of reviews of service plans conducted by DSHS in accordance with the HHSC DSHS Executive Directive. D: Number of reviews required.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.a.6. Number and percent of paid claims for services that were prior authorized by DSHS. N: Number of paid claims for services that were prior authorized by DSHS. D: Number of paid claims.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.a.7. Number and percent of waiver participants' service plans reviewed by the local mental health authority every 90 days. N: Number of waiver participants' service plans reviewed every 90 days by the local mental health authority. D: Number of waiver participants' service plans.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.a.8. Number and percent of waiver provider agencies enrolled by the DSHS according to the open enrollment process published by the DSHS. N: Number of waiver

provider agencies enrolled by the DSHS according to the open enrollment process published by the DSHS. D: Number of new waiver provider agencies.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Department of State Health Services Waiver Application File

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

Performance Measure:
A.a.9. Number and percent of rules approved by the HHSC prior to implementation by DSHS. N: Number of rules approved by HHSC prior to implementation by DSHS. D: Number of rules required to be approved.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medical Care Advisory Committee Meeting Minutes

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.a.10. Number and percent of waiver provider agencies enrolled by DSHS that signed a Medicaid provider agreement prior to delivery of services. N: Number of waiver provider agencies enrolled by DSHS that signed a Medicaid provider agreement prior to delivery of services. D: Number of waiver provider agencies.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Department of State Health Services, Mental Health Contract Management Unit

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.a.11. Number and percent of data reports submitted on time by DSHS to HHSC. N: Number of data reports submitted on time by DSHS to HHSC. D: Number of data reports required to be submitted by DSHS to HHSC.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DSHS Quality Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.a.12. Number and percent of provider remediation activities reviewed by HHSC in which DSHS implemented the appropriate course of action. N: Number of provider remediation activities reviewed by the HHSC in which DSHS implemented the appropriate course of action. D: Number of remediation activities.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
		☐ **Other**

	☐ **Continuously and Ongoing**	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
HHSC monitors DSHS' performance of the delegated functions of the YES waiver.

HHSC and DSHS hold regular status and update meetings directed at evaluating current quality systems and identifying and prioritizing enhancements. These meetings have resulted in plans to: enhance data reporting by DSHS to HHSC, baseline current activities, develop stakeholder performance measures, and develop a quality management strategy. Additionally, HHSC has formal processes to ensure that the waiver renewals, amendments, CMS 372 reports, Request for Evidentiary Information reports, and all state rules for waiver program operations are reviewed and approved by HHSC.

HHSC's involvement in and oversight of the development of enhanced waiver quality assurance mechanisms under the new CMS guidelines will assure HHSC oversight of all areas of waiver operations.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Individual problems may be discovered during monitoring activities by HHSC or any of the entities that have been delegated certain functions within the performance measures of this Appendix. The options for remediation are listed below:

If HHSC discovers that DSHS has not, within established timeframes:

*enrolled waiver participants appropriately,
*approved clinical eligibility for appropriate level of care,
*approved a service plan,
*credentialed an eligible waiver provider agency,
*executed Medicaid provider agreements,
*conducted prior authorization and utilization management responsibilities,
*adhered to requirements regarding rule promulgation and policy changes,
*managed waiver enrollment and expenditures within approved limits, or
*submitted required reports,

HHSC will require DSHS to take corrective action within five business days. HHSC will notify DSHS in writing of specific areas of the DSHS performance that fail to meet performance expectations, standards, or schedules set forth in the Executive Directive between DSHS and HHSC, by HHSC, or in the YES waiver documents. DSHS will, within 10 business days (or another date approved by HHSC) of receipt of written notice, provide HHSC with a written response that explains the reasons for the deficiency, outlines the DSHS' plan to address or cure the deficiency, and states the date by which the deficiency will be cured. If DSHS disagrees with HHSC's findings, this written response will state the reasons for disagreement with HHSC findings. DSHS' proposed cure of a deficiency is subject to approval by HHSC.

At its option, HHSC may require DSHS to submit to HHSC a written plan to correct or resolve any noncompliance with the operating agreement between the two agencies. The corrective action plan must provide a detailed explanation of the reasons for the cited deficiency, DSHS' assessment or diagnosis of the cause, and a specific proposal to cure or resolve the deficiency (including the date by which the deficiency will be cured). The corrective action plan must be submitted by the deadline set forth in HHSC's request for a corrective action plan. The corrective action plan is subject to approval by HHSC.

If DSHS discovers that the local mental health authority has not:

*enrolled waiver participants appropriately,
*assessed clinical eligibility for appropriate level of care,
*completed an appropriate service plan,
*conducted prior authorization and utilization management responsibilities,
*managed waiver enrollment and expenditures within approved limits, or
*submitted required reports,

it will remediate the deficiency with the local mental health authority. The remediation activities are progressive and appropriate to the potential or actual waiver participant impact and include, but are not limited to, correcting noted deficiency, corrective action plans, payment denial, contract suspension, and provider termination. These activities are noted in more detail in the applicable Appendices of the waiver application. The State collects remediation data and completed corrective action plans, which are retained in the State's database.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. **Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
[ ] Aged or Disabled, or Both - General					
	[ ]	Aged			[ ]
	[ ]	Disabled (Physical)			
	[ ]	Disabled (Other)			
[ ] Aged or Disabled, or Both - Specific Recognized Subgroups					
	[ ]	Brain Injury			[ ]
	[ ]	HIV/AIDS			[ ]
	[ ]	Medically Fragile			[ ]
	[ ]	Technology Dependent			[ ]
[ ] Intellectual Disability or Developmental Disability, or Both					
	[ ]	Autism			[ ]
	[ ]	Developmental Disability			[ ]
	[ ]	Intellectual Disability			[ ]
[x] Mental Illness					
	[ ]	Mental Illness			
	[x]	Serious Emotional Disturbance	3	18	

b. **Additional Criteria.** The State further specifies its target group(s) as follows:

Not applicable.

c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

- ○ **Not applicable. There is no maximum age limit**
- ◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

The local mental health authority, under its agreement with HHSC and DSHS, is required to ensure that waiver participants who turn 19 while in services are transitioned to adult services at least six months before their 19th birthday. A transition plan must be developed in consultation with the waiver participant, the legally authorized representative and the future providers with adequate time to allow both current and future providers to transition the waiver participant into adult services without a disruption in services. The transition plan must include:

1. a summary of the mental health community services and treatment the waiver participant received as a youth,
2. the waiver participant's current status (e.g., diagnosis, medications, level of functioning) and unmet needs,
3. information from the waiver participant and the legally authorized representative regarding the waiver participant's strengths, preferences for mental health community services, and responsiveness to past interventions, and
4. a plan of care that indicates the mental health and other community services the waiver participant will receive as an adult and ensures the waiver participant's continuity of services without disruption.
5. submission of the transition plan to DSHS one month prior to the date of transition.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- ○ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

  The limit specified by the State is *(select one)*

  - ○ **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - ○ **Other**

    Specify:

- ◉ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ○ **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to

that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is *(select one)*:

- **The following dollar amount:**

  Specify dollar amount:

  The dollar amount *(select one)*

  - **Is adjusted each year that the waiver is in effect by applying the following formula:**

    Specify the formula:

  - **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
- **The following percentage that is less than 100% of the institutional average:**

  Specify percent:

- **Other:**

  Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

The waiver is designed for waiver participants who need essential services and supports to continue to reside in his/her home. The waiver is not intended to serve waiver participants requiring intensive out-of-home residential treatment for an extended period of time.

Prior to initiating enrollment into the waiver, the local mental health authority conducts a brief interview and administers the State authorized assessment tool to determine the applicant's current level of need. If the applicant and his/her family indicate that their expectations of services include a minimal use of residential services, and the assessment indicates that the waiver participant qualifies for the waiver, waiver enrollment will be pursued. The waiver participant and family will be informed that if the waiver participant is determined to be a danger to self or others, and adequate safety cannot be assured in the community, the waiver participant will be placed in a more restrictive setting.

Upon application for the YES program, waiver participants and/or legally authorized representatives will be notified by the local mental health authority, verbally and in writing, of their right to a Medicaid fair hearing if they are not

given a choice to receive waiver services, are denied waiver services or providers of their choice, or their waiver services are denied, suspended, reduced, or terminated.

c. **Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

- [ ] **The participant is referred to another waiver that can accommodate the individual's needs.**
- [ ] **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

- [x] **Other safeguard(s)**

Specify:

Waiver participants must have a plan of care at a cost within the cost ceiling. For waiver participants with needs that exceed the cost limit, the State has a process to ensure their needs are met. The process includes examining third party resources or institutional services. Third-party resources are examined during the treatment team meeting that occurs when a waiver participant is enrolled in the program, during each subsequent treatment team meeting, and as the waiver participant approaches the cost limit. If a waiver participant's needs exceed the cost limit, the treatment team would explore a referral for other services or institutional settings.

The waiver participant will be informed of their right, and given the opportunity, to request a fair hearing if the State proposes to terminate the waiver participant's waiver eligibility.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	400
Year 2	800
Year 3	800
Year 4	800
Year 5	800

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- ( ) **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- (•) **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	400
Year 2	400
Year 3	400
Year 4	400
Year 5	400

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- (●) **Not applicable. The state does not reserve capacity.**
- ( ) **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. **Allocation of Waiver Capacity.**

Select one:

- ( ) **Waiver capacity is allocated/managed on a statewide basis.**
- (●) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

The waiver capacity is allocated by service area (county) to local mental health authorities. Allocation of waiver capacity is determined by DSHS using information on population, service demand / need and community infrastructure. DSHS reevaluates the allocation at least annually or more often as needed. Unused capacity will be reallocated to service areas with greater demand / need for services. On an annual basis, DSHS reviews each local mental health authority's use of waiver slots and will reallocate unused slots in accordance with need.

The State assures that these practices do not violate the requirement that waiver participants have comparable

access to waiver services across the geographic areas served by the waiver or impede the movement of participants across geographic areas.

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

The local mental health authorities must maintain an up to date inquiry list of waiver participants living in the local service area who are seeking services through the waiver. Vacancies are offered to waiver participants on a first come, first served basis according to the chronological date of the waiver participant's registration on the waiver inquiry list.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (●) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ( ) **No**
   - (●) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [x] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional State supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- ( ) **100% of the Federal poverty level (FPL)**
- ( ) **% of FPL, which is lower than 100% of FPL.**

Specify percentage: [ ]

- [x] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

All State Plan groups except for: 1634(b) Early Aged Widowe(r); 1634(d) Disabled Widowe(r); 1634(c) Disabled Adult Children; and the following Foster Care Groups: 1902(a)(10)(A)(i)(I) and 1902(a)(10)(A)(ii)(XVII)

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- ( ) **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- (•) **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

- ( ) **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- (•) **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

- [x] **A special income level equal to:**

Select one:

- (•) **300% of the SSI Federal Benefit Rate (FBR)**
- ( ) **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: [ ]

- ( ) **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

- [ ] **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- [ ] **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- [ ] **Aged and disabled individuals who have income at:**

Select one:

- ( ) **100% of FPL**
- ( ) **% of FPL, which is lower than 100%.**

Specify percentage amount: [ ]

- [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☐ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.** *Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.*

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

○ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

◉ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

◉ **The following standard included under the State plan**

Select one:

- ○ **SSI standard**
- ○ **Optional State supplement standard**
- ○ **Medically needy income standard**
- ◉ **The special income level for institutionalized persons**

(*select one*):

- ◉ **300% of the SSI Federal Benefit Rate (FBR)**
- ○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

- ○ **A dollar amount which is less than 300%.**

Specify dollar amount:

- ○ **A percentage of the Federal poverty level**

Specify percentage:

- ○ **Other standard included under the State Plan**

Specify:

- ○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

- ○ **The following formula is used to determine the needs allowance:**

Specify:

- ○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

- ○ **Not Applicable (see instructions)**
- ◉ **SSI standard**
- ○ **Optional State supplement standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

- ○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

- ○ **Not Applicable (see instructions)**
- ◉ **AFDC need standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

Specify dollar amount: [ ] The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- ○ **The amount is determined using the following formula:**

Specify:

- ○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The State does not establish reasonable limits.**
- ○ **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

   i. **Minimum number of services.**

   The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

   ii. **Frequency of services.** The State requires (select one):

   - ○ **The provision of waiver services at least monthly**
   - ◉ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

   If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

   Not applicable.

b. **Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

- ○ **Directly by the Medicaid agency**
- ◉ **By the operating agency specified in Appendix A**
- ○ **By an entity under contract with the Medicaid agency.**

Specify the entity:

- ○ **Other**

Specify:

c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Master's level clinicians perform the initial evaluation and make the recommendation regarding level of care. The educational / professional qualifications are: licensed clinical social worker, licensed marriage and family therapist, licensed professional counselor and licensed psychologist. A medical director is required to verify / concur with any recommendation to deny level of care.

d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

In order to be eligible for the YES waiver, the client must meet the following criteria:

Eligible waiver participants must have functional impairment or acute severe psychiatric symptomatology as

identified on the Child and Adolescent Needs and Strengths Comprehensive Assessment. The Child and Adolescent Needs and Strengths Assessment is a set of standardized measures used in Texas to determine level of service for community-based children's mental health care.

The Children and Adolescent Needs and Strengths Comprehensive Assessment is a multi-purpose tool developed to support care planning and level of care decision-making, to facilitate quality improvement initiatives utilizes a four level rating system for each of eight domains, designed to translate immediately into action items, with different action levels existing for different needs and strengths. It is designed to support care planning and level of care-decision making, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

The Child and Adolescent Needs and Strengths Comprehensive Assessment utilizes a four point scale for needs (0 = no evidence of need, 1 = watchful waiting/prevention, 2 = action needed, 3 = immediate/intensive action needed), and a four point scale for strengths, (0 = centerpiece strength, 1 = useful strength, 2 = identified strengths, 3 = no strengths). The eight domains are:
1) Child's Risk Behavior
2) Child's Behavior/Emotional Health Needs
3) Child's Life Domain Functioning
4) Child's Strength
5) Caregiver Strength's and Needs
6) Acculturation
7) Psychiatric History
8) Crisis History

For waiver clinical eligibility:

A. The applicant must score at the identified levels on the following domain:
- Child's Life Domain Functioning: 0 or 1 for Developmental OR 2 or 3 AND
- 0, 1, or 2 on Developmental Disability Module; Cognitive AND
- 0 or 1 on the Developmental Disability Module; Developmental

B. The applicant must score at the identified levels on one or more of the following domains:
- Child Risk Behaviors: 3 for Suicide Risk OR Self-Mutilation OR Other Self Harm
- Child Risk Behaviors: 2 or 3 for Danger to Others OR Sexual Aggression OR Fire Setting OR Delinquency
- Caregiver Strengths and Needs: 2 or 3 for Involvement with Care OR Family Stress OR Safety
- Life Domain Functioning: 2 or 3 for School AND
  2 or 3 on School Module; School Behavior OR 2 or 3 on School Module; Attendance
- Psychiatric Hospitalization: 1 for Psychiatric Hospitalization AND
  1, 2, or 3 on Psychiatric Hospitalization Module; Time Since Most Recent Discharge

C. The Medicaid eligible waiver participant must have a valid Axis I, DSM-IV-TR diagnosis as the principle admitting diagnosis;

D. Outpatient therapy or partial hospitalization must have been attempted and failed, OR a psychiatrist must have documented reasons why an inpatient level of care is required; AND

E. The Medicaid eligible waiver participants must meet at least one of the following criteria:
a) The Medicaid eligible waiver participant is presently a danger to self, demonstrated by at least one of the following:
- Recent suicide attempt or active suicidal threats with a deadly plan and an absence of appropriate supervision or structure to prevent suicide;
- Recent self-mutilative behavior or active threats of same with likelihood of acting on the threat and an absence of appropriate supervision or structure to prevent self-mutilation (i.e., intentionally cutting / burning self);
- Active hallucinations or delusions directing or likely to lead to serious self-harm or debilitating psychomotor agitation or retardation resulting in a significant inability to care of self; or
- Significant inability to comply with prescribed medical health regimens due to concurrent Axis I psychiatric illness and such failure to comply is potentially hazardous to the life of the waiver participant. A medical diagnosis of Axis III which must be treatable in a psychiatric setting.
b) The Medicaid eligible waiver participant is a danger to others. This behavior should be attributable to the

waiver participant's specific Axis I, DSM-IV-TR diagnosis and can be adequately treated only in a hospital setting. This danger is demonstrated by one of the following:

- Recent life-threatening action or active homicidal threats of same with a deadly plan and availability of means to accomplish the plan with the likelihood of acting on the threat;
- Recent serious assaultive or sadistic behavior or active threats of same with the likelihood of acting on the threat and an absence of appropriate supervision or structure to prevent assaultive behavior; or
- Active hallucinations or delusions directing or likely to lead to serious harm of others.

c) The Medicaid eligible waiver participant exhibits acute onset of psychosis or severe thought disorientation, or there is significant clinical deterioration in the condition of someone with chronic psychosis rendering the waiver participant unmanageable and unable to cooperate in treatment, and the waiver participant is in need of assessment and treatment in a safe and therapeutic setting.

d) The Medicaid eligible waiver participant has a severe eating or substance abuse disorder, which requires 24-hours-a-day medical observation, supervision, and intervention.

e) The proposed treatment / therapy requires 24-hours-a-day medical observation, supervision, and intervention.

f) The Medicaid eligible waiver participant exhibits severe disorientation to person, place, or time.

g) The Medicaid eligible waiver participant's evaluation and treatment cannot be carried out safely or effectively in other settings due to severely disruptive behaviors, and other behaviors which may include physical, psychological, or sexual abuse.

h) Medicaid eligible waiver participants requires medication therapy, or complex, diagnostic evaluation where the youth's level of functioning precludes cooperation with the treatment regimen.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- ○ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ◉ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The Texas Medicaid Inpatient Psychiatric Admission Instrument is used to determine level of care for the Waiver. This is the same instrument used to determine clinical eligibility for inpatient psychiatric stays under Texas' State Medicaid Plan and the results are fully comparable. In addition, the Child and Adolescent Needs and Strengths Comprehensive Assessment is used to determine level of need for waiver services. The Child and Adolescent Needs and Strengths Assessment is a standardized instrument used throughout Texas to assess clinical need for community-based levels of service within Texas' evidenced-based system for Children's mental health.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Evaluation: The local mental health authority's licensed master's level clinician (CMSW, LPC, LMFT or psychologist) conducts the initial clinical interview and completes standard instruments to recommend level of care. A medical doctor is required to verify / concur with any recommendation to deny level of care. DSHS is responsible for approving the level of care.

Re-evaluation: The community mental health center's case manager completes the standard instruments. The local mental health authority's master's level clinician reviews and confirms the recommendation and makes a recommendation regarding level of care. A medical doctor is required to verify / concur with any recommendation to deny level of care. DSHS is responsible for approving the level of care.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

Specify the other schedule:

h. **Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations *(select one)*:

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**
  Specify the qualifications:

i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

DSHS provides training and technical assistance to local mental health authorities to educate them on performance of required functions such as evaluation and reevaluation of level of care. The DSHS Quality Management Unit conducts data verification reviews on semi-annual basis. A representative sample of level of care evaluations / reevaluations is included in data verification reviews. Timeliness of completion is one factor examined. In addition, DSHS reviews all waiver claims to ensure that level of care is current prior to authorizing payment.

DSHS staff maintains a spreadsheet with a tickler that includes re-evaluation due dates for each waiver participant. One month prior to the due date of a re-evaluation, DSHS sends the waiver provider agency a secure email to advise that the re-evaluation is due.

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Records of evaluations and reevaluations of level of care are maintained in the following locations: DSHS, local mental health authority, and the waiver provider agency.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Level of Care Assurance/Sub-assurances**

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. **Sub-Assurances:**

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
B.a.1. Number and percent of waiver participants with an initial approved level of care prior to receiving waiver services. N: Number of waiver participants with an initial approved level of care prior to receiving services. D: Number of new waiver participants.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Semi-annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
B.b.1. Number and percent of enrolled waiver participants who received a level of care re-evaluation prior to the expiration of their last level of care. N: Number of enrolled waiver participants who received a level of care re-evaluation prior to expiration of the last level of care. D: Number of enrolled waiver participants.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
B.c.1. Number and percent of new waiver participants who received an initial level of care evaluation using the state-approved instruments. N: Number of new waiver participants who received an initial level of care evaluation using the state-approved instruments. D: Number of new waiver participants.

Data Source (Select one):
Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Semi-annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

B.c.2. Number and percent of enrolled waiver participants who received a level of care evaluation annually using the state approved instruments. N: Number of enrolled waiver participants who received a level of care evaluation anually using the state approved instruments. D: Number of enrolled waiver participants evaluated annually.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Semi-annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
DSHS waiver program staff confirms there is a valid medical necessity/level of care before authorizing waiver services. Records of evaluations and reevaluations of level of care are maintained at DSHS and the waiver provider agencies. DSHS waiver program staff monitors the dates for reevaluations for all participants and submits an email notification to the waiver provider agency one month prior to the end of the eligibility period for each individual.
DSHS waiver program staff performs annual on-site reviews of 100 percent of waiver participant charts to ensure medical necessity/level of care records contain each level of care assessment conducted and that the processes for determining level of care for the waiver have been performed in accordance with waiver requirements.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Individual problems may be discovered during monitoring activities by the State or any of the entities that have been delegated certain functions within performance measures of this appendix. The options for remediation are listed below:

A level of care must be approved by DSHS for each waiver participant prior to service delivery. Services delivered prior to the initial level of care or during the time frame when a level of care has expired are not reimbursed by DSHS. DSHS approves all levels of care and verifies that they are developed by qualified personnel using the prescribed tools and processes. Levels of care submitted that have not utilized approved instruments and processes are returned to the local mental health authority for correction prior to being approved.

The local mental health authority must complete redetermination of the level of care within 20 business days. The waiver provider agency is not paid for services until the level of care is completed. If not completed within 20 business days, the local mental health authority is contacted directly for resolution, and if necessary, a corrective action plan may be issued.

If the State requires a corrective action plan for any of the subassurances, the State will continue to monitor the waiver provider agencies to assure that the plan has resulted in a permanent system correction.

The State collects remediation data and completed corrective action plans, which are retained in the State's database.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. *informed of any feasible alternatives under the waiver; and*
ii. *given the choice of either institutional or home and community-based services.*

a. **Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The local mental health authority informs the waiver participant and their legally authorized representative of the services available under the waiver. Prior to enrollment, the local mental health authority informs them of the right to seek admission to a psychiatric facility, the choice of provider agencies available under the waiver, and the right to change provider agencies if available. The waiver participant's and legally authorized representative's decision is then documented on the Freedom of Choice form and signed by the waiver participant and legally authorized representative. The form will also include a statement informing the waiver participant and legally authorized representative that if the situation deteriorates, hospitalization may still occur to ensure the safety of the waiver participant or others.

b. **Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The local mental health authority retains the Freedom of Choice form in the waiver participant's case record.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
Under its contract with HHSC/DSHS, the local mental health authority is required to provide to waiver participants, including those with a disability (e.g., deafness, hard of hearing, and blindness), information about the waiver in a format and language that is easily understandable and based on the demographics of the population.

Documents that are provided to waiver participants throughout the enrollment process and service provision will be available in both English and Spanish. If the waiver participant's primary language is something other than English or Spanish, the local mental health authority, case manager, and waiver service provider agency are required to enlist the assistance of an interpreter.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. **Waiver Services Summary.** *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	Respite		
Statutory Service	Supported Employment		
Other Service	Adaptive Aids and Supports		
Other Service	Community Living Supports (CLS)		
Other Service	Employment Assistance		
Other Service	Family Supports		
Other Service	Minor Home Modifications		
Other Service	Non-Medical Transportation		
Other Service	Paraprofessional Services		
Other Service	Specialized Therapies		
Other Service	Supportive Family-based Alternatives		
Other Service	Transitional Services		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Respite is furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the waiver participant. Respite may be provided in:

* Waiver participant's home or place of residence;
* Private residence of a respite care provider, if that provider is a relative of the participant other than the waiver participant, spouse, legal guardian, or legally authorized representative;
* Foster home verified by the Texas Department of Family and Protective Services licensed child placing agency;
* General Residential Operations licensed by the Department of Family and Protective Services;
* Day or overnight camps accredited by the American Camping Association;
* Day or overnight camps licensed by DSHS;
* Child care centers or homes licensed by the Department of Family and Protective Services; and
* Child care homes registered with the Department of Family and Protective Services.

All settings must be located within the State of Texas.

The contracted waiver provider agency must approve and provide ongoing oversight of respite settings to ensure the safety of the setting. Respite services may be provided by a relative of the waiver participant other than the parents. Out-of-home respite providers are required to have a functional landline phone on the premises.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Payment may not be made for respite provided at the same time as other services that include care and supervision. Up to 720 consecutive or cumulative hours (30 days) of respite may be provided per individual service plan year. Temporary exceptions to the respite limit may be considered on a case by case basis. Such exceptions require the written approval of the Director of the DSHS waiver section. Exceptional circumstances may include, but are not limited to:
Ã‚Â• parent dies or is hospitalized while the waiver participant is receiving respite care, or
Ã‚Â• a catastrophic event, such as a hurricane, flood or other disaster, occurs while the waiver participant is receiving respite, temporarily disrupting the familyÃ‚Â's ability to provide shelter and care for the waiver participant.

Temporary exceptions will be granted for a defined time period. Costs for all waiver services, including any extended respite, cannot exceed the individual annual cost ceiling established under the waiver.

Respite services cannot be provided at the same time as supportive family-based alternatives, community living supports, supported employment, or employment assistance.

Federal financial participation is not to be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☑ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified YES Waiver Provider Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Certified YES Waiver Provider Agency
Provider Qualifications
License *(specify):*
Foster home verified by the Texas Department of Family and Protective Services licensed child placing agency - Title 40 of the Texas Administrative Code, Part 19, Chapter 749;
Child-placing agency licensed by the Department of Family and Protective Services - Title 40 of the Texas Administrative Code, Part 19, Chapter 749, Subchapter C;
Camps licensed by DSHS - Title 25 of the Texas Administrative Code, Part 1, Chapter 265;
Child-care centers licensed by the Department of Family and Protective Services - Title 40 of the Texas Administrative Code, Part 19, Chapter 746;
Child care homes registered or licensed by the Department of Family and Protective Services - Title 40 of the Texas Administrative Code, Part 19, Chapter 747;
General Residential Operations licensed by the Department of Family and Protective Services - Title 40 of the Texas Administrative Code, Part 19, Chapter 748.
Certificate *(specify):*
Waiver provider agency certified by DSHS as a local mental health authority or certified by Texas Medicaid and Healthcare Partnership as a Multispecialty Clinic.
Other Standard *(specify):*
Respite care personnel must be at least 18 years of age, have a current driver's license, and pass the criminal history and abuse registry checks as stipulated under item a in Appendix C-2.

Respite services may be provided by a relative of the waiver participant other than the parents, spouse, legal guardian, or legally authorized representative.

The contracted waiver provider agency must approve and provide ongoing oversight of respite settings to ensure the safety and appropriateness of the setting.

Respite care providers must complete training as required by DSHS.

The out-of-home respite provider must have a functional landline phone on the premises.
Verification of Provider Qualifications
Entity Responsible for Verification:
YES Waiver Provider Agency

DSHS
Frequency of Verification:

Annually

Waiver provider agencies are responsible for verifying the qualifications of all employees and subcontractors. DSHS conducts annual on-site reviews of waiver provider agencies to ensure compliance with the waiver provider agreement. During these reviews DSHS also verifies the qualifications of waiver provider agency employees and subcontractors. To do this, DSHS uses a statistical sampling methodology to assure that the sample of waiver provider agency employee and subcontractor qualifications to accurately assess the waiver provider agency's verification of employee and subcontractor qualifications. The sample size produces results with a confidence level of 95 percent and a confidence interval of plus or minus five percent.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Supported Employment means assistance provided, in order to sustain competitive employment, to an individual who, because of a disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting at which individuals without disabilities are employed. Supported employment includes employment adaptations, supervision, and training related to an individual's asssessed needs. Individuals receiving supported employment earn at least minimum wage (if not self-employed).

Transporting an individual to support the individual to be self-employed, work from home, or perform in a work setting is billable within the service.

In the state of Texas, this service is not available to individuals receiving waiver services under a program funded under section 110 of the Rehabilitation Act of 1973. Documentation is maintained in the individual's record that the service is not available to the individual under a program funded under the Individuals with Disabilities Education Act (20 U.S.C §1401 et seq.).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service may not be provided to the individual with the individual present at the same time that respite is provided.

The service does not include sheltered work or other types of vocational services in specialized facilities, or for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
(A) incentive payments made to an employer to encourage hiring the individual;
(B) payments that are passed through to the individual;
(C) payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business; or
(D) payments used to defray the expenses associated with starting up or operating a business.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified YES Waiver Provider Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency
Provider Type:
Certified YES Waiver Provider Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Waiver provider agency certified by DSHS as a local mental health authority or certified by Texas Medicaid and Healthcare Partnership as a Multispecialty Clinic.
Other Standard *(specify):*
The service provider must be at least 18 years of age, maintain a current driver's license and insurance if transporting the individual, and satisfy one of these options:
Option 1:
- have a bachelor's degree in rehabilitation, business, marketing, or a related human services field; and six month's paid or unpaid experience providing services to people with disabilities;

Option 2:
- have an associate's degree in rehabilitation, business, marketing, or a related human services field;

and one year of paid or unpaid experience providing services to people with disabilities; or

Option 3:
- have a high school diploma or Certificate of High School Equivalency (GED credentials) and two years' of paid or unpaid experience providing services to people with disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:
Waiver Provider Agency
DSHS
Frequency of Verification:
Annually

Waiver provider agencies are responsible for verifying the qualifications of all employees and subcontractors. DSHS conducts annual on-site reviews of waiver provider agencies to ensure compliance with the waiver provider agreement. During these reviews DSHS also verifies the qualifications of waiver provider agency employees and subcontractors. To do this, DSHS uses a statistical sampling methodology to assure that the sample of waiver provider agency employee and subcontractor qualifications to accurately assess the waiver provider agency's verification of employee and subcontractor qualifications. The sample size produces results with a confidence level of 95 percent and a confidence interval of plus or minus five percent.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Adaptive Aids and Supports

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Adaptive Aids and Supports are devices and supports recommended by the treatment team to effect a service under the approved service plan. The local mental health authority's case manager submits the treatment team recommendations to DSHS for approval. The waiver participant and legally authorized representative, local mental health authority, and waiver provider agency all sign off on the recommendation before it is submitted to DSHS for approval. Adaptive aids and supports address the waiver participant's needs that arise as a result of their serious emotional disturbance. These devices and supports contribute to the community functioning of waiver participants and thereby assist the participants to avoid institutionalization. Adaptive aids and supports include:

- Therapeutic Peer Support- Provides fees to facilitate the waiver participant's involvement in age-appropriate peer support activities recommended by the treatment team as part of a treatment plan. Includes participation in specialized groups to improve socialization or deal with issues resulting from serious emotional disturbance and/or concomitant physical health issues, such as obesity. For example, membership fees for peer support weight reduction groups recommended by a licensed dietician.

- Therapeutic equipment - items necessary to execute and /or maintain a therapeutic plan. May include equipment and supplies related to a professional services treatment plan that is not covered under the State plan under the Early and Periodic Screening, Diagnosis, and Treatment benefit.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Room and board, normal household expenses and items not related to the amelioration of the waiver participant's disability are not covered.

Costs for all waiver services cannot exceed the individual annual cost ceiling established under the waiver.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified YES Waiver Provider Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adaptive Aids and Supports

Provider Category:
Agency
Provider Type:
Certified YES Waiver Provider Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Waiver provider agency certified by DSHS as a local mental health authority or certified by Texas Medicaid and Healthcare Partnership as a Multispecialty Clinic.
Other Standard *(specify):*

Adaptive Aids and Supports are provided through the waiver provider agency, which purchases the aids and supports from appropriate outside vendors (e.g., art supply store, electronics store, or sporting goods store). The waiver participant's choice of services and service providers is determined during the treatment team meetings. Adaptive aids and supports may be provided by recreational equipment suppliers or specialized groups approved by the waiver provider agency, and specified in the waiver participant's plan of care and approved by DSHS.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver provider agency

DSHS

Frequency of Verification:

Annually.

Waiver provider agencies are responsible for verifying the qualifications of all employees and subcontractors. DSHS conducts annual on-site reviews of waiver provider agencies to ensure compliance with the waiver provider agreement. During these reviews DSHS also verifies the qualifications of waiver provider agency employees and subcontractors.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Living Supports (CLS)

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Community living supports are provided to the waiver participant and family to facilitate the waiver participant's achievement of his / her goals of community inclusion and remaining in their home. The supports

may be provided in the waiver participant's residence or in community settings (including but not limited to libraries, city pools, camps, etc.) Community living supports provide assistance to the family caregiver in the disability-related care of the waiver participant, while facilitating the waiver participant's independence and integration in to the community. The training in skills related to activities of daily living, such as personal hygiene, household chores, and socialization may be included, if these skills are affected by the waiver participant's disability. Community living supports may also promote communication, relationship-building skills, and integration into community activities. These supports must be targeted at enabling the waiver participant to attain or maintain his / her maximum potential. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. Training may be provided to both the caregiver and the waiver participant, dependent upon the waiver participant's age, on the nature of the emotional disorder, the role of medications, and self-administration of medications. Training can also be provided to the waiver participant's primary caregivers to assist the caregivers in coping with and managing the waiver participant's emotional disturbance. This includes instruction on basic parenting skills and other forms of guidance. Basic parenting skills for this population are those practices and techniques that are intended to help parents who may also be experiencing personal stress and family difficulties with a child who is having difficulty with behavior, friendships, emotional regulation, or school performance.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Costs for all waiver services cannot exceed the individual annual cost ceiling established under the waiver.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified YES Waiver Provider Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Living Supports (CLS)

Provider Category:
Agency

Provider Type:
Certified YES Waiver Provider Agency

Provider Qualifications

License *(specify):*
Not applicable

Certificate *(specify):*
Waiver provider agency certified by DSHS as a local mental health authority or certified by Texas Medicaid and Healthcare Partnership as a Multispecialty Clinic.

Other Standard *(specify):*
Community Living Supports (CLS) are provided either directly through the waiver provider agency staff or a direct service provider subcontracted with the waiver provider agency. The waiver participant’s choice of services and service providers is determined during the treatment team meetings.

Services will be provided by a credentialed Qualified Mental Health Professional - Community

Services (QMHP-CS) or an Qualified Mental Health Professional - Community Services equivalent, and is defined as an individual who:
(a) has a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention;
(b) is a registered nurse; or
(c) has a Master's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention.

Verification of Provider Qualifications

Entity Responsible for Verification:
Waiver provider agency

DSHS
Frequency of Verification:
Annually

Waiver provider agencies are responsible for verifying the qualifications of all employees and subcontractors. DSHS conducts annual on-site reviews of waiver provider agencies to ensure compliance with the waiver provider agreement. During these reviews DSHS also verifies the qualifications of waiver provider agency employees and subcontractors. To do this, DSHS uses a statistical sampling methodology to assure that the sample of waiver provider agency employee and subcontractor qualifications to accurately assess the waiver provider agency's verification of employee and subcontractor qualifications. The sample size produces results with a confidence level of 95 percent and a confidence interval of plus or minus five percent.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Employment Assistance

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Employment assistance is assistance provided to an individual to help the individual locate paid employment in the community. Employment assistance includes:
- identifying an individual's employment preferences, job skills, and requirements for a work setting and work conditions;
- locating prospective employers offering employment compatible with an individual's identified preferences, skills, and requirements; and
- contacting a prospective employer on behalf of an individual and negotiating the individual's employment.

Transporting the individual to help the individual locate paid employment in the community is a billable activity within the service.

Documentation is maintained in the individual's record that the service is not available to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 or under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq.).
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service may not be provided to the individual with the individual present at the same time that respite is provided.

The service does not include incentive payments, subsidies, or unrelated vocational training expenses such as the following:
(A) incentive payments made to an employer to encourage hiring the individual;
(B) payments that are passed through to the individual;
(C) payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business; or
(D) payments used to defray the expenses associated with starting up or operating a business.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified YES Waiver Provider Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Employment Assistance

Provider Category:
Agency
Provider Type:
Certified YES Waiver Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Waiver provider agency certified by DSHS as a local mental health authority or certified by Texas Medicaid and Healthcare Partnership as a Multispecialty Clinic.

Other Standard *(specify):*
The service provider must be at least 18 years of age, maintain a current driver's license and insurance if transporting the individual, and satisfy one of these options:
Option 1:
- have a bachelor's degree in rehabilitation, business, marketing, or a related human services field; and six month's paid or unpaid experience providing services to people with disabilities;

Option 2:
- have an associate's degree in rehabilitation, business, marketing, or a related human services field; and one year of paid or unpaid experience providing services to people with disabilities; or

Option 3:
- have a high school diploma or Certificate of High School Equivalency (GED credentials) and two years' of paid or unpaid experience providing services to people with disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:
Waiver provider agency

DSHS

Frequency of Verification:
Annually

Waiver provider agencies are responsible for verifying the qualifications of all employees and subcontractors. DSHS conducts annual on-site reviews of waiver provider agencies to ensure compliance with the waiver provider agreement. During these reviews DSHS also verifies the qualifications of waiver provider agency employees and subcontractors. To do this, DSHS uses a statistical sampling methodology to assure that the sample of waiver provider agency employee and subcontractor qualifications to accurately assess the waiver provider agency's verification of employee and subcontractor qualifications. The sample size produces results with a confidence level of 95 percent and a confidence interval of plus or minus five percent.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Family Supports

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Family supports provides peer mentoring and support to the primary caregivers; engages the family in the treatment process; models self-advocacy skills; provides information, referral and non-clinical skills training; maintains engagement; and assists in the identification of natural / non-traditional and community support systems.

Family Supports are peer-to-peer mentoring services and are not clinical skills training. By contrast, Community Living Supports consists of clinical skills training provided by a professional licensed clinician.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Costs for all waiver services cannot exceed the individual annual cost ceiling established under the waiver.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified YES Waiver Provider Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Supports

Provider Category:
Agency
Provider Type:
Certified YES Waiver Provider Agency
Provider Qualifications
License *(specify):*
Not applicable
Certificate *(specify):*

Waiver provider agency certified by DSHS as a local mental health authority or certified by Texas Medicaid and Healthcare Partnership as a Multispecialty Clinic.

Other Standard *(specify):*

Family Supports are provided either directly through the waiver provider agency staff or a direct service provider subcontracted with the waiver provider agency. The waiver participant's choice of services and service providers is determined during the treatment team meetings.

The waiver provider agency will credential family support providers. Family supports providers must meet credentialing requirements including passing a criminal background check and reference checks. Family supports providers are skilled and experienced as the primary caregiver to children / adolescents with behavioral health challenges like those of the population of waiver participants, including a serious emotional disturbance. A family supports provider must have a high school diploma, or a high school equivalency certificate issued in accordance with the law of the issuing state; at least one cumulative year of receiving mental health community services for a mental health disorder or one cumulative year of experience navigating the mental health system as the parent or primary caregiver of a child / adolescent receiving mental health community services; and be under the direct clinical supervision of a master's level therapist.

Family supports providers must complete a training process through the waiver provider agency on program philosophy, policies and procedures, including reporting of critical incidents and abuse, neglect, and exploitation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver provider agency

DSHS

Frequency of Verification:

Annually

Waiver provider agencies are responsible for verifying the qualifications of all employees and subcontractors. DSHS conducts annual on-site reviews of waiver provider agencies to ensure compliance with the waiver provider agreement. During these reviews DSHS also verifies the qualifications of waiver provider agency employees and subcontractors. To do this, DSHS uses a statistical sampling methodology to assure that the sample of waiver provider agency employee and subcontractor qualifications to accurately assess the waiver provider agency's verification of employee and subcontractor qualifications. The sample size produces results with a confidence level of 95 percent and a confidence interval of plus or minus five percent.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Minor Home Modifications

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Services related to addressing the waiver participant's needs that arise as a result of their serious emotional disturbance. These services contribute to the community functioning of waiver participants and thereby assist the waiver participants to avoid institutionalization. These services include home accessibility / safety adaptations - physical adaptations to the waiver participant's residence, required by the waiver participant's service plan, that are necessary to ensure the health, welfare and safety of the participant. May include alarm systems, alert systems, and other safety devices.

Minor home modifications must be age appropriate and related to specific therapeutic goals. The provider agency will be required to maintain written documentation of reasonable cost for services.

Home accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Room and board, normal household expenses, and items not related to the amelioration of the waiver participant's disability are not covered.

Costs for all waiver services cannot exceed the individual annual cost ceiling established under the waiver.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified YES Waiver Provider Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Minor Home Modifications

Provider Category:
Agency
Provider Type:
Certified YES Waiver Provider Agency
Provider Qualifications
License *(specify):*
Minor home modifications may be provided by alarm system providers licensed by DSHS under Title 25 of the Texas Administrative Code, Part 1, Chapter 140, Subchapter B for Personal Emergency Response Systems and/or the Texas Department of Public Safety under Title 37 of the Texas Administrative Code, Part 1, Chapter 35.
Certificate *(specify):*
Waiver provider agency certified by DSHS as a local mental health authority or certified by Texas Medicaid and Healthcare Partnership as a Multispecialty Clinic.
Other Standard *(specify):*
Minor Home Modifications are provided either directly through the waiver provider agency staff or an outside vendor subcontracted with the waiver provider agency (e.g., licensed contractor or licensed alarm system provider). The waiver participant's choice of services and service providers is determined during the treatment team meetings.

The waiver provider agency must hire a person or subcontractor who complies with the requirements for delivery of minor home modifications, in accordance with the service plan, and with requirements such as types of allowed modifications, time frames for completion, inspections of the modification, and follow-up on the completion of the modification.

Qualified contractors provide minor home modifications in accordance with state and local building codes and other applicable regulations.
Verification of Provider Qualifications
Entity Responsible for Verification:
Waiver provider agency

DSHS
Frequency of Verification:
Annually

Waiver provider agencies are responsible for verifying the qualifications of all employees and subcontractors. DSHS conducts annual on-site reviews of waiver provider agencies to ensure compliance with the waiver provider agreement. During these reviews DSHS also verifies the qualifications of waiver provider agency employees and subcontractors. To do this, DSHS uses a statistical sampling methodology to assure that the sample of waiver provider agency employee and subcontractor qualifications to accurately assess the waiver provider agency's verification of employee and subcontractor qualifications. The sample size produces results with a confidence level of 95 percent and a confidence interval of plus or minus five percent.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Non-Medical Transportation

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Non-medical transportation enables waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. This service is in addition to, and not instead of, medical transportation required under 42 CFR §431.53 and transportation services under the State Plan. Transportation services under the waiver are offered in accordance with the waiver participant's service plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Waiver transportation services may not be substituted for medical transportation services defined under the State Plan. Payment for non-medical transportation services is limited to the costs of transportation needed to access a waiver service included in the waiver participant's service plan or access other activities and resources identified in the service plan. When the costs of transportation are included in the provider rate for another waiver service that the waiver participant is receiving at the same time, non-medical transportation services cannot be reimbursed under the waiver.

Costs for all waiver services cannot exceed the individual annual cost ceiling established under the waiver.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified YES Waiver Provider Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:
Agency
Provider Type:
Certified YES Waiver Provider Agency
Provider Qualifications
License *(specify):*
Transportation providers must have a valid Texas driver's license and insurance appropriate to the vehicle used to provide transportation.
Certificate *(specify):*
Waiver provider agency certified by DSHS as a local mental health authority or certified by Texas Medicaid and Healthcare Partnership as a Multispecialty Clinic.
Other Standard *(specify):*
Non-Medical Transportation is provided directly through the waiver provider agency staff or a direct service provider subcontracted with the waiver provider agency. The waiver participantâ€™s choice of services and service providers is determined during the treatment team meetings.

Transportation providers must be over age 18 years of age.
Verification of Provider Qualifications
Entity Responsible for Verification:
Waiver provider agency

DSHS
Frequency of Verification:
Annually

Waiver provider agencies are responsible for verifying the qualifications of all employees and subcontractors. DSHS conducts annual on-site reviews of waiver provider agencies to ensure compliance with the waiver provider agreement. During these reviews DSHS also verified the qualifications of waiver provider agency employees and subcontractors.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Paraprofessional Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Services related to addressing the waiver participant's needs that arise as a result of their serious emotional disturbance. These services contribute to the community functioning of waiver participants and thereby assist the waiver participants to avoid institutionalization. The services are essential to promote community inclusion in typical child/youth activities and exceed what would normally be available for children in the community. The paraprofessional is a behavioral aide supporting the waiver participant to meet the behavioral goals outlined in their plan. The paraprofessional may model and coach appropriate behaviors. Parafessional services are provided under the direction of a licensed behavioral health professional.

Services include:

- Mentoring and coaching - Mentoring is provided by a person who has had additional training/experience working with children/youth with mental health problems. For example, a teenager with severe behavior problems may require mentoring from a person with behavioral management expertise.

- Paraprofessional Aide - This service may be reimbursed if delivered in a setting where provision of such support is not already required or included as a matter of practice. The aide assists the waiver participant in preventing and managing behaviors stemming from serious emotional disturbance that create barriers to inclusion in integrated community activities such as after-school care or day care.

Job placement- assistance in finding employment. Job placement can be provided by the paraprofessional to assist the waiver participant wiht developing a resume and completing applications. Job placement is not supported employment.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Costs for all waiver services cannot exceed the individual annual cost ceiling established under the waiver.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified YES Waiver Provider Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Paraprofessional Services

Provider Category:
Agency
Provider Type:
Certified YES Waiver Provider Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Waiver provider agency certified by DSHS as a local mental health authority or certified by Texas Medicaid and Healthcare Partnership as a Multispecialty Clinic.
Other Standard *(specify):*
Paraprofessional services are provided directly through the waiver provider agency staff or a direct service provider subcontracted with the waiver provider agency. The waiver participant's choice of services and service providers is determined during the treatment team meetings.

A paraprofessional must meet the following qualifications:
(A) Be at least 18 years of age;
(B) Have received:
(i) A high school diploma; or
(ii) A high school equivalency certificate issued in accordance with the law of the issuing state;
(C) Have a minimum of one year of documented full-time experience working with SED population. Experience may be considered if the documented experience includes activities that are comparable to services specified under the service definition;
(D) Demonstrate competency in the provision and documentation of the specified or comparable service. Competency is assessed and documented by the waiver provider agency and reviewed by DSHS; and
(E) Have received required training which includes, at a minimum:
(i) Orientation prior to delivering services; and
(ii) Systems of care and wraparound training within six months of hire.

Verification of Provider Qualifications
Entity Responsible for Verification:
Waiver provider agency

DSHS
Frequency of Verification:
Annually

Waiver provider agencies are responsible for verifying the qualifications of all employees and subcontractors. DSHS conducts annual on-site reviews of waiver provider agencies to ensure compliance with the waiver provider agreement. During these reviews DSHS also verifies the qualifications of waiver provider agency employees and subcontractors. To do this, DSHS uses a statistical sampling methodology to assure that the sample of waiver provider agency employee and subcontractor qualifications to accurately assess the waiver provider agency's verification of employee and subcontractor qualifications. The sample size produces results with a confidence level of 95 percent and a confidence interval of plus or minus five percent.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Specialized Therapies

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Services to waiver participants to assist them in meeting recovery goals. The intent of these services is to maintain or improve health, welfare, and/or effective functioning in the community. These services include:
- Art Therapy
- Music Therapy
- Animal-assisted Therapy
- Recreational Therapy
- Nutritional Counseling

Art Therapy: Art therapy is a human service profession in which waiver participants, facilitated by the art therapist, use art media, the creative process, and the resulting artwork to explore their feelings, reconcile emotional conflicts, foster self-awareness, manage behavior, develop social skills, improve reality orientation, reduce anxiety, and increase self-esteem.

Music Therapy: Music therapy utilizes musical or rhythmic interventions specifically selected by a registered music therapist to accomplish the restoration, maintenance, or improvement of social or emotional functioning, mental processing, or physical health. Music therapy is a prescribed use of music to therapeutically address physical, psychological, cognitive, or social functioning to optimize the individual's quality of life, improve functioning on all levels, enhance well being and foster independence. Music therapy provides an opportunity to move from isolation into active participation through an increase in verbal and nonverbal communication, social expression, behavioral and social functioning, and self awareness. Reductions are noted in maladaptive behaviors, anxiety, and stress among disabled individuals participating in music therapy. The reduction of maladaptive behaviors and improved social functioning assists a waiver participant to integrate into the community and to be less dependent upon others to monitor and intervene in social and community settings. It also encourages the improvement of communication skills for the individual.

Animal-Assisted Therapy: In animal assisted therapy, animals are utilized in goal directed treatment sessions, as a modality, to facilitate optimal physical, cognitive, social and emotional outcomes of a waiver participant such as increasing self-esteem and motivation, and reducing stress. Animal-assisted therapy is delivered in a variety of settings by specifically trained individuals in association with animals that meet specific criteria and in accordance with guidelines established by the American Veterinary Medical Association. Example programs include, but are not limited to Therapeutic Horseback Riding and Pet Partners.

Recreational Therapy: Recreational therapy helps to develop leisure time in ways that enhance health, independence, and well-being. Recreational therapy is a prescribed use of recreational and other activities as a treatment intervention to improve the functional living competence of persons with physical, mental, emotional, and/or social disadvantages. Treatment is designed to restore, remediate, or habilitate improvement in functioning and independence while reducing or eliminating the effects of an illness or a disability.

Nutritional Counseling: Nutritional counseling assists waiver participants in meeting their basic and/or special therapeutic nutritional needs. This includes, but is not limited to counseling waiver participants in nutrition principles, dietary plans, and food selection and economics.

This service is not available under a program funded under the IDEA (20 U.S.C 1401 et seq.).
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Costs for all waiver services cannot exceed the individual annual cost ceiling established under the waiver.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified YES Waiver Provider Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Therapies

Provider Category:
Agency
Provider Type:
Certified YES Waiver Provider Agency
Provider Qualifications
License *(specify):*
Licensed professionals, with documented training and experience relative to the specific service provided. These may include: licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, registered nurse, licensed vocational nurses, physical therapists, occupational therapists, or licensed dieticians.

Nutritional counseling is delivered by a registered, licensed, or provisionally licensed dietitian. The Texas Board of Examiners of Dietitians licenses and issues licenses for dietitians.

Or:
A person may also qualify to provide each specified professional service by meeting the appropriate certification standard listed below.
Certificate *(specify):*
Waiver provider agency certified by DSHS as a local mental health authority or certified by Texas Medicaid and Healthcare Partnership as a Multispecialty Clinic.

*Art Therapist certified by the Art Therapy Credentials Board (ATCB).

*Music Therapist certified by the Certification Board for Music Therapists (CBMT).

*Animal-Assisted Therapy providers and their animals must be appropriately trained and obtain certification specific to the type of program and animal(s) involved. Example certification programs include, but are not limited to: Pet Partners program, Equine Assisted Growth and Learning Association (EAGALA), and the Professional Association of Therapeutic Horsemanship International (PATH International).

*Recreational Therapist certified by the National Council of Therapeutic Recreation Certification (NCTRS) or Therapeutic Recreation Specialist Texas Certified (TRS/TXC) by Consortium for Therapeutic Recreation/Activities Certification, Inc. (CTRAC).

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver provider agency

DSHS

Frequency of Verification:

Annually

Waiver provider agencies are responsible for verifying the qualifications of all employees and subcontractors. DSHS conducts annual on-site reviews of waiver provider agencies to ensure compliance with the waiver provider agreement. During these reviews DSHS also verifies the qualifications of waiver provider agency employees and subcontractors. To do this, DSHS uses a statistical sampling methodology to assure that the sample of waiver provider agency employee and subcontractor qualifications to accurately assess the waiver provider agency's verification of employee and subcontractor qualifications. The sample size produces results with a confidence level of 95 percent and a confidence interval of plus or minus five percent.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Supportive Family-based Alternatives

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Supportive family-based alternatives are designed to provide therapeutic support to the waiver participant and to model appropriate behaviors for the waiver participant's family with the objective of enabling the waiver participant to successfully return to their family and live in the community with their family. Supportive family-based alternatives include services required for a waiver participant to temporarily reside within in a home other than the home of their family. The Child-Placing Agency will recruit, train and certify the support family and coordinate with the waiver participant's family. The support family must include at least one adult living in the home and no more than four non-related individuals may live in the home. The support family must have legal responsibility for the residence and either own or lease the residence. The home must be located in a typical residence in the community and provide an environment that assures community integration, health, safety and welfare of the waiver participant. The support family must provide services as authorized in the waiver participant's service plan. Services may include:

* Age and individually appropriate guidance regarding and / or assistance with the activities of daily living and instrumental activities of daily living (ambulating, bathing, dressing, eating, getting in/out of bed, grooming, personal hygiene, money management, toileting, communicating, performing household chores, and managing medications)
* Securing and providing transportation
* Reinforcement of counseling, therapy, and related activities
* Assistance with medications and performance of tasks delegated by a registered nurse or physician
* Supervision of the waiver participant for safety and security
* Facilitating inclusion in community activities, social interaction, use of natural supports, participation in leisure activities, and development of socially valued behaviors
* Assistance in accessing community and school resources

The cost of transportation is included in the provider rate. DSHS reviews the monthly billing claims to ensure no other claims are filed for transportation when supportive family-based alternatives is billed.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Supportive family-based alternatives must be prior authorized by DSHS. Room and board is not included in the payment for supportive family-based alternatives. Waiver participants are responsible for their room and board costs. A waiver participant may not receive respite or community living supports while receiving supportive family-based alternatives. Waiver participants eligible for, or receiving, Title IV-E services cannot receive supportive family-based alternatives. Supportive family-based alternatives may be authorized for up to 90 consecutive or cumulative days per individual service plan year, with individual exceptions possible on a case-by-case basis, if recommended by the local mental health authority and prior approved by DSHS.

Costs for all waiver services, including any extended Supportive Family-based Alternatives cannot exceed the individual annual cost ceiling established under the waiver.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified YES Waiver Provider Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supportive Family-based Alternatives

Provider Category:
Agency
Provider Type:
Certified YES Waiver Provider Agency
Provider Qualifications
License *(specify):*
Foster home verified by a Texas Department of Family and Protective Services licensed Child Placing Agency - Title 40 of the Texas Administrative Code, Part 19, Chapter 749.

Child-Placing Agency licensed by the Texas Department of Family and Protective Services - Title 40 of the Texas Administrative Code, Part 19, Chapter 749, Subchapter C.
Certificate *(specify):*
Waiver provider agency certified by DSHS as a local mental health authority or certified by Texas Medicaid and Healthcare Partnership as a Multispecialty Clinic.
Other Standard *(specify):*
Supportive family-based alternatives providers must be age 18 or over and not the parent, spouse, legal guardian, or legally authorized representative of the waiver participant; must have CPR and first aid training; pass a criminal background check, have a current Texas driver's license and insurance (if transporting the waiver participant).
Verification of Provider Qualifications
Entity Responsible for Verification:
Waiver provider agency

DSHS
Frequency of Verification:
Annually

Waiver provider agencies are responsible for verifying the qualifications of all employees and subcontractors. DSHS conducts annual on-site reviews of waiver provider agencies to ensure compliance with the waiver provider agreement. During these reviews DSHS also verifies the qualifications of waiver provider agency employees and subcontractors. To do this, DSHS uses a statistical sampling methodology to assure that the sample of waiver provider agency employee and subcontractor qualifications to accurately assess the waiver provider agency's verification of employee and subcontractor qualifications. The sample size produces results with a confidence level of 95 percent and a confidence interval of plus or minus five percent.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Transitional Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
A one-time non-recurring allowable expense when a waiver participant transitions from an institution, provider-operated setting, or family home to their own private community residence. Assistance may include:
* utility and security deposits for the home/apartment
* needed household items such as linens and cooking utensils
* essential furnishings
* moving expenses
* services necessary to ensure health and safety in the apartment/home (e.g., pest eradication, allergen control, one-time cleaning)

Services will be provided by the waiver provider agency. The waiver provider agency must demonstrate to DSHS that services provided meet the requirements of the approved plan of care and are of reasonable cost.

Transitional services may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider where the provision of those items and services are inherent to the service they are already providing. Transitional services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Transition services is limited to $2,500 dollars per waiver participant. Costs for all waiver services cannot exceed the individual annual cost ceiling established under the waiver.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified YES Waiver Provider Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Services

Provider Category:
Agency
Provider Type:
Certified YES Waiver Provider Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Waiver provider agency certified by DSHS as a local mental health authority or certified by Texas Medicaid and Healthcare Partnership as a Multispecialty Clinic.
Other Standard *(specify):*
Transitional services are provided either directly through the waiver provider agency staff or an outside vendor subcontracted with the waiver provider agency (e.g., furniture store, grocery store, or moving company). The waiver participant's choice of services and service providers is determined during the treatment team meetings.
Verification of Provider Qualifications
Entity Responsible for Verification:
Waiver provider agency

DSHS
Frequency of Verification:
Annually

Waiver provider agencies are responsible for verifying the qualifications of all employees and subcontractors. DSHS conducts annual on-site reviews of waiver provider agencies to ensure compliance with the waiver provider agreement. During these reviews DSHS also verifies the qualifications of waiver provider agency employees and subcontractors. To do this, DSHS uses a statistical sampling methodology to assure that the sample of waiver provider agency employee and subcontractor qualifications to accurately assess the waiver provider agency's verification of employee and subcontractor qualifications. The sample size produces results with a confidence level of 95 percent and a confidence interval of plus or minus five percent.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

- [ ] **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- [x] **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- [ ] **As an administrative activity.** *Complete item C-1-c.*

c. **Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

It is delivered under the Medicaid State Plan as a targeted case management service by the community mental health center case manager.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ( ) **No. Criminal history and/or background investigations are not required.**
- (•) **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

(a) A criminal history check is conducted for all direct service providers by the waiver provider agency prior to employment or assignment regardless of the activities the person will be performing.

(b) The criminal history check utilizes a statewide database maintained by the Texas Department of Public Safety. If the person lived outside the state of Texas at any time during the previous two years, then the criminal history check will include submission of fingerprints to the Federal Bureau of Investigations. A person who has been convicted of any of the criminal offenses delineated in Title 25 of the Texas Administrative Code, Part 1, Chapter 414, Subchapter K may not be employed or serve as a volunteer or intern.

(c) The waiver provider agency is responsible for conducting criminal history checks for all waiver service providers by utilizing the statewide database maintained by the Texas Department of Public Safety. The waiver provider agency is required to maintain documentation of the criminal history checks. During the annual review, DSHS will monitor waiver service provider agencies for completion of criminal history checks as required.

b. **Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ( ) **No. The State does not conduct abuse registry screening.**
- (•) **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Texas maintains two statewide abuse and misconduct registries:
1) Nurse Aide Registry maintained by the Department of Aging and Disability Services
2) Employee Misconduct Registry maintained by the Department of Aging and Disability Services.

A registry check is conducted for all employees, volunteers, and contracted providers prior to employment or assignment regardless of the activities the person will be performing. A person who is listed as having a finding entered into the Nurse Aide Registry concerning abuse, neglect, exploitation, or misconduct of a consumer or misappropriation of property may not be employed or serve as a volunteer or intern. A person who is listed in the Employee Misconduct Registry as having abused, neglected, or exploited a consumer may not be employed or serve as a volunteer or intern. (See Texas Health and Safety Code Sections 250.003 and 253.008)

The waiver provider agencies are required to conduct screening against the relevant registry. During the annual review, DSHS monitors the waiver provider agencies for completion of registry checks as required.

Waiver provider agencies must also screen all employees for exclusion prior to hiring and on an ongoing monthly basis by searching both the state and federal lists of excluded individuals and entities. If any exclusion is found it must immediately be reported.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- (●) **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ( ) **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ○ **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- ○ **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

  Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- ◉ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

  Specify the controls that are employed to ensure that payments are made only for services rendered.

  Respite and non-medical transportation, may be provided by a relative of the waiver participant other than the natural or adoptive parents or legal guardian. If a relative provides the service, they must subcontract with the waiver provider agency. The relative must meet qualifications for the service being provided as outlined in Appendix C-1/C-3, have a current driver's license, and pass the criminal history and abuse registry checks as stipulated under item a in Appendix C-2. The relative is required to complete the same training required by DSHS of all direct service providers.

  Prior to the provision of respite or non-medical transportation services by the relative, the waiver participant's plan of care must identify the need for the service and the relative as a provider of the service.

  After the provision of the services the legally authorized representative must sign a form indicating the date(s), time, and duration of the provision of services. The form will also include a statement as to the location of service provision (e.g., relative's home, waiver participant's home).

  DSHS waiver staff review all claims monthly to ensure that all waiver services were delivered according to the service plan and ensuring services are furnished in the best interest of the waiver participant.

- ○ **Other policy.**

  Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Waiver provider agencies must contract with the single State Medicaid Agency and the operating agency, DSHS. DSHS manages the provider enrollment process. A qualified provider may submit an application at any time. DSHS posts information on the provider agency enrollment process and requirements on the electronic state business daily and send periodic notices to provider associations, communities and advocacy groups. In addition, providers may contact DSHS directly at any time during the year to obtain an application. Qualified waiver provider agencies agree to provide all YES program services.

This model of service delivery accomplishes the following for YES program consumers:

* ensures the availability of each service in all counties included under the waiver;

* recognizes that a vast majority of waiver participants are not single service users, but require supports across service disciplines that must be closely integrated and coordinated to achieve beneficial outcomes;

* promotes effective response to temporary or permanent changes in the waiver participant's service needs as provider agencies are required to make all services available when and as they are needed by the waiver participants;

* establishes a single point of accountability for provision of needed services; and

* decreases administrative costs.

In addition to promoting efficient service delivery, the YES program service delivery model does not compromise a waiver participant's choice of qualified provider agencies or providers of waiver services. Provider agencies are enrolled in the YES program through an open enrollment process, which includes all willing, qualified provider agencies. In the included counties, waiver participants have a choice between at least two provider agencies if available.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Qualified Providers**

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. **Sub-Assurances:**

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
C.a.1. Number and percent of waiver provider agencies that initially meet licensing/certification requirements for the provision of waiver services. N: Number of waiver provider agencies that initially meet licensing/certification requirements for the provision of waiver services. D: Number of new waiver provider agencies.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
C.a.2. Number and percent of waiver provider agencies that continue to meet required licensing/certification standards for provision of waiver services. N: Number of waiver provider agencies that continue to meet required licensing/certification standards for provision of waiver services. D: Number of waiver provider agencies.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
C.c.1. Number and percent of direct service providers trained in the requirements to report allegations, acts constituting, and methods to prevent abuse,neglect,or exploitation. N: Number of direct service providers trained in the requirements to report allegations, acts constituting, and methods to prevent abuse,neglect,or exploitation. D: Number of direct service providers.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
C.c.2. Number and percent of waiver provider agencies that have a process that ensures direct service providers meet state requirements for provider training. N: Number of waiver provider agencies that have a process that ensures that direct service providers meet state requirements for provider training. D: Number of waiver provider agencies.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
DSHS is responsible for the oversight of the waiver provider agencies and conducts annual reviews of the agencies regarding compliance with the functions delegated in the approved waiver. DSHS monitors the waiver provider agencies for compliance with licensing requirements. When harmful or non-compliant practices are identified, corrective action is taken to bring the waiver provider agency back into compliance. Waiver provider agencies must allow DSHS representatives and other state and federal agencies full and free access to direct service staff and all locations where the waiver provider agencies or subcontractors perform duties related to the waiver. These reviews examine the waiver providers policies, procedures and operation of the functions delegated in the approved waiver. The waiver provider agencies

are responsible for verifying the qualifications of all employees and subcontractors. DSHS conducts annual reviews of the waiver provider agencies to ensure compliance with the waiver provider agreement. The reviews include an evaluation of the waiver participant clinical records to ensure that the waiver provider agency is providing adequate oversight and that the provider agency is responsive to findings. During these reviews DSHS verifies the qualifications of waiver provider agencies' employees and subcontractors, including compliance with requirements for criminal history and registry checks.

All waiver provider agencies and direct service staff are required to attend and satisfactorily complete the DSHS-sponsored YES waiver program specific training prior to the provision of waiver services or within other designated time frames. Waiver provider agencies must maintain training documentation in personnel files.

The YES waiver does not utilize non-licensed or non-certified providers; therefore, there is no performance measure for the subassurance "The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements".

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Individual problems may be discovered during monitoring activities by DSHS or any entities that have been delegated certain functions within the performance measures of this appendix. The options for remediation are listed below:

For all performance measures related to provider qualifications, DSHS initiates remediation if an unqualified provider is discovered delivering services by requiring the waiver provider agency or the employing agency to terminate the provider's contract, recoup payment, transition waiver participants to qualified providers, and refer to the Office of Inspector General and regulatory if appropriate. These actions pertain to both initial credentialing and re-credentialing requirements.

During its annual on-site reviews, DSHS reviews a waiver provider agency's compliance with YES waiver requirements. If DSHS finds a waiver provider agency to be out of compliance, DSHS includes the information in the official site review report, which is provided to the waiver provider agency and retained in DSHS records. The waiver provider agency must submit a plan of correction to DSHS no later than 30 days after the issuance of the site review report. This plan of correction must explain how the provider will (1) come into compliance with training requirements within 30 days, and (2) prevented future noncompliance. DSHS approves this plan of correction and requires the waiver provider to submit documentation of its progress addressing the concerns included in the site review report. The waiver provider agency retains documentation and DSHS retains the plan of correction in its files.

If DSHS discovers that provider training was not received according to State requirements, DSHS will require the waiver provider agency to take action including, but not limited to, completion of training within specified timeframes, corrective action plans, and contract suspension or termination. If DSHS requires a corrective action plan for any of the subassurances, the state will continue to monitor the waiver provider agency to assure that the plan has resulted in a permanent system correction. This will be in addition to quarterly desk reviews and annual site reviews.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- ◉ **No**
- ○ **Yes**
  Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- ○ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ◉ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☑ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

The following services will be limited to an annual maximum of $5,000 combined: adaptive aids and supports and minor home modifications. The family and waiver participants choose the services that will most support the waiver participant's recovery goals specified in the plan of care. This limit is based on historical expenditures for comparable programs in Texas. The local mental health authority informs waiver participants and legally authorized representatives of the limits upon enrollment.

The State does not plan to adjust this limit during the period the waiver is in effect. Should circumstances arise during the waiver period requiring adjustment of this limit, a waiver amendment will be submitted at that time.

Exceptions to this limit may be considered on a case by case basis, and written requests must be submitted to DSHS for written approval by the YES waiver program specialist and the DSHS Medicaid Services Unit Manager. Costs for all waiver services, including adaptive aids and supports and minor home modifications, cannot exceed the annual individual cost ceiling established under the waiver.

If necessary, a waiver participant's case manager will assist the waiver participant in locating additional resources through DSHS or the Department of Aging and Disability Services, or through family or local community organizations and other natural supports. To the extent that these efforts are unsuccessful, and the State finds that the absence of sufficient services prevents the State from assuring the waiver participant's health and welfare in the community, the waiver participant will be given an opportunity to request other services for which the waiver participant may be eligible. The waiver participant will be informed of and given the opportunity to request a fair hearing if the State proposes to terminate the waiver participant's waiver eligibility due to the inability of the waiver to assure health and welfare in the community.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Plan of Care

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- [ ] **Registered nurse, licensed to practice in the State**
- [ ] **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- [ ] **Licensed physician (M.D. or D.O)**
- [ ] **Case Manager** (qualifications specified in Appendix C-1/C-3)
- [x] **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Case management is delivered as a state plan service.

Case Managers have the following qualifications:

A case manager has a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention,

OR

as of August 31, 2004, has received a high school diploma or equivalency certificate, three continuous years of documented full time experience in the provision of mental health case management services, and demonstrated competency in the provision and documentation of case management services.

- [ ] **Social Worker**

Specify qualifications:

- [ ] **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. **Service Plan Development Safeguards.** *Select one:*

- ( ) **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- (•) **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

In Texas, a local mental health authority may also be a waiver provider agency as a last resort when there are no other provider agencies available in a locality or if the existing provider agencies do not have sufficient capacity. If the State contracts with a local mental health center to be a waiver provider agency, DSHS will conduct an initial review prior to implementation of quarterly desk reviews, and annual reviews reviews as part

of its oversight responsibilities to ensure full disclosure, right of free choice of providers, and provision of sufficient information regarding waiver services.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. **Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) At intake the waiver participant and legally authorized representative are informed of their rights and given the DSHS "Handbook of Consumer Rights." This handbook documents the waiver participant's and representative's right to participate in the development of the service plan. The documentation includes the waiver participant's right to request that other people be involved and the waiver participant's right to an explanation should the request be denied. The waiver participant and legally authorized representative are also informed of the conditions in which the right to request a Medicaid fair hearing apply.

(b) Per the Texas Administrative Code, the local mental health authority, case manager, and provider must include information obtained from the waiver participant and the legally authorized representative regarding the waiver participant's strengths, needs, natural supports, responsiveness to previous treatment, as well as preferences for, and objections to, specific treatment. The local mental health authority, case manager, and provider must also identify the representative's or family member's needs for education and support services related to the waiver participant's emotional disturbance and facilitate the representative's or family member's receipt of the needed education and support services. The case manager and provider must involve the waiver participant and the legally authorized representative in all aspects of planning the waiver participant's treatment. If the waiver participant has requested the involvement of additional family members, then the provider must involve the family member in all aspects of planning the waiver participant's treatment.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. **Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) The waiver utilizes an individualized planning process that addresses the waiver participant's unmet needs across all life domains. The family is a full and active partner and the expert on the waiver participant. The waiver participant and family selects the treatment team members. Team membership is as open as the waiver participant and family chooses and may include other service providers, neighbors, clergy, and other people who currently do, or may in the future, provide support to the family. If the waiver participant and family agrees, the team membership also includes an employee designated as a "family supports staff" (The family supports staff is an experienced parent or caregiver of a child or adolescent with a serious emotional disturbance who provides peer mentoring to the family and assists with engaging the family into services). The waiver participant and family are included in all decision making. The initial plan development occurs after the team has met, been oriented to their roles on the team, identified family strengths through "family strengths discovery," and developed the crisis and safety plan.

(b) The Child and Adolescent - Texas Recommended Assessment Guidelines is a broad measure of the waiver participant's current functioning. More detailed information is obtained through "Family Strengths Discovery." The discovery process focuses on the development of functional strengths and assets rather than the elimination of deficits. The process is responsive to cultural issues and the family's preferences and overarching goal for the waiver

participant.

(c) The waiver participant and family are informed of the services offered under the waiver at the time the local mental health authority has determined that the child or adolescent may qualify to receive services under the waiver. The local mental health authority staff person also informs the waiver participant and family of other treatment options such as hospitalization.

(d) The team, which includes the waiver participant and family, prioritizes the waiver participant's top 3-5 needs. The team develops a measurable outcome for each prioritized need. The team decides how each outcome will be measured. Outcome statements are chosen by the waiver participant and family. Multiple strategies are generated and evaluated for the extent to which they will meet the prioritized need, achieve the measurable outcome, are community-based, are built on or incorporate strengths, and are consistent with the family's values and culture. The selected strategies are based on the waiver participant's and family's preferences. The case manager, employed by the local mental health authority, has primary responsibility for coordinating waiver and other services. During the treatment planning meetings, the case manager explores third-party resources, including State Plan services.

(e) The case manager will have the responsibility of coordinating the agreed upon services and supports.

(f) The team assigns responsibility for completion of the action steps associated with each strategy. The case manager's responsibilities will include monitoring compliance with the plan by all members of the team.

(g) The plan will be reviewed by the treatment team at least every 90 days. More frequent review may be required to address significant life events or changes in the waiver participant's or family's functioning.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The Child and Adolescent-Texas Recommended Assessment Guidelines assess risk and is completed upon enrollment and as the waiver participant’s needs change, at a minimum every 90 days.

Because these youth are at high risk of placement for mental health treatment or are returning from such placements, crisis and safety plans are developed at the first meeting of the treatment teams. A crisis plan focuses on planning for, predicting, and preventing the occurrence of a crisis. Treatment team membership includes the waiver participant and caregiver to ensure that the waiver participant's and family's needs, strengths, and preferences are taken into consideration. Crisis plans are incorporated into the service plan with all team members knowing the roles they will play when crises arise. This helps to prevent crises and ensures crises are addressed immediately. If the waiver participants have safety or transition issues, safety and transition plans are also developed at the first meeting of the treatment team and incorporated into the plan of care. When safety plans are needed, the safety of the waiver participant and all other family members must be addressed to the satisfaction of all team members.

The service plan will include contingency plans for backup of services as well as a back up targeted case manager (Qualified Mental Health Provider), with their contact information.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Upon determination of eligibility, the local mental health authority provides the waiver participant or legally authorized representative with a list of all waiver provider agencies within the geographic limitation identified in item 4.C. of the waiver application. This list is also provided annually at plan renewal and any time upon request of

the waiver participant or legally authorized representative. The local mental health authority case manager assists the waiver participant in contacting providers and involving providers, as appropriate, in the development of the service plan.

The provision of the provider agency list and the final selection of a provider agency must be documented and retained in the waiver participant case record. DSHS will conduct periodic reviews to ensure that the local mental health authority objectively assists the waiver participant and legally authorized representative in the process of selecting a provider agency. DSHS will provide a list of interested and qualified providers to the local mental health authority and will provide updates to this list upon request.

The waiver participant's right to choose the service provider extends to the specific agency personnel that will be providing waiver services. The waiver participant's and legally authorized representative's selection of agency personnel will be documented and retained in the waiver participant's case record.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

DSHS YES waiver staff approve each individual plan of care and approve all criteria, processes, and documentation requirements related to the service plan.

The HHSC Medicaid/CHIP Division oversees DSHS in its role as the operating agency and participates with DSHS in at least one on-site review per year. HHSC staff monitors compliance with the executive directive between HHSC and DSHS. HHSC also reviews the methodology used for pulling samples, and the process used to assure that it is representative and unbiased.

DSHS Quality Management Unit reviews a sample of local mental health authorities to ensure that level of cares are completed and that case management functions are performed. DSHS Quality Management Unit determines the sample size using a formula that is designed to provide reliable and valid information at the local mental health authority level. A representative sample of waiver participants per local mental health authority is reviewed.

Additionally, DSHS YES waiver staff reviews each waiver participant’s service plan to verify that medical necessity determination has been met and that any applicable service limitations have not been exceeded. No sampling is performed at this time.

HHSC, through the executive directive with DSHS, delineates roles and responsibilities. The executive directive outlines HHSC's monitoring and oversight functions. HHSC delegates the day-to-day approval of individual plans of care to DSHS. DSHS approves all individual plans of care. In addition to quarterly sampling of service plans, DSHS also performs at least annual on-site reviews of the local mental health authorities. DSHS aggregates the data quarterly and annually and reports to HHSC. HHSC discusses any significant findings with DSHS and, together with DSHS, prepares a remediation plan or improvement plan as needed.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. **Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- (●) **Every three months or more frequently when necessary**
- ( ) **Every six months or more frequently when necessary**
- ( ) **Every twelve months or more frequently when necessary**
- ( ) **Other schedule**

Specify the other schedule:

i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- [ ] **Medicaid agency**
- [x] **Operating agency**
- [x] **Case manager**
- [x] **Other**

Specify:

The waiver provider agency, if applicable.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Case managers monitor the day to day implementation of the service plan, waiver participant health and welfare, and assess how well services are meeting a waiver participant's needs and enabling the waiver participant to achieve the stated goals and outcomes. The case manager must meet in person with the waiver participant at least once every 90 days. The case manager must also have at least one contact with the legally authorized representative every 90 days. The purpose of the required contacts is to verify:

- the safety and crisis plans are working as intended;
- services and supports are being implemented and provided in accordance with the service plan and continue to meet the waiver participant's needs, goals, and preferences;
- the waiver participant and legally authorized representative are satisfied with the implementation of services;
- the waiver participant's health and welfare are reasonably assured; and
- the waiver participant or legally authorized representative exercises free choice of providers and accesses non-waiver services including health services.

The local mental health authorities' quality management and supervisory staff provide oversight to the case manager's efforts ensuring that the required contacts occur, modifications to the service plan occur as necessary, and that the documentation generated by the case manager provides evidence of compliance with the requirements.

Service plan monitoring includes both desk and on-site reviews by DSHS staff. In the course of review, DSHS compares monthly service claim/encounter data to each waiver participant’s service plan to ensure that the services a waiver provider agency provides are consistent with a waiver participant’s service plan, including scope, frequency, and duration. DSHS staff performs desk and on-site reviews of all waiver provider agencies. During these reviews, DSHS ensures that all services indicated in the waiver participant’s service plan are available and delivered. If there are discrepancies, DSHS will follow up with the waiver provider agency and document reasons in the waiver participant’s case file. Freedom of provider choice is documented on the Provider Choice form. DSHS reviews the forms during its on-site and desk reviews. The treatment team meets at least once every 90 days and, among other things, considers whether waiver services are meeting the waiver participant’s needs. During its on-site and desk reviews, DSHS evaluates whether the treatment team has met at least every 90 days. The case manager and treatment team meet at least once every 90 days and, among other things, review the safety and crisis plans to ensure continued effectiveness. During its on-site and desk reviews, DSHS evaluates whether the treatment team has met at least once every 90 days. The case manager and treatment team meet at least once every 90 days and, among other things, review the waiver participant’s health and welfare. Curing its on-site and desk reviews, DSHS evaluates whether the treatment team has met at least once every 90 days. The local mental health authority case manager is responsible for coordinating all waiver and non-waiver services. DSHS reviews local mental health authorities’ case management to ensure service coordination.

The treatment team must review a waiver participant's service plan every 90 days, or more frequently when

necessary, to assess the appropriateness and adequacy of the identified services in light of the waiver participant's changing needs. Once reviewed, the service plan must be submitted to DSHS no less than every 90 days, even if the review did not result changes to the treatment plan.

DSHS performs on-site reviews of waiver provider agencies. The results are compiled and maintained in an internal database. DSHS provides HHSC monitoring results at least quarterly.

b. Monitoring Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

DSHS conducts quarterly desk reviews and annual on-site reviews of the waiver provider agencies. The reviews include an evaluation of the waiver participant case records to ensure that the provider agency is providing adequate oversight and that the provider agency is responsive to findings.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.a.1. Number and percent of waiver participants' service plans that reflect the participant's assessed needs. N: Number of waiver participants' service plans that reflect the participant's assessed needs. D: Number of waiver participants enrolled during the review period.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*		
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.a.2. Number and percent of waiver participants with service plans that reflect the participant's assessed health and safety risk factors. N: Number of waiver

participants with service plans that reflect the participant's assessed health and safety risk factors. D: Number of waiver participants enrolled during the review period.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.a.3. Number and percent of waiver participants with service plans that reflect the assessed personal goals. N: Number of waiver participants' service plans that reflect the assessed personal goals. D: Number of waiver participants enrolled during the review period.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.b.1. Number and percent of waiver participants' service plans that were developed in accordance with waiver policies and procedures. N: Number of waiver participants' service plans that were developed in accordance with waiver policies and procedures. D: Number of waiver participants enrolled during the review period.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how

themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.c.1. Number and percent of waiver participants' service plans that are reviewed and, if needed, revised every 90 days. N: Number and percent of waiver participants' service plans that are reviewed and, if needed, revised every 90 days. D: Number of waiver participants.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.c.2. Number and percent of waiver participants' service plans that are revised when warranted by changes in the participant's needs. N: Number of waiver participants' service plans that are revised when warranted by changes in the participant's need. D: Number of waiver participants with evidence of a change in need.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.d.1. Number and percent of waiver participants whose services are delivered according to the type, scope, and duration specified in their service plans. N: Number of waiver participants whose services are delivered according to the type, scope and duration specified in their service plans. D: Number of waiver participants enrolled.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.d.2. Number and percent of waiver participants whose services are delivered according to the amount and frequency specified in their service plans. N: Number of waiver participants whose services are delivered according to the amount and frequency specified in their service plans. D: Number of waiver participants enrolled.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.e.1. Number and percent of waiver participants who are afforded choice between home and community-based services and institutional care. N: Number of waiver participants who are afforded choice between home and community-based services and institutional care. D: Number of waiver participants enrolled during the review period.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.e.2. Number and percent of waiver participants who are afforded choice among the home and community-based waiver services. N: Number of waiver participants who are afforded choice among the home and community-based services. D: Number of waiver participants enrolled during the review period.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.e.3. Number and percent of waiver participants who are afforded choice of waiver provider agencies. N: Number of waiver participants who are afforded choice of waiver provider agencies. D: Number of waiver participants enrolled during the review period.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The case manager must monitor compliance with the overall service plan including the treatment plan. This includes ensuring individual health and welfare, assessing how well services are meeting an individual's needs, and enabling the individual to achieve the stated goals and outcomes.

The waiver provider agency will provide oversight of the case manager's efforts to ensure that the required contacts occur, the service plan is modified as necessary, and that the documentation generated by the case manager provides evidence of compliance with the waiver requirements. The waiver provider agencies must maintain a copy of the service plan within the waiver participant's clinical record.

DSHS conducts a review of each service plan prior to approving. If the plan is denied, DSHS will provide the waiver provider agency with justification of the denial. The waiver provider agency will submit a revision for further consideration and will inform the waiver participant of their right to a fair hearing. DSHS ensures all criteria, processes, and documentation requirements related to the service plan are met.

DSHS monitors service utilization data on a monthly basis in accordance with the approved service plan, as well as all service encounter claims to verify that the service has been authorized. These reviews include verification of the plan's service array, clinical eligibility and service documentation.

DSHS conducts annual on-site reviews of the waiver provider agencies. The reviews include an evaluation of the waiver participant's case records to ensure that the waiver provider agencies are providing adequate oversight and that the waiver provider agency is responsive to findings. Deficiencies in service plan development, monitoring, or implementation are recorded and plans of correction are required within specified time frames. DSHS annually obtains family satisfaction information regarding waiver services by sending a survey to all the individuals and their legally authorized representatives. Questions include, but are not limited to, satisfaction with frequency of treatment team meetings, if the team is assisting in obtaining natural supports, and assisting in reaching treatment goals. The timeframe for service plan deficiency corrections is dependent on the correction needed. The minimum timeframe for a correction response is within 30 days after DSHS notifies the waiver service provider of a deficiency.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Individual problems may be discovered during monitoring activities by DSHS or any of the entities that have been delegated certain functions within the performance measures of this appendix. The options for remediation are listed below:

If DSHS identifies that a waiver participant's service plan does not meet the participant's needs, goals, preferences, or risks, DSHS requires the waiver provider agency to revise the service plan based on the assessment, correcting any deficiencies within established timeframes.

If DSHS identifies that a waiver participant's service plan was not developed according to standards set by the State, DSHS requires the waiver provider agency to revise the service plan according policies and procedures within established timeframes. The State's system does not allow payment for services delivered to a person without a service plan. If a person receives services prior to the completion of the initial service plan (or without prior authorization) the waiver provider agency will not receive payment for the service(s) rendered. DSHS requires the waiver provider agency to complete the service plan within twenty business days. If not completed within twenty business days, the waiver provider agency is contacted directly for resolution, and, if necessary, a corrective action plan may be required.

If the annual service plan is not completed timely, the waiver provider agency must submit the updated service plan within twenty business days. The waiver provider agency is not paid for services until the plan is completed, and is responsible for continuing services until the plan is approved. If not completed within twenty business days, the waiver provider agency is contacted directly for resolution, and, if necessary, a corrective action plan may be issued.

The State collects data and completed corrective action plans, which are retained in the State's database.

If a participant's service plan is not updated to address changes in need within State requirement timeframes, the State requires the waiver provider agency to revise the service plan, correcting any deficiencies within State established timeframes.

If the State identifies that a waiver participant did not receive services according to the service plan, the waiver
provider agency will either be required to deliver the service according to the service plan, or to revise the plan if the participant's circumstances have changed.

If a participant's service plan does not indicate that the waiver participant was (1)provided choice of waiver services, (2)choice between waiver services and institutional care, or (3)informed of the right to change providers, the waiver provider agency is required to meet with the participant, within State established timeframes, to revise the waiver participant's service plan. The revised service plan must indicate that the waiver participant is offered the above choices and informed of the right to change providers.

If the State requires a corrective action plan for any of the subassurances, the state will continue to monitor the waiver provider agencies to assure that the plan has resulted in a permanent system correction. This will be in addition to the quarterly desk reviews and annual on-site reviews.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- ( ) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- (●) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- ( ) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

During the intake process the local mental health authority informs the applicant and the legally authorized representative verbally and in writing of the applicant's right to a fair hearing. In addition, the participant and legally authorized representative are informed verbally and in writing of the participant's right to a fair hearing. The applicant/waiver participant or legally authorized representative signs a Notification of Participant Rights document initially and at renewal that provides information as to how to file a grievance. If the waiver participant or legally authorized representative needs any assistance with the fair hearing process, the case manager will provide assistance.

The following explains the process used by the local mental health authority when there is a request for a fair hearing.

The local mental health authority will send a standardized DSHS generated letter stating the conditions under which the applicant/waiver participant may request a fair hearing:

- If found to be eligible for the waiver, the applicant/waiver participant was not given the choice of waiver services as an alternative to institutional care;
- The applicant/waiver participant was not given the opportunity to receive services from the provider the applicant/waiver participant chose; or
- Waiver services were denied, suspended, reduced, or terminated.

An applicant whose request for eligibility for the waiver program is denied or is not acted upon with reasonable promptness, or a waiver participant whose waiver services have been terminated, suspended, or reduced by DSHS, is entitled to a fair hearing in accordance with Title 25 of the Texas Administrative Code, Part 1, Chapter 419, Subchapter A. The local mental health authority must notify the applicant/waiver participant and legally authorized representative of the right to a fair hearing, conducted in accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 357, and Subchapter A. The notice informs the waiver participant of the right to continue to receive services while the hearing is pending and the actions the waiver participant of legally authorized representative must take for services to continue. Waiver participants submit the request for a fair hearing to DSHS. DSHS then requests that HHSC assign a fair hearing officer.

All notification letters and request forms are offered in both English and Spanish.

DSHS retains a copy of the notice of adverse action taken by DSHS and the notice to the applicant/waiver participant and legally authorized representative of the right to a fair hearing. If an applicant/waiver participant or legally authorized representative requests a fair hearing, a copy of the written request for a hearing is retained as well.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

   - (●) **No. This Appendix does not apply**
   - ( ) **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

DSHS operates the grievance/complaint system.

c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DSHS Consumer Services and Rights Protection Unit staff operates an 8am to 5pm toll free phone line with TTY capabilities during the work week. Complaints can also be submitted via email or written correspondence and may be anonymous. (a) There is no restriction on the types of complaints that waiver participants may register. (b) All complaints are acted upon immediately. Given the variety of complaints, there is no mandated time line for resolution to the complaint. (c) Consumer Rights and Protection Staff have access to all departments and units to resolve the waiver participant's complaint. DSHS resolves complaints within ten days of receipt unless circumstances outside of DSHS' control (e.g., unresponsiveness by the waiver participant) prevent resolution. If DSHS cannot resolve the complaint within ten days, DSHS documents the reason(s) and continues its investigation until resolution.

Complaints involving allegations of abuse, neglect, or exploitation are referred immediately to the Texas Department of Family and Protective Services, the department with statutory responsibility for investigation of such allegations.

HHSC's Office of the Ombudsman assists the public when DSHS' normal complaint process cannot or does not satisfactorily resolve an issue. The waiver participant and their families also have the option of contacting the Office of the Ombudsman directly for assistance. The Ombudsman's services include:
- Conducting independent reviews of complaints concerning agency policies or practices;
- Ensuring policies and practices are consistent with the goals of HHSC;
- Ensuring waiver participants are treated fairly, respectfully and with dignity; and
- Making referrals to other agencies as appropriate.

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

Waiver participants are given the contact information verbally and in writing for DSHS Consumer Rights and Protection, the Department of Family and Protective Services, and the Office of the Ombudsman at intake, when requested, at annual renewal, and when a need is identified or thought to exist.

Waiver participants are informed that filing a grievance or making a complaint is not a prerequisite or substitute for a fair hearing.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All waiver participants, legally authorized representatives, waiver provider agencies, and local mental health authorities are provided with the Department of Family and Protective Services toll-free telephone number in writing and are instructed to report to the Department of Family and Protective Services immediately, but no later than one hour after having knowledge or suspicion, that a waiver participant has been or is being abused, neglected, or exploited. Local mental health authorities and waiver provider agencies are required to train staff on identifying, preventing, and reporting abuse, neglect, and exploitation.

Waiver provider agencies' contracts and local mental health authorities' contracts include requirements to report any incidents that result in substantial disruption of program operation involving or potentially affecting persons served by the DSHS. Incidents include, but are not limited to: medical injuries, behavioral or psychiatric emergencies, allegations against client rights, criminal activities, death, restraints, property or vehicle loss or damage, medication errors, client departures, legal/juvenile justice department involvement, hospitalizations. All incidents involving waiver participants are to be reported to the program within 72 hours, by completing a Critical Incident Reporting form.

All instances of abuse, neglect, and exploitation must be reported to the Department of Family and Protective Services immediately as it is the designated investigative agency for all such reports. Once reports of abuse, neglect, and exploitation are filed with the Department of Family and Protective Services, the waiver provider agencies and local mental health authorities are required to submit accurate and timely information to DSHS in accordance with the Submission Calendar, as follows: within one business day after completion of the Client Abuse and Neglect Reporting form the information contained in the completed form, or if online access is unavailable, a copy of the completed form is sent to the DSHS Office of Mental Health Consumer and Substance Abuse Client Rights. In addition, waiver provider agencies are required to submit a Critical Incident Reporting form to the waiver program within 72 hours of a report of abuse, neglect, or exploitation.

In an instance in which the contractor must report abuse or neglect, investigations are conducted by the Department of Family and Protective Services. By December 2012, DSHS will sign a Memorandum of Understanding with the Department of Family and Protective Services that allows the waiver program to submit participantsâ€™ names to the Department of Family and Protective Services database quarterly and receive back a list of all reports made involving waiver participants.

If the perpetrator or alleged perpetrator is an employee or agent of the waiver provider agency or local mental health authority, the director shall ensure that the employee or agent is removed as a provider of services. The Department of Family and Protective Services submits a copy of the investigative report to DSHS and the director of the waiver provider agency or local mental health authority.

A Client Abuse and Neglect Reporting form is completed within 14 calendar days of the receipt of the investigative report or decision made after review or appeal using the Client Abuse and Neglect Reporting System Definitions and Classifications. Within one working day after completion of the Client Abuse and Neglect Reporting form, the administrator shall ensure that:

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

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

The director may not change a confirmed finding made by a Department of Family and Protective Services investigator. The director may request a review of the finding or the methodology used to conduct the investigation.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

At the time of admission into the waiver, the waiver participant and the legally authorized representative are informed verbally and in writing of the process for reporting allegations of abuse, neglect, and exploitation and given the toll-free number for the Department of Family and Protective Services. Verbal and written communication of this information is documented on the Notification of Participant Rights form, bearing the date and signatures of the waiver participant and/or legally authorized representative and the staff person who provided this information. The form is filed in the waiver participant's case record with a copy for the local mental health authority's records.

The waiver participant and legally authorized representative are also given a copy of DSHS's "Handbook of Consumer Rights, Mental Health Services" in either English or Spanish as appropriate. In addition to receiving the rights handbook, the waiver participant and legally authorized representative are informed orally of all rights in his or her primary language using plain and simple terms. The method used to communicate the information is designed for effective communication, tailored to meet each person's ability to comprehend, and responsive to any visual or hearing impairment. Verbal communications of rights is documented on a form bearing the date and signatures of the waiver participant and/or legally authorized representative and the staff person who explained the rights. The form is filed in the waiver participant's case record. The provider repeats the explanation of rights, including giving the waiver participant a copy of the handbook and required documentation, at least annually.

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

Waiver provider agencies are required to ensure direct service staff are trained annually on critical incident reporting.

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Critical incidents are managed as part of the contract oversight process by DSHS. Incidences which must be reported to DSHS include: Injury, Medical Emergency, Behavioral or Psychiatric Emergency (including psychiatric hospitalizations), Allegation against client rights, Criminal Activity, Death, Restraint, Property or Vehicle loss or damage, Medication Error, Client Departure (missing, runaway, attempted departure), and all incidences resulting in a report of abuse, neglect, or exploitation.

DSHS YES waiver staff are responsible for the review of critical event and incident reports. The staff evaluates reports on the basis of timeliness of report, as well as the nature of the response. If a waiver service provider was involved in the incident, the DSHS staff evaluates the report to ensure that the waiver provider agency followed approved DSHS protocols. If the responder responded inappropriately, a report must be made to the Department of Family and Protective Services and to the regulatory agency that is responsible for oversight and licensure of the specific provider.

Annually, DSHS does a comprehensive on-site review of waiver provider agencies and local mental health authorities, during which critical incident reports are reviewed. The Department of Family and Protective Services receives allegations of abuse, neglect, and exploitation of waiver participants from waiver providers. The Department of Family and Protective Services is statutorily responsible for review, investigation and response to those reports.

The Department of Family and Protective Services Investigations: Child Protective Services, a division of the Department of Family and Protective Services, is responsible for investigating allegations of abuse, neglect, or exploitation of children, including cases in which a waiver provider agency is alleged to have abused, neglected, or exploited an waiver participant. Child Protective Services records and tracks reports of abuse, neglect, or exploitation.

The Department of Family and Protective Services assigns one of four priority levels to complaints at the time of the complaint intake. The Department of Family and Protective Services complaint investigators must contact the alleged victim by phone within 24 hours of intake. The investigator may change the priority level as a result of the phone contact. The Department of Family and Protective Services must make the initial face-to-face contact with the alleged victim based on the priority level. Priority one cases require response within 24 hours; priority two cases require response within three calendar days; priority three cases require response within 7 calendar days; and priority four cases require response within 14 calendar days. Depending on the severity of the allegation, the Department of Family and Protective Services investigations must be completed within 14 to 21 days.

Under a Memorandum of Understanding between DSHS and the Department of Family and Protective Services, the Department of Family and Protective Services notifies DSHS of substantiated abuse, neglect, or exploitation complaints providing due process to the perpetrator. DSHS may coordinate with Child Protective Services to determine the resolution of the abuse, neglect, or exploitation allegation. Waiver provider agencies are required to protect waiver participants from abuse, neglect, or exploitation under consumer rights rules and report potential incidences of abuse, neglect, or exploitation to the Department of Family and Protective Services.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DSHS is the agency that is responsible for overseeing the reporting of and response to critical incidents that affect waiver participants. DSHS conducts risk assessment of the local mental health authorities and waiver provider agencies quarterly which includes a review of any reported critical incidents and events. DSHS will report data from critical incident reviews to HHSC on at least an annual basis.

The Quality Oversight Plan delineates specific indicators related to each sub-assurance. Data from these reviews is reported to HHSC via these indicators and associated reports. HHSC coordinates with DSHS through formal Quality Review Team meetings to discuss findings and trends and, when necessary, to develop and monitor remediation plans.

In the case of critical incidents, waiver provider agencies are expected to take immediate action to resolve, when feasible, and to report to the appropriate state and/or law enforcement entities. The waiver program also requires waiver provider agencies to submit a Critical Incident Report form to DSHS within 72 hrs of an incident.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

According to the Texas Administrative Code, the use of chemical restraint is prohibited. The use of mechanical restraints and seclusion are also prohibited.

The Texas Administrative Code defines personal restraint as, "The application of physical force alone restricting the free movement of the whole or a portion of the waiver participant's body to control physical activity." Personal restraint is used only as a last resort after less restrictive measures have been found to be ineffective or are judged unlikely to protect the waiver participant or others from harm. The intervention is used for the shortest period possible and terminated as soon as the waiver participant demonstrates the release behaviors specified by the ordering physician.

Waiver providers shall be trained in the safe use of personal restraint by the waiver provider agencies. Providers shall not use personal restraint unless it is necessary to intervene to prevent imminent probable death or substantial bodily harm to the waiver participant or imminent physical harm to another, and less restrictive methods have been tried and failed.

Providers shall not use more force than is necessary to prevent imminent harm and shall ensure the safety, well-being, and dignity of waiver participants who are personally restrained, including attention for personal needs.

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

(A) techniques, methods, or tools that would help the waiver participant effectively cope with his or her environment;

(B) pre-existing medical conditions or any physical disabilities and limitations, including substance use disorders, that would place the waiver participants at greater risk during restraint;

(C) any history of sexual or physical abuse that would place the waiver participant at greater psychological risk during restraint; and

(D) any history that would contraindicate restraint.

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

Provider shall record the following information in the waiver participant's record within 24 hours:

* the circumstances leading to the use of personal restraint;

* the specific behavior necessitating the restraint and the behavior required for release;

* less restrictive interventions that were tried before restraint began;

* the names of the providers who implemented the restraint;

* the date and time the procedure began and ended; and

* the waiver participant's response.

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

The State requires a waiver provider agency to document use of restraints in a waiver participant's case file within 24 hours after use of the restraints. The waiver provider agency must notify the waiver participant's family and legally authorized representative within the same day. DSHS has a client rights hotline that is staffed to receive allegations of any violations or perceived violations of a client's rights. The waiver provider agency provides the hotline number to each waiver participant and legally authorized representative. DSHS must investigate all complaints made to the client rights hotline. Suspicion of abuse, neglect, or exploitation in relation to the use of a restraint is reported to the Department of Family and Protective Services for investigation.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The Department of State Health Services (DSHS) is responsible for overseeing the use of personal restraints by waiver providers. The use of mechanical restraints and seclusion is prohibited in community settings. For general residential operations, the Department of Family and Protective Services is responsible for oversight of restraint.

The oversight of personal restraint for local mental health authorities is accomplished through the quarterly risk assessment conducted by DSHS. The use of personal restraint must be documented as a critical incident by the waiver provider agencies and local mental health authorities and follow the procedures specified in Appendix G-1 for Critical Incident Reporting. Additionally, the waiver program requires submission of the Critical Incident Reporting form to the program within 72 hours by the waiver provider agencies in the use of personal restraint.

Unauthorized use of restraint and seclusion will be detected by record review and through complaints.

The Quality Oversight Plan delineates specific indicators related to each sub-assurance. Data from these reviews is reported to the State Medicaid Agency, which is within HHSC, via these indicators and associated reports. At a minimum, HHSC coordinates with DSHS no less than quarterly to discuss findings and trends and, when necessary, develop and monitor remediation plans.

In the case of critical incidents, waiver provider agencies are expected to take immediate action to resolve, when feasible, and to report to appropriate state and law enforcement entity.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

- (●) **The State does not permit or prohibits the use of restrictive interventions**

  Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

  There are no other restrictive interventions permitted other than the personal restraint specified in Appendix G-2:a.

  The State does not permit the use of restrictive interventions. DSHS has a client rights hotline that is staffed to investigate any violations or perceived violations of a client's rights. The waiver provider agency provides the hotline number to each waiver participant and legally authorized representative. DSHS must investigate all complaints made to the client rights hotline. Suspicion of abuse, neglect, or exploitation in relation to the use of a restrictive intervention is reported to the Department of Family and Protective Services for investigation.

- ( ) **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

  i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

  ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

- ( ) **The State does not permit or prohibits the use of seclusion**

  Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

- ( ) **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

  i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. **Applicability.** Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. **Medication Management and Follow-Up**

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

General Residential Operations: The Department of Family and Protective Services is responsible for licensing and regulating General Residential Operations in Texas. The Department of Family and Protective Services staff enforce these rules through regular inspections and investigations at licensed facilities. Every licensed facility receives at least one unannounced inspection annually. Minimum standard rules address a wide variety of requirements, including medication requirements. Medication requirements include consent for giving medications, administration, records, storage, destruction, medication errors, response to side effects and adverse reactions, and regular review of psychotropic medications.

Other waiver providers: The waiver provider agency is responsible for ensuring that waiver providers act within the scope of their respective licenses in relation to medication management. If the service plan includes medication management activities, the waiver provider agency documents these activities in the waiver participant's case records. Any errors must be reported to DSHS as critical incidents.

DSHS reviews medication management during on-site and desk reviews. If DSHS identifies any potentially harmful practices during a review, DSHS initiates sanctions as appropriate and follows up with the waiver provider agency to ensure the practice has been corrected. DSHS continues to analyze the utilization of behavior modifying medications.

Second line monitoring is conducted through an ongoing process of retrospective analysis of the Medicaid utilization data by DSHS. The focus of the review varies, but the next review will be to ensure medications are dispensed according to standard methodologies.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

General Residential Operations: The Department of Family and Protective Services conducts inspections and monitors the facilities and reviews for compliance with minimum standards and contract requirements related to medications by assessing clinical records, medication logs and other documentation of medication. Identification of harmful practices are reported to the Department of Family and Protective Services and appropriate corrective actions are taken to bring facilities back into compliance. The

Department of Family and Protective Services also provides technical assistance on meeting and maintaining standards and achieving quality in child care.

Other waiver providers: DSHS conducts surveys and monitors providers for compliance with licensing requirements. When harmful or non-compliant practices are identified, corrective action is taken to bring the facility back into compliance. DSHS includes medication management review as part of its quarterly risk review of contracted waiver provider agencies.

In accordance with 42 CFR Sec. 431.10 (e), the single State Medicaid Agency retains administrative authority over the waiver program. HHSC is actively involved in the development of, and will provide final approval of, the initial waiver prior to submission to CMS. Subsequent amendments, CMS 372 reports, and all state rules for waiver program operations are coordinated with, and approved by, HHSC. Additionally, HHSC is actively involved in the development of the Quality Oversight Plan, which outlines the frequency of each agency's activities. HHSC and DSHS analyze data regarding each assurance through reports presented at Quality Review Team meetings no less than annually, and when potentially harmful practices are identified, develop remediation or improvement plans, as needed. In the case of medication management, it is likely that the remediation plans will involve communication and other technical assistance to waiver provider agencies about issues and trends identified through the quality process.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

For General Residential Operations: The Department of Family and Protective Services minimum standard rules for residential child care facilities are found Title 40 of the Texas Administrative Code, Part 19, Chapters 748 and 749. Minimum standard rules address a wide variety of requirements, including medication requirements. Medication requirements include consent for giving medications, administration, records, storage, destruction, medication errors, response to side effects and adverse reactions, and regular review of psychotropic medications.

If a nurse or physician delegates medication management to unlicensed staff it must be documented in the waiver participant’s case file. DSHS monitors, through annual on-site reviews and waiver provider agency self-reporting, to ensure that unlicensed staff receive training regarding the delegation of medication from the delegating medical professional. The provider must implement written procedures to ensure safe medication service delivery including medication delegation.

For other waiver providers:

• The direct service provider must be qualified under the scope of their licensure to administer medications.
• The parent or legally authorized representative must sign an authorization for the direct service provider to administer each medication according to label directions.
• The medication must be in the original container labeled with the waiver participant's full name and expiration date.
• The direct service provider must administer the medication according to the label directions or as amended

by a physician.
• The direct service provider must administer the medication only to the waiver participant for whom it is intended.
• The direct service provider must not administer the medication after its expiration date.
• The direct service provider may provide non-prescription medications if the waiver provider agency obtains consent from the parent or legally authorized representative prior to administration of the medication. Consent may be given over the phone and documented as such by the respite provider.
• The direct service provider must document the following:
- Full name of the waiver participant to whom the medication was given,
- Name of the medication,
- Date, time, and amount of medication given, and
- Full name of individual provider administering the medication.
• All medication records must be kept for three months after administering the medication.
• All medications must be stored as follows:
- Out of reach of children or in locked storage
- In a manner that does not contaminate food
- Refrigerate if require and kept separate from food
• Unused prescription medications are to be returned to the parent or legally authorized representative.

Self-administration of medications may occur under the supervision of a direct service provider. The provider must ensure:

• The parent or legally authorized representative has signed an authorization for the waiver participant to self-administer each medication according to label directions.
• The medication must be in the original container labeled with the waiver participant's full name and expiration date.
• The waiver participant administers the medication in amounts according to the label directions or as amended by a physician.
• The waiver participant must administer the medication only to him or herself.
• The waiver participant must not administer the medication after its expiration date.
• The waiver participant may provide self-administer non-prescription medications if the direct service provider obtains consent from the parent or legally authorized representative prior to the self-administration of the medication. Consent may be given over the phone and documented as such by the respite provider.
• The direct service provider must document the following:
- Full name of the waiver participant who self-administered the medication,
- Name of the medication,
- Date, time, and amount of medication given, and
- Full name of waiver provider supervising the self-administration of the medication

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

DSHS

(b) Specify the types of medication errors that providers are required to *record:*

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

(c) Specify the types of medication errors that providers must *report* to the State:

Medication given to the wrong waiver participant, giving the waiver participant the wrong medication, giving the incorrect dosage, failing to give the medication at the correct time, failing to use the correct

route, or failing to accurately document the administration of the medication. All medication errors are reported as critical incidents by the waiver provider agencies.

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.

Specify the types of medication errors that providers are required to record:

iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

General Residential Operations: The Department of Family and Protective Services is responsible for monitoring the performance of providers administering medications to waiver participants. The Department of Family and Protective Services staff enforce requirements through regular inspections and investigations at licensed facilities. Every licensed facility receives at least one unannounced inspection annually.

Other waiver providers: DSHS is responsible for monitoring the performance of providers administering medications to waiver participants. DSHS conducts annual on-site chart reviews of all waiver provider agencies. These reviews include medication management and administration. If the review identifies any issues, DSHS completes follow-up remediation in accordance with each waiver provider agencies' corrective action plan.

DSHS staff enforce requirements through quarterly risk assessment and review of critical incidents. The waiver provider agencies are responsible for reporting medication errors to DSHS through the critical incident reporting process. Medication errors are monitored through the DSHS quarterly risk assessment process. The waiver program requires the submission of the Critical Incident Reporting form by the waiver provider agencies within 72 hours of a medication management incident.

In accordance with 42 CFR Sec. 431.10 (e), the single State Medicaid Agency retains administrative authority over the waiver program. HHSC is actively involved in development of, and provides final approval of, the waiver activities prior to submission to CMS. Subsequent amendments, CMS 372 reports and all state rules for waiver program operations are coordinated with and approved by HHSC. Additionally, HHSC is actively involved in the development of the Quality Oversight Plan, which outlines the frequency of each agency's activities. HHSC and DSHS analyze data regarding each assurance through reports presented at Quality Review Team meetings no less than annually, and when potentially harmful practices are identified, develop remediation or improvement plans, as needed. In the case of medication management, it is likely that the remediation plans will involve communication and other technical assistance to waiver provider agencies about issues and trends identified through the quality process.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G.a.1. Number and percent of waiver participants who are free from confirmed abuse, neglect, or exploitation. N: Number of waiver participants who are free from confirmed abuse, neglect, or exploitation. D: Number of waiver participants listed as the victim in a report of abuse, neglect, or exploitation.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.2. Number and percent of waiver participants free from an allegation of abuse, neglect, or exploitation. N: Number of waiver participants without an allegation of abuse, neglect, or exploitation. D: Number of waiver participants enrolled during the review period.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.3. Number and percent of waiver participants who received information on how to report abuse, neglect, or exploitation. N: Number of waiver participants who received information on how to report abuse, neglect, or exploitation. D: Number of waiver participants enrolled during the review period.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified**

		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.4. Number and percent of waiver participants or legally authorized representative informed orally and in writing of the process for filing complaints. N: Number of waiver participants or legally authorized representative that were informed orally and in writing of the process for filing complaints. D: Number of waiver participants enrolled during the review period.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	

		☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.5. Number and percent of waiver participants critical incidents in which waiver provider agencies followed the required process for responding to critical incidents. N: Number of waiver participants critical incidents in which waiver provider agencies followed required process for responding to critical incidents. D: Number of critical incidents found during record review.

Data Source (Select one):

Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
G.a.6. Number and percent of waiver participants' critical incidents that were reported by provider agencies within state required timeframes. N: Number of waiver participants' critical incidents that were reported by provider agencies within state required timeframes. D: Number of critical incidents found during record review.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
DSHS is responsible for overseeing the reporting of and response to critical incidents that affect waiver participants. DSHS reports data from complaints/critical incidents to HHSC on no less than an annual basis.

DSHS Participant Rights Notification form is explained orally by the waiver provider agency case manager to the waiver participant and his or her legally authorized representative. This explanation occurs prior to the waiver participant or legally authorized representative and case manager signing this form. The case manager explains the complaint procedures including a 24-hour, 7 days a week toll-free number and website information for reporting any allegation of abuse, neglect, or exploitation to the Department of Family and Protective Services. The case manager explains the documented process for contacting DSHS Office of Consumer Services and Rights Protection to register a complaint or report an incident, and the HHSC Office of the Ombudsman's telephone number if the waiver participant has problems or complaints about a state agency health and human service or program. All waiver participants and legally authorized representatives acknowledge receipt of the DSHS Handbook of Consumer Rights, and Mental Health Services. Information is provided by the case manager orally regarding how to request a Medicaid fair hearing, which is also provided in the handbook.

The waiver requires a review of each waiver participant's service plan every 90 days, and recommends monthly wraparound team meetings in order to ensure that the waiver participant's safety and crisis plans continue to be effective. The case manager is responsible for determining if any existing situations jeopardize the waiver participant's health and welfare. Revisions to the safety and crisis plans may be made at any time by the wraparound team or the case manager to ensure the health and safety of the waiver participant. If there is a revision to the service plan, it must be submitted to DSHS for approval with reasons for the change documented. The case manager must document in the individual's clinical record that the plan was effective or that revisions were required.

Waiver provider agencies must develop, implement, and enforce a written policy that includes, at a minimum, DSHS child abuse screening, documenting, and reporting policy for contractors/providers and train all direct service staff on reporting requirements.

An allegation of abuse, neglect, or exploitation must be reported to the Department of Family and Protective Services immediately and within one business day after the allegation, a Client Abuse and Neglect Reporting form is submitted to the Department of Family and Protective Services. The waiver provider agency must report allegations of abuse, neglect, and exploitation to the waiver program staff within 72 hours of the incident. This documentation at a minimum includes date of contact, the name of the individual on whose behalf the report is being made, a brief synopsis of allegations, and the name of the Department of Family and Protective Services employee taking the report. The Department of Family and Protective Services sends provider agencies copies of each investigation outcome involving an individual enrolled in the Youth Empowerment Services waiver. The waiver provider agency must retain reporting documentation on site and make it available for inspection by DSHS when requested.

All contacts related to reporting of suspected abuse, neglect and exploitation must be documented by all direct service staff. This documentation, at a minimum, shall include date of contact, the name of the waiver participant on whose behalf the report is being made, a brief synopsis of allegations, and the name of the Department of Family Protective Services employee taking the report.

Critical incidents related to abuse, neglect, and exploitation are also reported to Child Protective Services at the Department of Family and Protective Services if a parent is involved. These incidents are reported to law enforcement if the alleged perpetrator is not a parent. Depending on the severity of the allegation,

Department of Family and Protective Services investigations must be completed within 14 to 21 days. Investigation results are provided to the participant or legally authorized representative in writing no later than 15 days after the investigation is closed by the supervisor.

The director of the waiver provider agency may not change a confirmed finding made by a Department of Family and Protective Services investigator. The director may request a review of the finding or the methodology used to conduct the investigation.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
If the State discovers that a waiver participant or legally authorized representative was not informed of how to report allegations of abuse, neglect, or exploitation or other complaints, the waiver provider agency is required to provide the waiver participant or legally authorized representative with appropriate educational material. The waiver provider agency may also be subject to various remedies which may include communicating with the waiver provider agency directly and requiring corrective actions to be completed when appropriate.

If the State discovers that waiver provider agencies have not followed the contractually required process for reporting and responding to critical incidents, the waiver provider agency is subject to various remedies which may include DSHS communicating with the waiver provider agency, requiring corrective actions to be completed when appropriate, freezing enrollment into the waiver provider agency, and termination of the waiver provider agency's contract. If a corrective action is required, DSHS will monitor the waiver provider agency less than quarterly to ensure change in system occurs. All remedies are accompanied by the requirement that the waiver provider agency will resolve the complaint.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

YES waiver system improvement begins with the collection and analysis of data on system performance. System performance data is compiled in the YES waiver performance data book, which enables staff to effectively track and trend system performance and analyze discovery and remediation processes. This performance data book includes measures identified within the waiver application, and also includes other quality and performance information on provider networks and subcontractors, inquiry lists, service plans, waiver participant-level service encounter data (both waiver and select state plan services), billing, clinical assessment data, hospitalization rates, complaints, appeals and Medicaid fair hearings, abuse, neglect, and exploitation, adverse incidents, and waiver participant and/or family satisfaction.

The YES waiver data book is updated monthly and posted online quarterly, and is distributed by means of email to relevant staff at DSHS, HHSC, the local mental health authorities, and key stakeholders for review and comment. The purpose of this data is to have an easy to interpret, updateable, and comprehensive monitoring tool with data tables and graphs to regularly keep staff and stakeholders informed on the progress of the program, maintain transparency on measures that are being tracked and trended, and to solicit feedback on possible new measures or ideas for system improvements or course corrections.

Beginning in January 2011, a standing interagency quality workgroup consisting of DSHS YES program staff, DSHS senior policy analyst, DSHS Medicaid Coordinator, HHSC staff from the Long-Term Services and Supports unit, HHSC policy analyst from Office of Health Services, and other ad hoc members such as the DSHS Consumer Service Rights and Protections staff, convened to review performance data that will be tracked in the data book. This standing work group meets at least semiannually, and documentation of meetings will be maintained so that there is an ongoing history of discussions, ideas, proposed interventions, and evaluations of attempted system improvements that are generated by the workgroup. Interventions proposed by the workgroup or corrective action plans required by remediation processes are monitored by the YES program staff and their progress is reported back through the performance data book and to the workgroup and stakeholders for review. HHSC staff are ultimately responsible for ensuring system improvements are implemented.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The process employed by the workgroup for monitoring and analyzing the effectiveness of the program, and any system changes consists of a cyclical process of establishments of benchmarks for levels of performance, collection/tracking of relevant data, data/report sharing with key staff and stakeholders, determinations of interventions if data indicates the need, measurement of the effectiveness of the interventions, and continued tracking of data. These benchmarks drive system improvement activities by drawing attention to areas that fall below anticipated performance levels. Note that all deviations from expected performance are expected to be remediated to 100 percent and that the benchmarks are intended to drive system improvement rather than remediation activities.

The YES program data book is populated on a monthly basis. This data book is shared by staff on the interagency quality workgroup as well as the local mental health authorities and YES waiver provider agencies. Interventions that are proposed by the workgroup or corrective action plans required by remediation processes will be monitored by YES waiver program staff and progress will be reported back through the performance data book to the workgroup and stakeholders for review. Identified issues continue to be monitored by YES waiver program staff through follow-up site reviews, desk reviews (as needed), other consultation and the interagency quality workgroup, until there is a general consensus by the workgroup that the data demonstrates that the requisite improvement has been achieved. HHSC staff are ultimately responsible for ensuring system improvements are implemented.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

DSHS and HHSC monitor how the workgroup is structured and how frequently it meets to ensure that its composition is such that it represents a cross section of staff and professionals at various levels of involvement with the YES program (policy, day-to-day operations, staff in the field, waiver participants, etc.). The YES waiver data book is also reviewed periodically for relevance by the YES waiver program staff and the interagency quality workgroup. If certain measures are determined by the group as no longer relevant or meaningful, they can be discontinued and new measures can be introduced as warranted. Additionally, benchmarks for systems improvements are also revised as needed. At least annually, the overall structure of the workgroup, the activities performed by the workgroup, and the data reviewed by the workgroup will be evaluated for relevance and effectiveness.

If other commitments by the standing members of the workgroup prohibit meaningful engagement or substantive contributions to the evaluation and review process, new membership can be solicited. It is important to recognize that while the workgroup convenes at least semiannually, the performance data book is published and distributed at least quarterly. It is this regular distribution of the data that stimulates interaction among workgroup members and stakeholders between regularly scheduled meetings and maintain an ongoing dialogue about the program's performance.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The waiver program staff's annual on-site review of the waiver provider agencies compares the billed services to the services documented in the individual's case record. The waiver program staff verifies that billings submitted to and paid by DSHS are for billable time and activities. DSHS reviews all billings to ensure that they are properly supported by documentation of the actual provision of waiver services. DSHS staff reviews a sample of service plans to verify that financial eligibility has been met and that any applicable service and cost limitations have not been exceeded. Additionally, annual audit reports from the waiver provider agencies are received by DSHS no later than the February following the close of each state fiscal year. In addition to measuring fiduciary compliance, the audit reports are used to assure fund expenditures and reconcile fund balances.

Independent audits ensure fiduciary compliance, propriety of and support for fund expenditures, and accurate and timely reconciliation of fund balances. The State requires each waiver provider agencies to obtain an independent

audit at least annually and submit the completed audit to DSHS.

Only those costs allowable under Texas' Uniform Grants Management Standards (UGMS) are allowable costs under the waiver. Applicable cost principles, audit requirements, and administrative requirements include:
Applicable Cost Principles - OMB Circular A-87, State, Local & Tribal Governments
Audit Requirements - OMB Circular A-133 and UGMS
Administrative Requirements - UGMS.

The provider shall obtain a comprehensive financial and compliance audit for the previous state fiscal year. The provider will submit four copies of the audit to DSHS and one copy to the Office of the Inspector General, Single Audit, HHSC, Office of Inspector General, Compliance / Audit, mail Code 1326, P.O. Box 85200, Austin, TX 78708. The provider will not engage the same audit firm for more than 6 consecutive years.

The State Auditor's Office conducts periodic independent audits of the waiver program under the provisions of the Single Audit Act. The Office of Inspector General is responsible for performing audits on contracts between DSHS and providers.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*
   i. **Sub-Assurances:**

      a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
I.a.1. Number and percent of claims that were paid in accordance with the state's reimbursement methodology. N: Number of claims that were paid in accordance with the state's reimbursement methodology. D: Number of claims.

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
I.a.2. Number and percent of waiver service claims reviewed that were submitted for participants who were enrolled in the waiver the date the service was delivered. N: Number of waiver service claims reviewed that were submitted for participants who were enrolled in the waiver the date the service was delivered. D: Number of service claims.

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

Performance Measure:
I.3. Number and percent of service encounters billed at approved rates. N: Number and percent of service encounters billed at approved rates. D: Number of encounters billed.

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
DSHS contracts with waiver provider agencies to deliver services across Texas.

Local mental health authorities are non profit governmental entities and as such are required to have annual independent audits by external qualified firms to ensure fiduciary compliance, propriety of and support for fund expenditures, and accurate and timely reconciliation of fund balances. Verification of internal controls is an integral part of the audits. Other waiver provider agencies are also required to obtain an independent audit at least annually and submit to DSHS.

Annual audit reports are received by DSHS no later than the February following the close of each state fiscal year. In addition to measuring fiduciary compliance, the audit reports are used to assure fund expenditures and reconcile fund balances.

The DSHS' Contract Oversight Unit reviews quarterly local mental health authority financial statements. The DSHS' Contract Quality Management Unit does quarterly risk assessments and issues quarterly Risk Assessment Reports. If Quality Management identifies problems of service delivery and billing, onsite reviews are conducted to evaluate billing and internal controls.

DSHS uses a the Medicaid Claims Oversight Review and Evaluation (Medicaid CORE) section of the Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW) to review every paid claim by Mental Health Medicaid providers.

Providers are required to monitor Medicaid Claims Oversight Review and Evaluation reports that indicate paid claims without authorizations, as well as claims that do not have supporting encounters in Mental Retardation and Behavioral Health Outpatient Warehouse. Providers are required to repay any identified overpayment; DSHS conducts yearly recoupment of any identified overpayments that are not repaid. DSHS will perform desk reviews of samples from those claims identified as paid correctly.

DSHS conducts annual reviews of reported service encounters to verify the validity of the service. Encounters are linked to paid claims and any identified invalid services are expected to be repaid by the providers. These data verification reviews include verification of diagnosis, treatment plan, medical necessity, server credentials, as well as service documentation.

DSHS reviews all waiver provider agencies billing invoices within five business days after receipt to ensure all required information is provided and that the amount requested is within approved limits of the service plan. DSHS staff make additional inquires until a complete invoice is received and approved. The invoice review includes:
Verifying the individual's eligibility for waiver services on the date of service delivery. Waiver services provided outside of the eligibility period will not be reimbursed.
Comparing the invoice to each individual's approved service plan and applicable service and cost limits within the waiver. Services that are not on the service plan and or exceed the limits approved by DSHS will not be reimbursed.

DSHS, on behalf of the Texas Health and Human Services Commission and Medicaid, provides payment for waiver services to a waiver provider agency within 30 days of receiving a complete invoice and in accordance with the terms of the provider agreement and the current YES reimbursement rates.
The waiver provider agency is required to maintain documentation of service provision for each invoiced amount in the individual's clinical record. DSHS may access the individual's clinical record at any time to compare invoiced amounts with documentation of service provision.
The waiver program staff's annual on-site review of the waiver provider agencies compares the billed services to the services documented in the individual's case record. The waiver program staff verifies that billings submitted to and paid by DSHS are for billable time and activities. DSHS staff reviews a sample of service plans to verify that financial eligibility has been met and that any applicable service and cost limitations have not been exceeded. Additionally, annual audit reports from the waiver provider agencies are received by DSHS no later than the February following the close of each state fiscal year. In addition to measuring fiduciary compliance, the audit reports are used to assure fund expenditures and reconcile fund balances.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Individual problems may be discovered during monitoring activities by the State or any of the entities that have been delegated certain functions within the performance measures of this appendix. The options for remediation are listed below:

If HHSC determines that claims were not paid in accordance with the state's reimbursement methodology HHSC will require DSHS to take corrective action within five business days. HHSC will notify DSHS in writing of specific area(s) of the DSHS performance that fail to meet performance expectations, standards, or schedules set forth in the Directive between DSHS, HHSC or the YES waiver documents. DSHS will, within 10 business days (or another date approved by HHSC) of receipt of written notice, provide HHSC with a written response that explains the reasons for the deficiency, outlines the DSHS' plan to address or cure the deficiency, and states the date by which the deficiency will be cured. If DSHS disagrees with HHSC's findings, this written response will state the reasons for disagreement with HHSC's findings. DSHS' proposed cure of a deficiency is subject to approval by HHSC.

At its option, HHSC may require DSHS to submit to HHSC a written plan to correct or resolve any noncompliance with the Directive between the two agencies. The corrective action plan must provide a detailed explanation of the reasons for the cited deficiency; DSHS' assessment or diagnosis of the cause; and a specific proposal to cure or resolve the deficiency (including the date by which the deficiency will be

cured).

The corrective action plan must be submitted by the deadline set forth in HHSC's request for a corrective action plan. The corrective action plan is subject to approval by HHSC.

If the State discovers that a payment was made to a waiver provider agency for a non-eligible individual or for services that were not in the service plan, the State recoups the funds from the waiver provider agency. At the end of the month in which the waiver participant becomes ineligible, the waiver participant is removed from the program, considered for other available services, and provided with information on how to request a fair hearing.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annual

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Texas Health and Human Services Commission (HHSC), the State Medicaid Agency, determines payment rates at a minimum of every two years. Payment rates are determined for each service. The rates for services are prospective and uniform statewide. HHSC determines payment rates after analysis of financial and statistical information, and the effect of the payment rates on achievement of program objectives, including economic conditions and budgetary considerations.

Texas will use existing service rate methodologies from other HCBS waivers to set service rates for the YES Waiver. The rates for the YES Waiver are available on the Rate Analysis webpage located at http://www.hhsc.state.tx.us/rad/long-term-svcs/yes/index.shtml.

HHSC models the rates for the following services from other Medicaid HCBS waiver programs that use cost reports to determine rates: respite in the waiver participant's home or place of residence or the private residence of a respite care provider; respite in a foster home verified by a Texas Department of Family and Protective Services licensed child placing agency; respite in a general residential operation licensed by the Department of Family and Protective Services; respite in a day or overnight camp accredited by the American Camping Association or licensed by DSHS; respite in a child care center or home licensed by the Department of Family and Protective Services or a child care home registered with the Department of Family and Protective Services; family supports; paraprofessional services; specialized therapies; and supportive family-based alternatives, supported employment; and employment assistance.

Providers of these services are required to submit annual cost reports to HHSC. Providers are responsible for eliminating all unallowable expenses from the cost report prior to submission of the cost report. The HHSC Office of Inspector General reviews all cost reports and a sample of cost reports are audited on-site. The Office of Inspector General removes any unallowable costs and corrects any errors detected on the cost report in the course of the review or on-site audit. Audited cost reports are used in the determination of statewide prospective rates.

In general, recommended unit of service rates for each service are determined as follows: 1) total allowable costs for each provider are determined from the audited cost report; 2) each providers total allowable costs are projected from the historical cost reporting period to the prospective reimbursement period; 3) payroll taxes and benefits are allocated to each salary item; 4) total projected allowable costs are divided by the number of units of service to determine the projected cost per unit of service; 5) the allowable costs per unit of service for each contracted provider are arrayed and weighted by the number of units of service and the median cost per unit of service is calculated; and 6) the median cost per unit of service for each waiver service is multiplied by 1.044.

When comparable services do not exist, reimbursement rates are determined using a pro forma approach. This approach involves using historical costs of delivering similar services, where appropriate data are available, and estimating the basic types and costs of products and services necessary to deliver services meeting federal and state requirements to set waiver rates. HHSC models rates as specified below.

Adaptive aids and supports and minor home modification are paid at cost. Providers are given additional payments for the cost of acquiring adaptive aids and supports and minor home modifications for waiver participants; these payments are called requisition fees. The rates for the requisition fees are determined by modeling the estimated time required for staff to conduct the assessment of the need for the service, purchase the item, and complete any necessary follow-up.

The rates for community living supports (CLS) are determined by modeling the salary for a Qualified Mental Health Provider-Community Services (QMHP-CS) staff position. This rate is updated periodically for inflation.

Non-medical transportation is paid at the rate set by the Texas Comptroller of Public Accounts.

The rate for transitional services is a one-time payment for the procurement of items and services the waiver participant needs to move from an institution, a provider-operated setting, or family home to their own private community residence. The rate is determined by modeling the estimated salary for a person with the necessary skills and training, and the estimated time spent with the waiver participant and procuring the necessary goods and services. The salary and time estimates were based upon the experience of providers delivering similar services under a different program. This rate is updated periodically for inflation.

HHSC holds a public hearing before it approves rates. The purpose of the hearing is to give interested parties an opportunity to comment on the proposed rates. Notice of the hearing is provided to the public. The notice of the public hearing includes information about the proposed rate changes and identifies the name, address, and telephone number of the staff member to contact for the materials pertinent to the proposed rates. At least ten working days before the public hearing takes place, material pertinent to the proposed statewide uniform rates is made available to the public. The public may present comments at the hearing or submit written comments regarding the proposed rates. Information about payment rates is made available to waiver participants through HHSC and DADS websites as well as through the Texas Register via a public notice.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Provider billings will flow directly from providers to DSHS and will not be routed through intermediaries. DSHS will review the billings in relation to waiver requirements and authorize payment through the state's accounting system. DSHS will submit data to HHSC for draw-down of the federal share.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The providers submit an invoice, either through secure email or traditional mail, to DSHS staff responsible for the implementation and oversight of the waiver. DSHS staff review to ensure all required information has been sent with the invoice and that the amount requested is within expected parameters. Any anomalies require the DSHS staff to make additional inquires until the issue is resolved. (a) The DSHS review of the invoice includes verifying the waiver participant's eligibility for waiver services on the date of service delivery. Waiver services provided outside of waiver eligibility are not reimbursed. (b) The DSHS review of the invoice compares each invoice to each waiver participant's approved plan of care and within the limits of the waiver. Services that are not on the plan of care and or exceed the limits approved by DSHS are not reimbursed. (c) DSHS' annual review of the waiver provider agency will compare the billed services to the services documented in the waiver participant's case

record. DSHS will also conduct interviews with some of the waiver participants to verify satisfaction with waiver services and verify the delivery of services.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- ○ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ○ **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ◉ **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

  DSHS pays waiver provider agencies directly for waiver services through an interagency agreement with HHSC.

  The State has not begun processing waiver claims through the MMIS system. Because of the system changes that must be implemented for this waiver, and the additional changes being made to the State's claims processing system for other programs, the State needs sufficient time to make system changes and test and implement these changes. The State has performed preliminary analysis and is the process of developing the criteria for the YES waiver to be able to process payments to MMIS.

  The State plans to process waiver claims through MMIS in a manner similar to that used for other Texas 1915 (c) waivers. Texas will use its Clinical Management for Behavioral Health Services (CMBHS) system, an automated clinical record system for mental health and substance abuse services to collect and review information about waiver clients, including service plan, level of care, and eligibility information. YES waiver provider agencies will submit claims to CMBHS. CMBHS will check the claim information against the service authorization and eligibility information, and send all claims information to Texas Medicaid and Healthcare Partnership for loading into MMIS and for federal reporting purposes. Texas Medicaid and Healthcare Partnership is a state-contracted Medicaid claims system.

- ○ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- ☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☐ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- ☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- ☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- ◉ **No. The State does not make supplemental or enhanced payments for waiver services.**
- ○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- (●) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ( ) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ( ) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- (●) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ( ) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- [ ] **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

Check each that applies:

- [ ] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

  Check each that applies:
  - [ ] **Health care-related taxes or fees**
  - [ ] **Provider-related donations**
  - [ ] **Federal funds**

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- ( ) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- (●) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Individuals in the YES waiver live in their own homes. Payment of the cost of room and board is the responsibility of the individual except when the individual is receiving out-of-home respite services under the waiver. Room and board is included in the rate for out-of-home respite services.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. **Co-Payment Requirements.**

ii. **Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. **Co-Payment Requirements.**

iii. **Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. **Co-Payment Requirements.**

iv. **Cumulative Maximum Charges.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. **Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Hospital

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	3172.60	15213.00	18385.60	38700.64	13085.51	51786.15	33400.55
2	2155.81	15852.00	18007.81	40326.07	13636.15	53962.22	35954.41
3	2260.72	16518.00	18778.72	42019.76	14208.86	56228.62	37449.90
4	3587.08	17212.00	20799.08	43784.59	14805.64	58590.23	37791.15
5	3771.56	17935.00	21706.56	45623.54	15427.47	61051.01	39344.45

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)		
		Level of Care:		
		Hospital		
Year 1	400		400	
Year 2	800		800	
Year 3	800		800	
Year 4	800		800	
Year 5	800		800	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The calculation of average length of stay for Year 1 of the waiver renewal is based on the average length of stay for waiver participants during Year 1 of the waiver pilot. It is assumed that length of stay will remain consistent and will not increase or decrease as a result of any of the expected changes to the waiver.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D estimates were established utilizing data from Year 1 of the waiver pilot. Estimates for years 1-5 of waiver renewal were calculated by applying the August 2012 Medical Consumer Price Index (4.2 percent) published by the U.S. Department of Labor, Bureau of Labor Statistics. This inflation factor was applied to Year 1 to determine estimates for years 2-3 of the waiver pilot. The inflation factor was then applied yearly to years 1-5 of the waiver renewal.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

For purposes of estimating the annual per capita Medicaid expenditures for all other services provided to waiver participants data from Year 1 of the waiver pilot was used. Estimates for years 1-5 of waiver renewal were calculated by applying the August 2012 Medical Consumer Price Index (4.2 percent) published by the U.S. Department of Labor, Bureau of Labor Statistics. This inflation factor was applied to Year 1 to determine estimates for years 2-3 of the waiver pilot. The inflation factor was then applied yearly to years 1-5 of the waiver renewal. No additional services were included or excluded from these calculations that were not included/excluded in the original Factor D' derivations from the original waiver application.

When the D' value is derived, data from Year 1 of the current waiver application was used. Because no Year 1 waiver participants were dual eligibles, prescribed drugs furnished to dual eligibles were not included in Factor D' estimate.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

For purposes of estimating the annual average per capita Medicaid expenditures for inpatient psychiatric hospital care that would be incurred for waiver participants, were the waiver not granted data from the original Factor G estimates was used and inflated yearly by applying the August 2012 Medical Consumer Price Index (4.2 percent) published by the U.S. Department of Labor, Bureau of Labor Statistics. The

original data used was initially calculated by obtaining institutional Medicaid expenditure data for any Medicaid enrolled child who had an inpatient psychiatric stay for the state fiscal year ending August 31, 2005 from the TMHP.
Using this data, Factor G was estimated for the target population by identifying all Medicaid inpatient psychiatric expenditures in SFY 2005 for each target population child. Inpatient psychiatric stays were identified as those inpatient stays where the primary diagnosis for the patient was '290' to '31499'.
To calculate Factor G, these expenditures were totaled and then divided them by the unduplicated number of Medicaid enrollees in the target population to estimate the average annual inpatient psychiatric expenditures per person for SFY 2005.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' estimates were calculated using Factor G' data from the original waiver application which were then inflated yearly by applying the August 2012 Medical Consumer Price Index (4.2 percent) published by the U.S. Department of Labor, Bureau of Labor Statistics. Original G' data was based on historical utilization of all Medicaid services other than inpatient psychiatric institutional services by children with three or more inpatient psychiatric stays in State Fiscal Year 2005. It includes expenditures for other Medicaid services those children received while in inpatient psychiatric hospitals and other Medicaid services received when those children were not in inpatient psychiatric hospitals. Without the waiver, it is assumed that the children would experience multiple inpatient stays during the year, but would likely not be in a psychiatric institution for the entire year. G' does not include inpatient psychiatric costs since these costs are already included in factor G. Accordingly, the YES waiver Factor G' estimate includes all Medicaid services, other than institutional services, for Medicaid children with three or more acute inpatient psychiatric stays in State Fiscal Year 2005.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Respite	
Supported Employment	
Adaptive Aids and Supports	
Community Living Supports (CLS)	
Employment Assistance	
Family Supports	
Minor Home Modifications	
Non-Medical Transportation	
Paraprofessional Services	
Specialized Therapies	
Supportive Family-based Alternatives	
Transitional Services	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						**147818.16**
Respite	Day	200	8.34	88.62	**147818.16**	
Supported Employment Total:						**0.00**
Supported Employment	Hour	0	0.00	0.01	**0.00**	
Adaptive Aids and Supports Total:						**99600.00**
Adaptive Aids and Supports	Per Item	400	0.83	300.00	**99600.00**	
Community Living Supports (CLS) Total:						**284847.84**
Community Living Supports (CLS)	Hour	400	21.27	33.48	**284847.84**	
Employment Assistance Total:						**0.00**
Employment Assistance	Hour	0	0.00	0.01	**0.00**	
Family Supports Total:						**79439.36**
Family Supports	Hour	400	10.01	19.84	**79439.36**	
Minor Home Modifications Total:						**41500.00**
Minor Home Modifications	Per item	200	0.83	250.00	**41500.00**	
Non-Medical Transportation Total:						**34434.40**
Non-Medical Transportation	Trip	100	20.02	17.20	**34434.40**	
Paraprofessional Services Total:						**65185.12**
Paraprofessional Services	Hour	400	10.01	16.28	**65185.12**	
Specialized Therapies Total:						**154880.00**
Wrap-around - Professional	Hour	400	5.00	77.44	**154880.00**	
Supportive Family-based Alternatives Total:						**247211.61**
Supportive Family-based Alternatives	Day	24	75.06	137.23	**247211.61**	
Transitional Services Total:						**114125.00**
Transitional Services	Transition	55	0.83	2500.00	**114125.00**	
				GRAND TOTAL:		**1269041.49**
				Total Estimated Unduplicated Participants:		**400**
				Factor D (Divide total by number of participants):		**3172.60**
				Average Length of Stay on the Waiver:		146

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						**184680.00**
Respite	Day	400	5.00	92.34	**184680.00**	
Supported Employment Total:						**4796.88**
Supported Employment	Hour	23	8.00	26.07	**4796.88**	
Adaptive Aids and Supports Total:						**250080.00**
Adaptive Aids and Supports	Per Item	800	1.00	312.60	**250080.00**	
Community Living Supports (CLS) Total:						**355878.00**
Community Living Supports (CLS)	Hour	800	12.75	34.89	**355878.00**	
Employment Assistance Total:						**8994.15**
Employment Assistance	Hour	23	15.00	26.07	**8994.15**	
Family Supports Total:						**99216.00**
Family Supports	Hour	800	6.00	20.67	**99216.00**	
Minor Home Modifications Total:						**52100.00**
Minor Home Modifications	Per item	400	0.50	260.50	**52100.00**	
Non-Medical Transportation Total:						**43008.00**
Non-Medical Transportation	Trip	200	12.00	17.92	**43008.00**	
Paraprofessional Services Total:						**81408.00**
Paraprofessional Services	Hour	800	6.00	16.96	**81408.00**	
Specialized Therapies Total:						**193656.00**
Wrap-around - Professional					**193656.00**	
				GRAND TOTAL:		**1724647.93**
				Total Estimated Unduplicated Participants:		**800**
				Factor D (Divide total by number of participants):		**2155.81**
				Average Length of Stay on the Waiver:		146

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Hour	800	3.00	80.69		
Supportive Family-based Alternatives Total:						**308858.40**
Supportive Family-based Alternatives	Day	48	45.00	142.99	**308858.40**	
Transitional Services Total:						**141972.50**
Transitional Services	Transition	109	0.50	2605.00	**141972.50**	
			GRAND TOTAL:			**1724647.93**
			Total Estimated Unduplicated Participants:			**800**
			Factor D (Divide total by number of participants):			**2155.81**
			Average Length of Stay on the Waiver:			146

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						**320989.92**
Respite	Day	400	8.34	96.22	**320989.92**	
Supported Employment Total:						**9593.76**
Supported Employment	Hour	46	8.00	26.07	**9593.76**	
Adaptive Aids and Supports Total:						**130292.00**
Adaptive Aids and Supports	Per Item	800	0.50	325.73	**130292.00**	
Community Living Supports (CLS) Total:						**370770.00**
Community Living Supports (CLS)	Hour	800	12.75	36.35	**370770.00**	
Employment Assistance Total:						**17988.30**
Employment Assistance	Hour	46	15.00	26.07	**17988.30**	
Family Supports Total:						**103392.00**
			GRAND TOTAL:			**1808577.32**
			Total Estimated Unduplicated Participants:			**800**
			Factor D (Divide total by number of participants):			**2260.72**
			Average Length of Stay on the Waiver:			146

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family Supports	Hour	800	6.00	21.54	103392.00	
Minor Home Modifications Total:						54288.00
Minor Home Modifications	Per item	400	0.50	271.44	54288.00	
Non-Medical Transportation Total:						44832.00
Non-Medical Transportation	Trip	200	12.00	18.68	44832.00	
Paraprofessional Services Total:						84864.00
Paraprofessional Services	Hour	800	6.00	17.68	84864.00	
Specialized Therapies Total:						201792.00
Wrap-around - Professional	Hour	800	3.00	84.08	201792.00	
Supportive Family-based Alternatives Total:						321840.00
Supportive Family-based Alternatives	Day	48	45.00	149.00	321840.00	
Transitional Services Total:						147935.35
Transitional Services	Transition	109	0.50	2714.41	147935.34	
				GRAND TOTAL:		1808577.32
				Total Estimated Unduplicated Participants:		800
				Factor D (Divide total by number of participants):		2260.72
				Average Length of Stay on the Waiver:		146

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						334467.36
Respite	Day	400	8.34	100.26	334467.36	
Supported Employment Total:						9593.76
				GRAND TOTAL:		2869660.73
				Total Estimated Unduplicated Participants:		800
				Factor D (Divide total by number of participants):		3587.08
				Average Length of Stay on the Waiver:		146

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment	Hour	46	8.00	26.07	9593.76	
Adaptive Aids and Supports Total:						225368.24
Adaptive Aids and Supports	Per Item	800	0.83	339.41	225368.24	
Community Living Supports (CLS) Total:						644566.08
Community Living Supports (CLS)	Hour	800	21.27	37.88	644566.08	
Employment Assistance Total:						17988.30
Employment Assistance	Hour	46	15.00	26.07	17988.30	
Family Supports Total:						179779.60
Family Supports	Hour	800	10.01	22.45	179779.60	
Minor Home Modifications Total:						93902.88
Minor Home Modifications	Per item	400	0.83	282.84	93902.88	
Non-Medical Transportation Total:						77917.84
Non-Medical Transportation	Trip	200	20.02	19.46	77917.84	
Paraprofessional Services Total:						147507.36
Paraprofessional Services	Hour	800	10.01	18.42	147507.36	
Specialized Therapies Total:						350440.00
Wrap-around - Professional	Hour	800	5.00	87.61	350440.00	
Supportive Family-based Alternatives Total:						559383.15
Supportive Family-based Alternatives	Day	48	75.06	155.26	559383.15	
Transitional Services Total:						228746.16
Transitional Services	Transition	109	0.83	2528.42	228746.16	
GRAND TOTAL:						2869660.73
Total Estimated Unduplicated Participants:						800
Factor D (Divide total by number of participants):						3587.08
Average Length of Stay on the Waiver:						146

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and

Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						**348511.92**
Respite	Day	400	8.34	104.47	**348511.92**	
Supported Employment Total:						**9593.76**
Supported Employment	Hour	46	8.00	26.07	**9593.76**	
Adaptive Aids and Supports Total:						**234836.88**
Adaptive Aids and Supports	Per Item	800	0.83	353.67	**234836.88**	
Community Living Supports (CLS) Total:						**671621.52**
Community Living Supports (CLS)	Hour	800	21.27	39.47	**671621.52**	
Employment Assistance Total:						**17988.30**
Employment Assistance	Hour	46	15.00	26.07	**17988.30**	
Family Supports Total:						**187307.12**
Family Supports	Hour	800	10.01	23.39	**187307.12**	
Minor Home Modifications Total:						**97847.04**
Minor Home Modifications	Per item	400	0.83	294.72	**97847.04**	
Non-Medical Transportation Total:						**81201.12**
Non-Medical Transportation	Trip	200	20.02	20.28	**81201.12**	
Paraprofessional Services Total:						**153673.52**
Paraprofessional Services	Hour	800	10.01	19.19	**153673.52**	
Specialized Therapies Total:						**365160.00**
Wrap-around - Professional	Hour	800	5.00	91.29	**365160.00**	
Supportive Family-based Alternatives Total:						**582873.93**
Supportive Family-based Alternatives	Day	48	75.06	161.78	**582873.93**	
Transitional Services Total:						**266634.09**

GRAND TOTAL:	**3017249.20**
Total Estimated Unduplicated Participants:	**800**
Factor D (Divide total by number of participants):	**3771.56**
Average Length of Stay on the Waiver:	146

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transitional Services	Transition	109	0.83	2947.21	266634.09	
				GRAND TOTAL:		3017249.20
				Total Estimated Unduplicated Participants:		800
				Factor D (Divide total by number of participants):		3771.56
				Average Length of Stay on the Waiver:		146