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:
Community Living Assistance and Support Services (CLASS)

C. Waiver Number: TX.0221
Original Base Waiver Number: TX.0221.

D. Amendment Number: TX.0221.R04.01

E. Proposed Effective Date: *(mm/dd/yy)*

09/01/09

Approved Effective Date: 09/01/09
Approved Effective Date of Waiver being Amended: 09/01/09

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
Allow individuals to participate in Medicaid Buy-In Option
Update Unduplicated Count of Participants in B-3-a
Update Appendix J
Update rates for services
Revise the comparison population

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

☐ **Appendix A – Waiver Administration and Operation**	
☑ **Appendix B – Participant Access and Eligibility**	B-3-a & B-4
☐ **Appendix C – Participant Services**	
☐ **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**	
☑ **Appendix J – Cost-Neutrality Demonstration**	J-1 & 2

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:

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*):
Community Living Assistance and Support Services (CLASS)

C. Type of Request: amendment

Original Base Waiver Number: TX.0221
Waiver Number: TX.0221.R04.01
Draft ID: TX.33.04.01

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

E. Proposed Effective Date of Waiver being Amended: 09/01/09
Approved Effective Date of Waiver being Amended: 09/01/09

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**

- [x] **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

  If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:
  Level of Care VIII - Persons with Related Conditions

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:

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 Community Living Assistance and Support Services (CLASS) Program, first authorized September 1, 1991, provides services and supports to individuals with related conditions living in their own homes or with their families. The goal of CLASS program is to provide individuals with meaningful choices regarding long term care services. This goal will be accomplished primarily by facilitating the development and utilization of services which allow individuals to avoid institutional placement. Services and supports are intended to enhance an individual's quality of life, functional independence, and health and welfare, and to supplement, rather than replace, existing informal or formal supports and resources.

The Department of Aging and Disability Services (DADS) is the operating agency administering the CLASS waiver. The Health and Human Service Commission (HHSC), the single State Medicaid agency, supervises administration of the waiver and promulgates policies and rules related to the waiver.

HHSC directly performs financial eligibility determinations for prospective enrollees, develops the reimbursement rate methodology and sets reimbursement rates, and conducts Medicaid Fair Hearings in accordance with 42 CFR §431 Subpart E, and as described in 1 Texas Administrative Code Part 15, Chapter 357, Subchapter A (relating to Medicaid Fair Hearings).

HHSC delegates to DADS routine functions necessary for the operation of the waiver. These functions include managing waiver enrollment against approved limits; monitoring waiver expenditures against approved levels; conducting level of care evaluation activities and authorizing levels of care. Additionally, DADS authorizes the individual service plan and conducts utilization management. DADS enrolls providers and executes the Medicaid provider agreements; conducts training and technical assistance concerning waiver requirements; and performs quality management functions.

CLASS services are provided using contracted providers. The case management agency provides only case management services that include coordinating the development of the individual's service plan; informing the individual of the service delivery options (consumer directed services option and provider managed services option) and assisting the individual in accessing non-waiver services. If the individual chooses the consumer directed services option, a consumer directed services agency provides financial management services and may provide support consultation. A direct service agency, licensed as a Home and Community Support Services Agency, provides all other services. When notified of their release from the CLASS Interest List, applicants choose a case management agency and direct service agency to complete their enrollment. DADS does not provide CLASS waiver services to individuals who are inpatients of a hospital, nursing facility, or Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR). CLASS waiver services are available statewide.

The direct service agency completes assessments to establish a level of care for CLASS waiver services. DADS reviews that information to authorize the level of care. After all requirements for eligibility are met, and at least annually thereafter, the case manager, the applicant or individual, direct service agency representative(s), and other persons requested by the individual or the individual's legally authorized representative, develop a person-centered individual service plan that addresses the individual's needs. The process emphasizes the provision of supports and services necessary to maintain successful integration in the community. The service plan describes the waiver services to be furnished, their frequency, and the type of provider who will furnish each. The service plan also includes the justification for those services based on needs identified by the individual or LAR and supported by assessments. Providers deliver all waiver services according to the service plan. An individual must continue to meet financial, and level of care requirements to remain eligible for CLASS waiver services.

When the service plan is developed, the individual receiving services may choose to self-direct habilitation, support consultation, nursing, physical therapy, occupational therapy, speech hearing and language therapy and respite services through the consumer directed service option. All other services are provided by the direct service agency chosen by the individual. An individual choosing the provider managed service delivery option selects a direct service agency for all services included in the service plan except case management. Case management services are provided to all individuals receiving services in CLASS.

The single State Medicaid agency, the Texas Health and Human Service Commission (HHSC), exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver.

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:

- [ ] **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/MR.

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:
On November 20, 2008, DADS notified service providers and other stakeholders that a meeting was scheduled for December 4, 2008 to solicit public input into the renewal of the CLASS waiver renewal application. During this meeting, stakeholders were encouraged to discuss the CLASS Program and offer suggestions regarding possible changes to improve the program. DADS collected all comments and suggestions and considered these during the preparation of this application.

Public Notice was posted in the Texas Register on February 27, 2009.

Tribal notification was mailed on March 2, 2009, allowing for comments until April 4, 2009. No comments were received.

The State regularly conducts focus groups, especially in evaluating current stakeholder experience, evolving needs, model design, barriers to participation, and new initiatives. In addition, communications with advocate groups are ongoing The State assures multiple opportunities for stakeholder and public comment in the formal rule promulgation process. HHSC facilitates the State's Consumer Directed Services Workgroup, which regularly convenes to discuss and recommend improvements in the consumer directed services option offered through DADS community-based programs.
DADS conducts quarterly teleconferences with provider agencies to receive input about waiver operations and waiver services. Regular discussions with stakeholders and advocacy groups provide additional opportunities for suggestions to improve the program.

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:	Johnson
First Name:	Betsy
Title:	Policy Analyst
Agency:	Texas Health and Human Services Commission
Address:	11209 Metric Blvd. H-620
Address 2:	
City:	Austin
State:	**Texas**
Zip:	78758
Phone:	(512) 491-1199 **Ext:** ☐ ☐ **TTY**
Fax:	(512) 491-1953
E-mail:	betsy.johnson@hhsc.state.tx.us

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

Last Name:	Henderson
First Name:	Don
Title:	Director of the Center for Policy and Innovation
Agency:	Texas Department of Aging and Disability Services
Address:	701 West 51st Street
Address 2:	PO Box 149030, Mail Code: W521
City:	Austin
State:	**Texas**
Zip:	78714-9030
Phone:	(512) 438-4507 **Ext:** ☐ **TTY**
Fax:	(512) 438-5135
E-mail:	don.henderson@dads.state.tx.us

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:	Christine Longoria
	State Medicaid Director or Designee
Submission Date:	May 5, 2010

Last Name:	Milwee
First Name:	Billy
Title:	State Medicaid Director
Agency:	Texas Health and Human Services Commission
Address:	11209 Metric Blvd H-100
Address 2:	
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Phone:	(512) 491-1463
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Attachment #1: Transition Plan

Specify the transition plan for the waiver:

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:
     Department of Aging and Disability Services (DADS)

     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 the state Medicaid Agency. In accordance with 42 CFR §431.10(e), 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 state's health and human services agencies.

The designation of HHSC as the single state agency with authority to specifically direct the workings of the Medicaid program in each agency is echoed in Texas Government Code §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 Aging and Disability Services (DADS), 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.

HHSC and the operating agency, have signed an operating agreement that delineates the roles and responsibilities of each agency with regard to home and community-based services waivers. 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 Director's office is directly responsible for monitoring and oversight. Annual monitoring by HHSC began with the evidentiary review and continues on an ongoing basis.

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 DADS to modify, clarify, or provide additional information in considering approval or disapproval of proposed changes.

The Long-Term Supports and Services Policy Unit is actively involved in the development of quality assurance activities at DADS. In September 2004, HHSC presented to DADS the new CMS guidelines and related quality assurance information. Since that time, HHSC and DADS have held regular status and update meetings directed at evaluating current quality systems and identifying and prioritizing enhancements. These meetings have resulted in the formation of a Quality Review Team that is updating the quality assurance plan and re-formulating the Oversight Plan. These plans will: enhance data reporting to the Medicaid agency; create a baseline for current activities; and develop a quality management strategy that spans more than one waiver and potentially other types of long-term supports and services.

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 DADS:
(1) Disseminates and oversees dissemination of information concerning the waiver to potential enrollees and assists individuals in waiver enrollment;
(2) Manages waiver enrollment against approved limits and monitors waiver expenditures against approved levels by reviewing DADS interest list 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;
(3) Approves level of care evaluations;
(4) Reviews the service plan to ensure that waiver requirements are met; and
(5) Performs prior authorization of waiver services, when required; and

(6) Conducts utilization management functions.

HHSC also reviews and approves DADS' entries on CMS Form 372 prior to its submission to CMS.

For level of care, service plan, and prior authorizations, DADS, with HHSC concurrence, has implemented procedures that reject processing or payment when programmatic requirements for services and items approved by HHSC are not met or are not in place. Providers are required to maintain this information for inspection during on-site reviews by DADS' staff. In accordance with CMS quality framework guidelines, DADS has developed quality indicators related to these items. The indicators will be reported to HHSC at least annually.
HHSC will additionally ensure that DADS:
(1) Conducts utilization management functions which are reported to HHSC;
(2) Recruits providers under rules governing the recruitment and enrollment of providers adopted by HHSC;
(3) Executes the Medicaid provider agreement on behalf of HHSC, the Texas Single State Medicaid Agency. The requirements in the Provider Agreement used by DADS exceed Medicaid requirements and include additional state requirements;
(4) Conducts training and technical assistance concerning waiver requirements. The need for training and technical assistance is identified through results of DADS' provider monitoring, technical assistance contacts, and the use of newly developed quality indicators. HHSC monitors DADS' training using the quality indicators and, when indicated, discusses, reviews, and suggests additional training topics for DADS providers.

Texas' quality oversight processes provide the infrastructure for all monitoring processes, including HHSC's oversight of DADS' performance in relation to the delegated functions. The key formal mechanism for monitoring DADS' performance is the Quality Review Team process. The Quality Review Team meets quarterly and reviews comprehensive quality reports from each waiver at least annually. These reports include data on all of the waiver's Quality Improvement Strategy measures. These reports also include remediation activities and outcomes. Improvement plans are developed as issues are identified, and the Quality Review Team reviews, modifying if needed, and approves all improvement plans. All active improvement plans for all waivers are monitored at each quality review team meetings. Many of the delegated functions are addressed in quality measures related to waiver assurances. For example, the delegated function "level of care evaluation" is addressed by the quality measures in Appendix B regarding the level of care assurance. DADS will also provide supplemental status reports to HHSC for each of the waivers. These status reports augment the annual comprehensive report, providing additional detail for delegated functions that aren't clearly subsumed by a particular assurance and related measures. HHSC will analyze the status reports at least annually to monitor compliance with waiver assurances and performance of delegated functions.

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 There is a current operating agreement between HHSC, the single state Medicaid umbrella agency, and DADS, an operating agency of HHSC.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Operating Agreement

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 The operating agreement outlines the roles and responsibilities of HHSC and DADS for operating the waiver.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Operating Agreement

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.3 HHSC and DADS annually reviews the operating agreement.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Minutes of Operating Agreement review meeting.

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.4 HHSC and DADS meet to review quality performance and develop remediations and program improvements.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Minutes of Quality review meeting

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.
In accordance with 42 CFR §431.10 (e), the single state Medicaid agency retains administrative authority over the waiver program. DADS and HHSC develop the initial waiver, subsequent amendments, CMS 372 reports and all state rules for waiver program operations. DADS conducts on-site reviews of the provider agencies. Additionally, DADS and HHSDC are actively involved in program design changes such as the implementation of consumer direction options and in the development of quality assurance activities. DADS and HHSC hold regular status and update meetings directed at evaluating current quality systems and identifying and prioritizing enhancements.

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.
HHSC employs a variety of mechanisms for resolving issues with DADS performance. These mechanisms have varying levels of formality, and include:

• Informal conversations: Day to day, DADS and HHSC staff function in a collaborative manner to support waiver operation and administration. When HHSC has a concern about a delegated function, the appropriate DADS staff member is called to discuss the concern. In most instances, the issue is clarified or the problem resolved. DADS staff and leadership are accessible to HHSC staff and leadership to discuss and resolve issues.

• Waiver Strategic Planning meetings: Waiver strategic planning occurs at quarterly meetings of DADS and HHSC staff led by DADS Community Services. This group evaluates changes needed to existing waivers, including those identified via the Quality Review Team, legislative mandates or direction, CMS, HHSC, other internal workgroups, and staff. Waiver activities, including amendments, renewals, and, at times, new applications and remediation activities, are discussed and methods and timing for formal communications with CMS about changes needing formal approval are planned.

• Quarterly Review Team meetings: The quality review team is facilitated by HHSC and is comprised of leadership

from DADS and HHSC. The Quality Review Team meets quarterly and reviews comprehensive quality reports from each waiver at least annually. These reports include data on all of the waiver's quality improvement strategy measures. These reports also include remediation activities and outcomes. Improvement plans are developed as issues are identified and the Quality Review Team reviews, modifies, if needed, and approves all improvement plans. All active improvement plans for all waivers are monitored at each quality review team meetings. Leadership that participate in the Quality Review Team meetings can direct remediation activities.

• Action memos: Action memos are formal communication from agency staff to the DADS commissioner or HHSC executive commissioner. Action memos are utilized as needed to ensure leadership at the highest level is informed and supports actions needed to correct problems or make improvements.

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 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 a group 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 waiver target group, check each of the subgroups in the selected target group 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**			☐
◉ **Mental Retardation or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☑	**Developmental Disability**	0		☑
	☐	**Mental Retardation**			☐
○ **Mental Illness**					
	☐	**Mental Illness**			
	☐	**Serious Emotional Disturbance**			

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

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:

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: 200

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 service planning team includes the applicant or individual, the case manager, the direct service agency representative, and other persons identified by the applicant or individual receiving services. The service planning team supports the applicant's active participation in the assessment and planning process. The applicant has the opportunity to review the assessment of services and make choices regarding the service plan. The case manager informs the applicant of the consequences of service choices, including cost implications. The service planning team develops a service plan that includes waiver and non-waiver services and has a reasonable expectation of adequately meeting the health and welfare needs of the waiver applicant in the community setting. The applicant or their representative, the case manager, a direct service agency representative, and a representative of any other contracted provider sign the service plan prior to implementation and certify that the waiver services are necessary as an alternative to institutionalization and appropriate to meet the needs of the applicant or individual in the community.
An applicant whose request for eligibility for the waiver program is denied is entitled to a fair hearing in accordance 1 Texas Administrative Code, Part 15, Chapter 357 Subchapter A. DADS must send written notification to the individual, or legally authorized representative, indicating the individual's right to a fair hearing and the process to follow to request a fair hearing.

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:

All individuals participating in the waiver must have a service plan at a cost within the cost ceiling (200 percent of ICF/MR costs). For individuals 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 including family supports, state and community resources, and state general revenue funds, or possible transition to another waiver or institutional services.

The individual will be informed of and given the opportunity to request a fair hearing in accordance with 1 Texas Administrative Code, Part 15, Chapter 357, Subchapter A, if the State denies eligibility or proposes to suspend, terminate or reduce services, including denying a prior authorization request for Medicaid-covered services.

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	4804
Year 2	6165
Year 3	6201

Year 4 (renewal only)	6210
Year 5 (renewal only)	6219

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	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

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:

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

If funding is not available, DADS maintains an interest list for CLASS applicants and assigns an applicant's placement on the interest list chronologically based on the date of the registration for CLASS services. DADS offers a vacancy to an individual on a "first-come-first-served" basis according to the chronological date of the individual's registration on the CLASS interest list as funding is available. Once an offer to apply for CLASS is made to an individual, the applicant must choose a case management agency and a direct service agency from a list of all contracted CLASS providers and notify DADS of the choices. DADS will then notify the chosen providers. The case manager must schedule and conduct initial face-to-face contact. The direct service agency meets with them to conduct the level-of-care eligibility assessment. If the applicant is determined eligible for CLASS services, the case manager schedules a meeting for the service planning tream to develop the service plan.

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:

- ☑ **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)**
- ☑ **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 other categorically needy groups under the Medicaid State Plan.

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:

    - ☑ **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 4)

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 State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

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 *(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 4)

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

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. 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**
- ( ) **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

- **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.*

- [x] **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 4)

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 4)

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).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- [ ] **SSI standard**
- [ ] **Optional State supplement standard**
- [ ] **Medically needy income standard**
- [x] **The special income level for institutionalized persons**
- [ ] **A percentage of the Federal poverty level**

  Specify percentage:
- [ ] **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 formula:
- [ ] **Other**

  Specify:

ii. **If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.**

Select one:

- (●) **Allowance is the same**
- ( ) **Allowance is different.**

Explanation of difference:

iii. **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 uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

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:

Case management must be provided at least quarterly.

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:

Physician (M.D. or D.O.) licensed by the Texas Medical Board
Registered nurse licensed by the Texas Board of Nursing
Licensed vocational nurse licensed by the Texas Board of Nursing
Qualified mental retardation professional (QMRP) as defined in 42 CFR Sec. 483.430(a).
Licensed social worker licensed by Texas State Board of Social Worker Examiners
Licensed professional counselor licensed by Texas State Board of Examiners of Professional Counselors
Psychologist licensed by the Texas Board of Examiners of Psychologists

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.

The required ICF/MR Level of Care VIII is defined in 40 Texas Administrative Code §9.239 (ICF/MR Level of Care VIII Criteria) as follows:
To meet the LOC VIII criteria, a person must:
(1) have a primary diagnosis by a licensed physician of a related condition that is included on the DADS Approved Diagnostic Codes for Persons with Related Conditions (posted on the DADS website at http://www.dads.state.tx.us/providers/guidelines/ICD-9-CM_Diagnostic_Codes.pdf.) and
(2) have an adaptive behavior level of II, III, or IV (i.e., moderate to extreme deficits in adaptive behavior) obtained by administering a standardized assessment of adaptive behavior.

The CLASS program additionally requires an individual to exhibit deficiencies in at least three of the six areas assessed on the Related Conditions Eligibility Screening Instrument.

The standardized assessment tools authorized by the CLASS program to determine adaptive behavior level are the Inventory for Client and Agency Planning, Scales of Independent Behavior-Revised, American Association on Mental Retardation Adaptive Behavior Scales, and Vineland Adaptive Behavior Scales.

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.

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:

Before enrollment, an applicant is visited by the registered nurse employed by the direct services agency. The registered nurse completes the following assessments:
Mental Retardation/Related Condition Assessment;
Adaptive Behavior Level assessment (with assistance from the applicant or individual); and
Related Conditions Eligibility Screening Instrument.
The direct services agency submits the Mental Retardation/Related Condition Assessment to the applicant's physician. The direct service agency ensures that the physician completes the section describing Primary Diagnosis, date of onset, and the International Classification of Diseases, Ninth Revision, Clinical Modification code for the primary related condition, and items 48-55 in the Physician's Evaluation and Recommendation section. The direct service agency sends the original signed and completed Mental Retardation/Related Condition Assessment along with a copy of the adaptive behavior level assessment tool and the Related Conditions Screening Instrument to DADS for level of care determination.
The Reevaluation is different because the applicant's physician is not required to complete the section describing Primary Diagnosis, date of onset, and the International Classification of Diseases, Ninth Revision, Clinical Modification code for the primary related condition, and items 48-55 in the Physician's Evaluation and Recommendation section.

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:

  Registered nurse licensed by the Texas Board of Nursing
  Licensed Vocational Nurse licensed by the Texas Board of Nursing
  Qualified Mental Retardation Professional as defined in 42 CFR Sec. 483.430(a).
  Licensed social worker licensed by Texas State Board of Social Worker Examiners
  Licensed professional counselor licensed by Texas State Board of Examiners of Professional Counselors
  Psychologist licensed by the Texas Board of Examiners of Psychologists

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):*

The direct service agency is required to track each level of care expiration date. DADS' Program Consultants monitor and review the level of care periods during on-site monitoring visits and upon submission to DADS for renewal. The individual service plan is rejected in the Claims Management System if a level of care has expired. The direct service agency is notified and instructed to correct the deficiency. A Purpose Code "E" is completed by the direct service agency to cover a gap in dates for level of care coverage.

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:

The case manager and the direct service agency must maintain this information in accordance with record retention requirements as required by State law.
DADS maintains records of evaluations and reevaluations of level of care.

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**
   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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 Percent of initial level of care documents reviewed by the State.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CLASS Access Database

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 levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 Percent of enrolled participants re-evaluated annually by the State.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CLASS Access Database

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 Percentage of level of care documents submitted by the direct service agency that are not completed accurately.

Data Source (Select one):
Other

If 'Other' is selected, specify:
CLASS Access Database

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:
B.c.2 Percent of level of care documents submitted by direct service agency prior to annual expiration date.

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

CLASS Access database

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. Following the acceptance of an offer of CLASS Program services by an individual or his/her legally authorized representative or family, the direct services agency collects documentation of the individual's eligibility for an ICF/MR Level of Care and completes the Mental Retardation Related Conditions Assessment form. The direct service agency must complete and submit the form to the State. The state approves or denies the level of care

submitted. The Service Authorization System Online prohibits the completion of an individual's enrollment without an approved level of care. The system also prohibits the renewal of an individual's service plan if the individual's level of care is not current.

As part of each direct service agency's annual monitoring visit, the State verifies that the level of care assessments were completed timely and accurately according to the form instructions. The State also checks for the qualifying level of care determination and diagnoses that make the participant eligible for CLASS program services and that the level of care was appropriately authorized.

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.
The State routinely provides technical assistance during on-site reviews of program providers to clarify program requirements and offer suggestions for performance or process improvement. Minimally, the State conducts quarterly teleconferences with CLASS provider agencies to assist in resolving issues and answer questions that have arisen. State staff is available to respond to concerns or questions from program providers by telephone or by e-mail. Problems with the level of care submissions are documented in an Access database and are used to identify and address common errors. If the program compliance issues require additional corrective action, the state requires a corrective action plan and can apply both financial and administrative sanctions.

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 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).

During the initial contact, the case manager informs each applicant of all CLASS services and any available alternatives, including the choice of institutional care instead of home and community-based waiver services and documents the applicant's decision to accept or refuse the home and community-based services on the "Freedom of Choice" Verification Form.

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 contracted case manager retains a copy of the Freedom of Choice Verification Form as required by State law.

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):
DADS' operational policy A-572 acknowledges the department's legal obligation to ensure that programs and services are accessible to the diverse population of Texas and requires DADS service delivery to comply with state and federal laws and mandates.
Each DADS program, activity, and provider must offer a variety of methods to ensure access to services in a timely manner by providing language assistance services to individuals and stakeholders who are Limited English Proficient.
The Language Services Unit of the Communications Office coordinates translations for DADS. DADS routinely provides Spanish translation of forms and letters and is responsive to other translation needs. The case manager must make an interpreter available to the applicant or individual's representative upon request. The case manager must make written material available in alternative languages upon request and maintain a copy of the material in the alternative language in the case record. The direct service agency must make an interpreter available to the applicant or individual's representative upon request. The provider agency must make written material available to the individual's representative in alternative languages upon request and maintain a copy of the material in the alternative languages provided.

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	**Adult Day Health**
Statutory Service	**Case Management**
Statutory Service	**Prevocational Services**
Statutory Service	**Residential Habilitation**
Statutory Service	**Respite (In-Home and Out–of-Home)**
Statutory Service	**Supported Employment**
Extended State Plan Service	**Adaptive Aids/Medical Supplies**
Extended State Plan Service	**Dental Services**
Extended State Plan Service	**Occupational Therapy**
Extended State Plan Service	**Physical Therapy**
Extended State Plan Service	**Prescriptions**
Extended State Plan Service	**Skilled Nursing**
Extended State Plan Service	**Speech, hearing, and language services**

Supports for Participant Direction	**Financial Management Services**
Supports for Participant Direction	**Support Consultation**
Other Service	**Behavioral Support**
Other Service	**Continued Family Services**
Other Service	**Minor Home Modifications**
Other Service	**Specialized Therapies**
Other Service	**Support Family Services**
Other Service	**Transition Assistance 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:

Adult Day Health

Alternate Service Title (if any):

Service Definition *(Scope):*

The Adult Day Health facility must provide services that include the following:

(1) Nursing services. Nursing services must include:

(A) assessing, observing, evaluation, and documenting a individual's health condition, and instituting appropriate nursing intervention to stabilize or improve a individual's condition or prevent complications;

(B) assisting the individual to order, maintain, or administer prescribed medications or treatments, as indicated by physician's orders; and

(C) counseling the individual on his health need and illness and involving significant others in the discussions of his immediate and long-term health goals.

(2) Physical rehabilitative services. Physical rehabilitative services must include:

(A) restorative nursing; and/or

(B) group and individual exercises, including range of motion exercises.

(3) Nutrition/food service

(A) one hot noon meal served between the hours of 11:00 a.m. and 1:00 p.m.;

(B) special diets as required by the individual's plan of care;

(C) a supplementary mid-morning and mid-afternoon snack;

(D) dietary counseling and nutrition education for the individual and his family; and

(E) assisting the individual with his meals if necessary.

(4) Other supportive services in Adult Day Health facilities. Other supportive services must include:

(A) community interaction, cultural enrichment, educational or recreational activities, and other social activities on site or in the community in a planned program to meet the social needs and interests of the individuals;

(B) providing at least three social activities per day; and

(C) posting a monthly activity calendar at least one week in advance.

(5) Transportation services in Adult Day Health facilities.

(A) Transportation services must include:

(i) transportation to and from the Adult Day Health facility, or coordination of transportation with other resources if the Adult Day Health facility does not provide transportation; and

(ii) transportation to and from an Adult Day Health facility to therapies provider, if the individual requires specialized services on days of attendance at the Adult Day Health facility.

(6)Attendant services. Attendant services must include:

(A) providing assistance in dressing, eating, grooming, bathing, toileting, transferring/ambulation, etc.

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

All state plan Medicaid services must be exhausted prior to receing this service. Services are limited to five days per

week.

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	Adult Day Care Facility

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:
Agency

Provider Type:
Adult Day Care Facility

Provider Qualifications

License *(specify)*:
Licensed by DADS as an Adult Day Care Facility under 40 Texas Administrative Code Part 1, Chapter 98.

Certificate *(specify)*:

Other Standard *(specify)*:
The facility must comply with rules found under 4 Texas Administrative Code Part 1, Chapter 25, Subchapter A, Child and Adult Food Program.

Verification of Provider Qualifications

Entity Responsible for Verification:
DADS

Frequency of Verification:
Annually

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:
Case Management

Alternate Service Title (if any):

Service Definition *(Scope):*
Case managers assist individuals who receive waiver services in gaining access to needed waiver and other State Plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. Case managers are responsible for ongoing monitoring of the provision of services included in the service plan. Case managers initiate and oversee the process of assessment and reassessment of the individual's service plan and review service plans annually or as individual needs require. Case managers advocate for an individuals needs when necessary and appropriate.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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	Case Management Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency
Provider Type:
Case Management Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The case management agency must complete the provider agreement application and all necessary documents. The CMA must show proof of an office in the catchment area to be served and hire staff that meets case manager qualifications. Those qualifications are: have the formal educational equivalent of a bachelor's degree in a health and human services field plus two years experience in the delivery of human services to persons with disabilities,
Or: Hold an high school degree or equivalent with four years experience in the coordination and delivery of human services to person's with disabilities.
Verification of Provider Qualifications
Entity Responsible for Verification:
Case Management Provider Agency holding a CLASS Medicaid Provider Agreement
DADS
Frequency of Verification:
Case Management Provider Agency prior to hiring
DADS during biennial on-site reviews

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:

Prevocational Services

Alternate Service Title (if any):

Service Definition *(Scope):*

This service refers to those prevocational services not already available through a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving, and safety. When compensated, individuals are paid at less than 50 percent of the minimum wage. Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. Documentation is maintained in the file of each individual that this service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142. Prevocational Services are provided to persons not expected to be able to join the general work force within one year (excluding supported employment programs).

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

Prevocational Services are provided under this waiver when no other financial resource is available or when other available resources have been exhausted.

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	Direct Service Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Direct Service Agency

Provider Qualifications

License *(specify):*
Home and Community Support Service Agency Agency Licensure 40 Texas Administrative Code, Part I, Chapter 97
Certificate *(specify):*

Other Standard *(specify):*
Provider must be age 18 or older. Can be family member if not spouse or parent of minor child; Cardio-pulminary resuscitation/First aid trained; client specific competencies; pass criminal background check, maintains current drivers license and insurance if transporting client.

Verification of Provider Qualifications

Entity Responsible for Verification:
Direct Service Agency holding a CLASS Medicaid provider agreement
DADS
Frequency of Verification:
At employment and annually thereafter
Biennial on-site reviews

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:
Residential Habilitation

Alternate Service Title (if any):

Service Definition *(Scope):*
Residential Habilitation means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the individual to reside in the most integrated setting appropriate to his/her needs. Residential Habilitation also includes personal care and protective oversight and supervision. Payment is not made to members of the individual's immediate family, except as provided in Appendix C-2. Payment for habilitation does not include payments made to the individual's spouse or the parent of a individual who is a minor child. Payments will not be made for the routine care and supervision, which would be expected to be provided by a family member or for activities or supervision for which a payment is made by a source other than Medicaid. Residential Habilitation is furnished in the individual's own home, or the home of a relative. Assisting with tasks delegated by a Registered Nurse must be in accordance with state law. Personal assistance may be an incidental component to habilitation for some activities of daily living for some individuals in the program.
Individuals in the CLASS program must have an ongoing demonstrated need for, be able to benefit from, and receive Residential Habilitation services based on the needs assessment and service plan developed by the service planning team.

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

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

- [x] **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	Direct Service Agency
Individual	Consumer Directed Services direct service provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency

Provider Type:
Direct Service Agency

Provider Qualifications

License *(specify):*
Home and Community Support Service Agency Agency Licensure 40 Texas Administrative Code, Part I, Chapter 97

Certificate *(specify):*

Other Standard *(specify):*
Provider must be age 18 or older. Can be family member if not spouse or parent of minor child; Cardio-pulmonary resuscitation /First aid trained; client specific competencies; pass criminal background check and other required registry checks, maintains current drivers license and insurance if transporting individual. The attendant must also receive training in tasks performed for a specific individual when the attendant is assigned to provide care to that individual. Training in tasks performed for specific individuals will occur in the individual's home with full participation from the individual receiving services and his allies, as appropriate. If the individual is receiving certain health related services which require supervision by the individual receiving the service, the individual receiving the service will provide training in these tasks to the attendant. Habilitation providers must receive training before providing services. Training must include philosophy and values of community integration, overview of related conditions, integration training, and program elements.

Verification of Provider Qualifications

Entity Responsible for Verification:
Direct Service Agency holding a CLASS Medicaid provider agreement
DADS

Frequency of Verification:
At employment and annually thereafter
DADS during biennial on-site reviews

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Individual

Provider Type:

Consumer Directed Services direct service provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Provider must be age 18 or older. Can be family member if not spouse or parent of minor child; Cardio-pulmonary resuscitation/First aid trained; client specific competencies; pass criminal background check, maintains current drivers license and insurance if transporting client. The attendant must also receive training in tasks performed for a specific individual when the attendant is assigned to provide care to that individual. Training in tasks performed for specific individuals will occur in the individual's home with full participation from the individual receiving services and his allies, as appropriate. If the individual is receiving certain health related services which require supervision by the individual receiving the service, the individual receiving the service will provide training in these tasks to the attendant. Habilitation providers must receive training before providing services. Training must include philosophy and values of community integration, overview of related conditions, integration training, and program elements.
If a guardian appointed by the court chooses the consumer directed services option, the guardian must perform employer functions.

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual/employer and Consumer Directed Service Agency
DADS

Frequency of Verification:

Individual/employer and Consumer Directed Service Agency prior to hiring
DADS during biennial on-site reviews

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):

Respite (In-Home and Out–of-Home)

Service Definition *(Scope):*

Respite is provided for the planned or emergency short-term relief of the unpaid primary caregiver who lives with the individual. Respite is provided intermittently when the primary caregiver is temporarily unavailable to provide supports due to non-routine circumstances. This component provides an individual with personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene) and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement of behavioral support or specialized therapies activities; assistance with medications and the performance of tasks delegated by a registered nurse in accordance with state law; and supervision of the individual's safety and security. This component includes activities that facilitate the individual's inclusion in community activities, use of natural supports and typical community services available to all people, social interaction, and participation in leisure activities, and development of socially valued behaviors and daily living and functional living skills.

Federal Financial Participation will not be claimed in expenditures for the cost of room and board, except when provided as part of respite care in a facility approved by the state that is not a private residence (nursing facility, foster home, or community residential facility). Payment for room and board is not included in the rate for in-home respite.
Respite care will be provided in the following locations:

Individual's home or place of residence;
Adult Foster Home licensed or certified by DADS;
Licensed Assisted Living Facilities
Medicaid certified nursing facility;
Medicaid certified Intermediate Care Facility for Persons with Mental Retardation; and Approved Outdoor Camps that meet health and welfare requirements of DADS and have American Camping Association accreditation. Approved camps provide activities for socialization and recreation; assist as needed in activities of daily living, and provide medical care as needed. The individual benefits from time away from home while temporary relief is provided for the primary caregiver.

Residential habilitation services may not be provided during the time that respite services are provided. The provision of respite care precludes the provision of, or payment for, other duplicative services under the waiver.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Respite is limited to 30 days for each service plan year. Respite cannot be provided during the same time period that residential habilitation, continued family service, or support family services are provided.

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

- [x] **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	Direct Service Agency
Individual	Consumer Directed Service direct service provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite (In-Home and Out–of-Home)

Provider Category:
Agency
Provider Type:
Direct Service Agency
Provider Qualifications
License *(specify):*
Home and Community Support Service Agency Agency Licensure 40 Texas Administrative Code, Part I, Chapter 97
Certificate *(specify):*

Other Standard *(specify):*
Provider must be age 18 or older. Can be family member if not spouse or parent of minor child; Cardio-pulmonary resuscitation/First Aid trained; client specific competencies; pass criminal history conviction record check, maintains current driver's license and insurance if transporting client.
Facilities delivering out-of-home respite must meet the applicable standards established by the State of Texas for licensed or certified foster homes, and institutions licensed as nursing facilities, or intermediate care facilities for persons with mental retardation. Approved Outdoor Camps must meet health and safety requirements of DADS and have American Camping Association accreditation.
Verification of Provider Qualifications

Entity Responsible for Verification:
Direct Service Agency with Medicaid Provider Agreement and other Licensed Providers
DADS
Frequency of Verification:
Prior to hiring
Biennial on-site reviews

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite (In-Home and Out–of-Home)

Provider Category:
Individual
Provider Type:
Consumer Directed Service direct service provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Provider must be age 18 or older. Can be family member if not spouse or parent of minor child; Cardio-pulmonary resuscitation/First Aid trained; client specific competencies; pass criminal history conviction record check, maintains current driver's license and insurance if transporting client.
Facilities delivering out-of-home respite must meet the applicable standards established by the State of Texas for licensed or certified foster homes, and institutions licensed as nursing facilities or intermediate care facilities for persons with mental retardation. Approved Outdoor Camps must meet health and safety requirements of DADS and have American Camping Association accreditation.
Verification of Provider Qualifications
Entity Responsible for Verification:
Individual/employer and Consumer Directed Service Agency
DADS
Frequency of Verification:
Individual/employer and Consumer Directed Service Agency prior to hiring
DADS during biennial on-site reviews

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):

Service Definition *(Scope):*
Supported Employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform

in a work setting. Supported Employment is conducted in a variety of settings; particularly work sites in which persons without disabilities are employed. Supported Employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training.

Supported Employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or Public Law 94-142. Documentation will be maintained in the file of each individual receiving this service that:

The service is not otherwise available under a program funded under the Rehabilitation Act of 1973 (29 U.S.C. § 701 et seq), or Individuals with Disabilities Education Act (20 U.S.C. §1411); and Federal Financial Participation will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
(1) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
(2) Payments that are passed through to users of supported employment programs; or
(3) Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation will be provided between the individual's place of residence and the site of the supported employment services. The cost of this transportation is included in the rate paid to providers of the supported employment services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
When Supported Employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

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	Direct Service 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:
Direct Service Agency
Provider Qualifications
License *(specify):*
Home and Community Support Service Agency Provider Agency Licensure per 40 Texas Administrative Code, Part I, Chapter 97
Certificate *(specify):*

Other Standard *(specify):*
Provider must be age 18 or older. Can be family member if not spouse or parent of minor child; Cardio-

pulmonary resuscitation/First aid trained; client specific competencies; pass criminal background check, maintains current drivers license and insurance if transporting client.

Verification of Provider Qualifications

Entity Responsible for Verification:

Direct Service Agency holding a CLASS Medicaid provider agreement
DADS

Frequency of Verification:

At employment and annually thereafter
Biennial on-site reviews

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:

Extended State Plan Service

Service Title:

Adaptive Aids/Medical Supplies

Service Definition *(Scope):*

This service provides devices, controls, or appliances that are necessary to address specific needs identified by the individual's service plan. Adaptive aids enable individuals to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live.

Adaptive aids include items that assist an individual with mobility and communication and ancillary supplies and equipment necessary to the proper functioning of such items. Also included are medically necessary supplies and items needed for life support. Items reimbursed with waiver funds must be in addition to any medical equipment and supplies furnished under the Medicaid State Plan. All items must meet applicable standards of manufacture, design, and installation.

An adaptive aid is provided for a specific individual and becomes the exclusive property of that individual.

Excluded are those items and supplies, which are not of direct medical or remedial benefit to the individual and items and supplies that are available to the individual through the Medicaid State plan, through other governmental programs, or through private insurance. The individual's service planning team must authorize all adaptive aids. Items costing more than $500 must be authorized by the service planning team based upon written evaluations and recommendations by the individual's physician, a licensed occupational or physical therapist, a psychologist or behavior analyst, a licensed nurse, a licensed dietitian, or a licensed audiologist or speech/language pathologist qualified to assess the individual's need for the specific adaptive aid. The written evaluation and recommendation must document the necessity and appropriateness of the adaptive aid to meet the specific needs of the individual.

Adaptive aids are limited to the following categories including repair and maintenance not covered by warranty:

(A) Lifts, including vehicle lifts
(B) Positioning Devices
(C) Control switches/pneumatic switches and devices
(D) Environmental control units
(E) Medically necessary supplies
(F) Communication aids (including batteries)
(G) Adaptive/modified equipment for activities of daily living
(H) Safety restraints and safety devices

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

Nutritional supplements and enteral feeding formulas and supplies are limited to those documented by the Statistical Analysis DME Regional Carrier Product Classification List for Enteral Nutrition in effect at the time.

Adaptive Aids/Medical Supplies are provided under this waiver when no other financial resource is available or when other available resources have been exhausted.

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	Direct Service Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Adaptive Aids/Medical Supplies

Provider Category:
Agency

Provider Type:
Direct Service Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Adaptive aids must be provided by contractors/suppliers capable of providing aids meeting applicable standards of manufacture, design and installation.

Verification of Provider Qualifications

Entity Responsible for Verification:
Direct Service Agency holding a CLASS Medicaid provider agreement
DADS

Frequency of Verification:
Direct Service Agency prior to completing service agreement.
DADS during annual on-site reviews

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:
Extended State Plan Service

Service Title:
Dental Services

Service Definition *(Scope):*
This service component includes the following elements:
(A) Routine preventive, therapeutic, orthodontic treatment, and emergency dental treatment, to include:
1. Emergency dental treatment: Those procedures necessary to control bleeding, relieve pain, and eliminate acute infection; operative procedures that are required to prevent the imminent loss of teeth; and treatment of injuries to the teeth or supporting structures.

2. Preventive dental treatment: Examinations, X-rays, cleanings, sealants, oral prophylaxes, and topical fluoride applications.
3. Therapeutic dental treatment: Treatment that includes, but is not limited to: fillings, scaling, extractions, crowns, pulp therapy for permanent and primary teeth; restoration of carious permanent and primary teeth; maintenance of space; and limited provision of removable prostheses when masticatory function is impaired, when an existing prosthesis is unserviceable, or when aesthetic considerations interfere with employment or social development.
4. Orthodontic dental treatment: Procedures that include treatment of retained deciduous teeth; cross-bite therapy; facial accidents involving severe traumatic deviations; cleft palates with gross malocclusion that will benefit from early treatment; and severe, handicapping malocclusions affecting permanent dentition with a minimum score of 26 as measured on the Handicapping Labio-lingual Deviation Index.
(B) Sedation necessary to perform dental treatment including non-routine anesthesia, e.g., intravenous sedation, general anesthesia, or sedative therapy prior to routine procedures. Sedation does not include administration of routine local anesthesia only. Cosmetic orthodontia is excluded from the Dental Treatment component.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Cosmetic orthodontia is excluded from the Dental Service component.
Dental Service is provided under this waiver when no other financial resource for such treatment is available or when other available resources have been exhausted. Individuals who are under 21 years of age must first access dental treatment benefits through the Texas Health Steps--Comprehensive Care Program (EPSDT) before dental service may be provided under this 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	Direct Service Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Dental Services

Provider Category:
Agency
Provider Type:
Direct Service Agency
Provider Qualifications
License *(specify):*
Home and Community Support Service Agency Agency Licensure 40 Texas Administrative Code, Part I, Chapter 97

Texas State Board of Dental Examiners must license dentists through the Texas Occupations Code Chapter 251.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Direct Service Agency with CLASS Medicaid Provider Agreement

DADS
Frequency of Verification:
Prior to completing the service agreement; verify license renewal

DADS during biennial on-site reviews.

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:
Extended State Plan Service
Service Title:
Occupational Therapy
Service Definition *(Scope):*
Occupational Therapy services consists of the full range of activities provided by a licensed occupational therapist, or a licensed occupational therapy assistant, under the direction of a licensed occupational therapist, within the scope of state licensure. Texas assures that Occupational Therapy is cost-effective and necessary to avoid institutionalization. Individuals who are under 21 years of age must access occupational therapy benefits through the Texas Health Steps--Comprehensive Care Program before Occupational Therapy may be provided under this waiver. The scope of Occupational Therapy services offered in this waiver exceeds the state plan occupational therapy benefit. Under the waiver, Occupational Therapy will be provided to maintain the individual's optimim condition.
These services include:
(1) Screening and assessing;
(2) Developing therapeutic treatment plans and recommendations for adaptive aids;
(3) Direct therapeutic intervention;
(4) Training and assisting with adaptive aids;
(5) Consulting with other service providers and family members; and
(6) Participating on the service planning team when appropriate
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Occupational Therapy is provided under this waiver when no other financial resource is available or when other available resources have been exhausted.

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

- [x] **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	Direct Service Agency
Individual	Consumer Directed Service direct service provider

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:
Agency
Provider Type:
Direct Service Agency
Provider Qualifications
License *(specify):*
Home and Community Support Service Agency Agency Licensure 40 Texas Administrative Code, Part I, Chapter 97
Texas Board of Occupational Therapy Examiners must license Occupational Therapists through the Texas Occupations Code Chapter 454
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Direct Service Agency with CLASS Medicaid Provider Agreement
DADS
Frequency of Verification:
Prior to completing service agreement; verify license renewal
Biennial on-site reviews

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:
Individual
Provider Type:
Consumer Directed Service direct service provider
Provider Qualifications
License *(specify):*
Texas Board of Occupational Therapy Examiners must license Occupational Therapists through the Texas Occupations Code Chapter 454.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Individual/employer and Consumer Directed Service Agency
DADS
Frequency of Verification:
Individual/employer and Consumer Directed Service Agency prior to hiring; verify license renewal
DADS during biennial on-site reviews

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:

Extended State Plan Service

Service Title:

Physical Therapy

Service Definition *(Scope):*

Physical Therapy services consist of the full range of activities provided by a licensed physical therapist, or a licensed physical therapy assistant under the direction of a licensed physical therapist, within the scope of his state licensure. Individuals who are under 21 years of age must access physical therapy benefits through the Texas Health Steps--Comprehensive Care Program before Physical Therapy may be provided under this waiver. The scope of Physical Therapy services offered in this waiver exceeds the state plan physical therapy benefit. Under the waiver, Physical Therapy will be provided to maintain the individual's optimum condition.

These services include:

Screening and assessing;
Developing therapeutic treatment plans and recommendations for adaptive aids;
Direct therapeutic intervention;
Training and assisting with adaptive aids;
Consulting with other service providers and family members; and
Participating on the service plannuing team, when appropriate.

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

Physical Therapy is provided under this waiver when no other financial resource is available or when other available resources have been exhausted.

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

- [x] **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
Individual	Consumer Directed Service direct service provider
Agency	Direct Service Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:

Individual

Provider Type:

Consumer Directed Service direct service provider

Provider Qualifications

License *(specify):*
Texas Board of Physical Therapy Examiners must license Physical Therapists through the Texas Occupations Code Chapter 453.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Individual/employer and Consumer Directed Service Agency
DADS
Frequency of Verification:
Individual/employer and Consumer Directed Service Agency prior to hiring
DADS during biennial on-site reviews

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:
Agency
Provider Type:
Direct Service Agency
Provider Qualifications
License *(specify):*
Home and Community Support Service Agency Agency Licensure 40 Texas Administrative Code, Part I, Chapter 97
The Texas Board of Physical Therapy Examiners must license Physical Therapists through the Texas Occupations Code Chapter 453
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Direct Service Agency holding a CLASS Medicaid Provider Agreement
DADS
Frequency of Verification:
Prior to completing service agreement; verify license renewal
DADS during biennial on-site reviews

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:
Extended State Plan Service
Service Title:
Prescriptions

Service Definition *(Scope):*
Unlimited prescribed medications beyond the three per month limit available under the Texas Medicaid State Plan are provided to individuals enrolled in the waiver, unless the individual is eligible for both Medicaid and Medicare (dually eligible). An individual who is dually eligible must obtain prescribed medications through the Medicare Prescription Drug Plan, or, for medications excluded from Medicare, through the Texas Medicaid State Plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
An individual who is dually eligible must obtain prescribed medications through the Medicare Prescription Drug Plan, or for certain medications excluded from Medicare, through the Texas Medicaid State Plan.

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	Pharmacies holding a Medicaid Provider Agreement—Vendor Drug with Texas Health and Human Services Commission (HHSC)

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Prescriptions

Provider Category:
Agency
Provider Type:
Pharmacies holding a Medicaid Provider Agreement—Vendor Drug with Texas Health and Human Services Commission (HHSC)
Provider Qualifications
License *(specify):*
Pharmacy or Texas State Board of Pharmacy
Certificate *(specify):*

Other Standard *(specify):*
Must hold Vendor Drug Provider Agreement with HHSC. The provider must complete training as required by HHSC.
Verification of Provider Qualifications
Entity Responsible for Verification:
Texas State Board of Pharmacy
Frequency of Verification:
Biennially

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:

Extended State Plan Service

Service Title:

Skilled Nursing

Service Definition *(Scope):*

The skilled nursing service provides treatment and monitoring of medical conditions prescribed by a physician/medical practitioner and/or required by standards of professional practice or state law to be performed by licensed nursing personnel.

Skilled nursing is provided under this waiver when no other financial resource for such service is available or when other available resources have been used. Individuals who are under 21 years of age must access skilled nursing benefits through the Texas Health Steps--Comprehensive Care Program before skilled nursing may be provided under this waiver.

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

Nursing services are those services listed in the plan of care that are within the scope of the Texas Nurse Practice Act and are provided by a registered nurse, or licensed vocational nurse under the supervision of a registered nurse, licensed to practice in the state. Skilled Nursing is provided under this waiver when no other financial resource is available or when other available resources have been exhausted.

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

- [x] **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
Individual	Consumer Directed Service direct service provider
Agency	Direct Service Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Skilled Nursing

Provider Category:

Individual

Provider Type:

Consumer Directed Service direct service provider

Provider Qualifications

License *(specify):*

Texas Board of Nursing licenses registered nurses and licensed vocational nurses through the Texas Occupations Code Chapter 301 and 22 Texas Administrative Code, Examining Boards, Part 11, Texas Board of Nursing.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Individual/employer and Consumer Directed Service Agency
DADS

Frequency of Verification:
Individual/employer and Consumer Directed Service Agency prior to hiring; verify license renewal
DADS during biennial on-site reviews

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Skilled Nursing

Provider Category:
Agency

Provider Type:
Direct Service Agency

Provider Qualifications

License *(specify):*
Home and Community Support Service Agency Agency Licensure 40 Texas Administrative Code, Part I, Chapter 97

Texas Board of Nursing licenses registered nurses and licensed vocational nurses through the Texas Occupations Code Chapter 301 and Texas Administrative Code Title 22, Examining Boards, Part 11, Texas Board of Nursing.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Direct Service Agency holding a Medicaid provider agreement
DADS

Frequency of Verification:
Prior to completing service agreement; verify license renewal
Biennial on-site reviews

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:
Extended State Plan Service

Service Title:
Speech, hearing, and language services

Service Definition *(Scope):*
Speech/Language Therapy services consist of the full range of activities provided by a licensed speech/language pathologist, or a licensed associate in speech/language pathology, under the direction of a licensed speech/language pathologist, within the scope of licensure. Individuals who are under 21 years of age must access speech, hearing, and

language benefits through the Texas Health Steps--Comprehensive Care Program before speech, hearing, and language services may be provided under this waiver. The scope of speech, hearing, and language services offered in this waiver exceeds the state plan speech, hearing, and language benefit. Under the waiver, speech, language, and hearing services will be provided to maintain the individual's optimum condition.

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

Speech, Hearing, and Language Services are provided under this waiver when no other financial resource is available or when other available resources have been exhausted.

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

- [x] **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
Individual	Consumer Directed Service direct service provider
Agency	Direct Service Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech, hearing, and language services

Provider Category:

Individual

Provider Type:

Consumer Directed Service direct service provider

Provider Qualifications

License *(specify)*:

State Board of Examiners for Speech-Language Pathology and Audiology through the Texas Occupations Code, Chapter 401.

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual/employer and Consumer Directed Service Agency
DADS

Frequency of Verification:

Individual/employer and Consumer Directed Service Agency prior to hiring; verify license renewal
DADS during biennial on-site reviews

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Speech, hearing, and language services

Provider Category:
Agency
Provider Type:
Direct Service Agency
Provider Qualifications
License *(specify):*
Home and Community Support Service Agency: Agency Licensure 40 Texas Administrative Code, Part I, Chapter 97

State Board of Examiners for Speech-Language Pathology and Audiology through the Texas Occupations Code, Chapter 401.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Direct Service Agency holding CLASS Medicaid Provider Agreement
DADS
Frequency of Verification:
Direct Service Agency prior to completing service agreement; verify license renewal.
DADS during biennial on-site reviews

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:
Supports for Participant Direction
The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
Support for Participant Direction:
Financial Management Services
Alternate Service Title (if any):

Service Definition *(Scope):*
The Financial Management Service component provides assistance to individuals with managing funds associated with the services elected for self-direction. The service includes initial orientation and ongoing training that is limited to budget development and management as well as the legal and programmatic requirements of being an employer. The Financial Management Services provider, referred to as the Consumer Directed Services Agency also provides assistance in the development, monitoring and revision of the individual's budget for each service component delivered through the Consumer Directed Service option and must maintain a separate account for each individual's budget. The Consumer Directed Services Agency provides assistance in determining staff wages and benefits subject to state limits, assistance in hiring by verifying employee's citizenship status and qualifications, and conducting required background checks. The Consumer Directed Services Agency verifies and maintains documentation of employee qualifications, including citizenship status, and documentation of services delivered. The Consumer Directed Services Agency also collects timesheets, processes timesheets of employees, processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance. The Consumer Directed Services Agency makes payments directly to all service providers. The Consumer Directed Services Agency tracks disbursement of funds and provides periodic reports to the individual of all expenditures and the status of the individual's Consumer Directed Services budget. The Consumer Directed Services Agency must not provide case management to the individual.

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

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	Consumer Directed Service Agencies holding a Medicaid provider agreement

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Financial Management Services

Provider Category:
Agency

Provider Type:
Consumer Directed Service Agencies holding a Medicaid provider agreement

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
The provider of Financial Management Services must contract to be a Consumer Directed Services Agency. The Consumer Directed Services Agency must successfully complete a mandatory three-day orientation and training conducted annually by DADS to contract with DADS to provide financial management services. Topics covered in the training include: the definition and responsibilities of a vendor employer-agent, in accordance with IRS Revenue Procedure 70-6. contracting requirements and procedures, Consumer Directed Services Agency responsibilities, consumer/employer responsibilities, case manager/service coordinator responsibilities, support advisor responsibilities, enrollment in the Consumer Directed Services option, transfer, suspension and termination of the Consumer Directed Services option, employer budgets, service back-up plans, corrective action plans, reporting of abuse, neglect or exploitation allegations, oversight of Consumer Directed Services, contract compliance and fiscal monitoring.
The Consumer Directed Services Agency must complete initial and periodic training provided. The Consumer Directed Services Agency must not provide other waiver services to the individual other than support consultation. The Consumer Directed Services Agency must not provide case management to the individual.
The Consumer Directed Services Agency provider must be at least 18 years of age and must not be the individual's legal guardian; the spouse of the individual's legal guardian; the individual's designated representative; or the spouse of the individual's designated representative.
On request of an individual or an individual's legally authorized representative, the Consumer Directed Services Agency must have support consultation services available.

Verification of Provider Qualifications

Entity Responsible for Verification:
DADS

Frequency of Verification:
Biennial on-site reviews

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:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):
Support Consultation

Service Definition *(Scope):*
Support Consultation is an optional service that offers practical skills training and assistance to enable an individual or his or her legally authorized representative to successfully direct those services the individual or the legally authorized representative elect for consumer-direction. This service is provided by a certified support advisor, and includes skills training related to recruiting, screening, and hiring workers, preparing job descriptions, verifying employment eligibility and qualifications, completion of documents required to employ an individual, managing workers, and development of effective back-up plans for services considered critical to the individual's health and welfare in the absence of the regular provider or an emergency situation. Skills' training involves such activities as training and coaching the employer regarding how to write an ad, how to interview potential job candidates, and role-play in preparation for interviewing potential employees. In addition, the support advisor assists the individual or his or her legally authorized representative to determine staff duties, to orient and instruct staff in duties and to schedule staff. Support advisors also assist the individual or his or her legally authorized representative with activities related to the supervision of staff, the evaluation of the job performance of staff, and the discharge of staff when necessary. This service provides sufficient information and assistance to ensure that individuals and their representatives understand the responsibilities involved with consumer-direction. Support Consultation does not address budget, tax or workforce policy issues. The state defines Support Consultation activities as the types of support provided beyond that provided by the financial management services provider. The scope and duration of Support Consultation will vary depending on an individual's need for Support Consultation. Support Consultation may be provided by a certified support advisor associated with a Consumer Directed Services Agency selected by the individual/employer or by an independent certified support advisor hired by the individual/employer. Support Consultation has a specific reimbursement rate and is a component of the individual's service budget. In conjunction with the interdisciplinary team, individuals or legally authorized representatives determine the level of Support Consultation necessary for inclusion in each individual's service plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Support Consultation certification is only available to individuals. Entities are not allowed to be certified to provide Support Consultation.

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

- [x] **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
Individual	Consumer Directed Service Direct Service Provider
Agency	Consumer Directed Services Agency

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Support Consultation

Provider Category:
Individual

Provider Type:
Consumer Directed Service Direct Service Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Individual provider must have Support Advisor certificate issued by DADS to indicate successful completion of required training conducted or approved by DADS. Support Consultation certification is only available to individuals. Entities are not allowed to be certified to provide Support Consultation.

Other Standard *(specify):*
The certified support advisor must be at least 18 years of age. The support advisor must have a high school diploma or Certificate of High School Equivalency (GED credentials); pass a criminal background check; complete initial training required by and conducted or authorized by DADS and pass a test based on the initial training. The Support Advisor Certification training topics include: self-determination; roles and responsibilities of the consumer directed service agency, employer, case manager/service coordinator and support advisor; overview of programs with support consultation; workforce employer resources; service back-up plans; corrective action plans; recruitment/procurement of contractors and vendors; negotiation of service agreements; employer/employee interactions, recognizing and reporting abuse, neglect and exploitation; and the billing process for support consultation. DADS certified support advisers must also attend and complete any ongoing training as required by and conducted or authorized by DADS. The support advisor does not provide case management or any other waiver service except for financial management services to the individual.
The support advisor cannot be the individual's legal guardian; the spouse of the individual's legal guardian; the individual's designated representative; or the spouse of the individual's designated representative.
The support advisor must complete initial and periodic training provided by the employer.

Verification of Provider Qualifications

Entity Responsible for Verification:
Consumer Directed Service Agency and individual/employer
DADS

Frequency of Verification:
Consumer Directed Service Agency and individual/employer prior to completing service agreement.
DADS during biennial on-site reviews of consumer directed service agencies.

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Support Consultation

Provider Category:
Agency

Provider Type:
Consumer Directed Services Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Individual provider must have Support Advisor certificate issued by DADS to indicate successful completion of required training conducted or approved by DADS. Support Consultation certification is only available to individuals. Entities are not allowed to be certified to provide Support Consultation.

Other Standard *(specify):*
The certified support advisor must be at least 18 years of age. The support advisor must have a high school diploma or Certificate of High School Equivalency (GED credentials); pass a criminal background check; complete initial training required by and conducted or authorized by DADS and pass a test based on the initial training. The Support Advisor Certification training topics include: self-determination; roles and responsibilities of the consumer directed service agency, employer, case manager/service coordinator and support advisor; overview of programs with support consultation; workforce employer resources; service back-up plans; corrective action plans; recruitment/procurement of contractors and vendors; negotiation of service agreements; employer/employee interactions, recognizing and reporting abuse, neglect and exploitation; and the billing process for support consultation. DADS certified support advisers must also attend and complete any ongoing training as required by and conducted or authorized by DADS. The support advisor does not provide case management or any other waiver service except for financial management services to the individual.
The support advisor cannot be the individual's legal guardian; the spouse of the individual's legal guardian; the individual's designated representative; or the spouse of the individual's designated representative.
Support Advisors can be independent or can be employed by or contract with the Consumer Directed Services Agency.
The support advisor must complete initial and periodic training provided by the employer.

Verification of Provider Qualifications

Entity Responsible for Verification:
Consumer Directed Service Agency holding a Medicaid Provider Agreement and individual/employer
DADS

Frequency of Verification:
Consumer Directed Service Agency and individual/employer prior to completing service agreement.
DADS during biennial on-site reviews of consumer directed service agencies.

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:
Behavioral Support

Service Definition *(Scope):*
Behavioral Support services provide specialized interventions that assist an individual to increase adaptive behaviors to replace or modify maladaptive or socially unacceptable behaviors that prevent or interfere with the individual's inclusion in home and family life or community life. Behavioral Support services can include the full range of psychological activities within the scope of state licensure for psychologists and other licensed professionals in addition to specific behavioral support services. The scope of Behavioral Support services offered in this waiver exceeds the state plan psychological services benefit and may be provided by a certified behavior analyst. Under the waiver, Behavioral Support services will be provided to maintain the individual's optimum condition.

This service includes:
(1) Assessment and analysis of assessment findings of the behavior(s) to be targeted so that an appropriate behavioral

support plan may be designed;
(2) Development of an individualized behavioral support plan consistent with the outcomes identified in the individual's person-directed plan;
(3) Training of and consultation with family members or other support providers and, as appropriate, with the individual in the purpose/objectives, methods, and documentation of the implementation of the Behavioral Support plan or revisions of the plan;
(4) Monitoring and evaluation of the success of the behavioral support plan implementation; and
(5) Modification, as necessary of the behavioral support plan based on documented outcomes of the plan's implementation.
(6) Counseling with and educating the family, friends, or other service providers about the techniques to use in assisting an individual to control maladaptive behaviors or emotions.
(7) Counseling with an individual regarding his emotions, behaviors, or social interactions.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Behavioral support services are provided under this waiver when no other financial resource is available or when other available resources have been exhausted.

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	Direct Service Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Support

Provider Category:
Agency

Provider Type:
Direct Service Agency

Provider Qualifications

License *(specify)*:
Home and Community Support Service Agency-Agency Licensure 40 Texas Administrative Code, Part I, Chapter 97

Psychological service provider must be licensed or certified by the Texas Board of Examiners of Psychologists

Licensed professional counselor must be licensed by Texas State Board of Examiners of Professional Counselors

Licensed clinical social worker must be licensed by Texas State Board of Social Worker Examiners

Certificate *(specify)*:
Board-Certified Behavior Analyst (Certification by the national Behavior Analyst Certification Board, Inc.)

Other Standard *(specify)*:
Psychologist (Texas Occupations Code Chapter 501)

Licensed psychological associate (Texas Occupations Code Chapter 501)

Licensed professional counselor (Texas Occupations Code Chapter 503)

Licensed clinical social worker (Texas Occupations Code Chapter 505)

Verification of Provider Qualifications

Entity Responsible for Verification:

Direct Service Agency holding a CLASS Medicaid Provider Agreement
DADS

Frequency of Verification:

Direct Service Agency prior to completing service agreement; verify license renewal
Biennial on-site reviews

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:

Continued Family Services

Service Definition *(Scope):*

Continued Family Services provides a 24-hour family living arrangement in a home using the same criteria for support family services and meeting the requirements of a support family home. Continued Family Services is for persons who are unable to continue in the support family service. A continued family agency must be contracted with DADS to provide Continued Family Services. The continued family agency will recruit, train, and certify the Continued Family Services provider. The case manager, the continued family agency, the natural family and the direct service agency, will coordinate placements into a Continued Family Services provider.

The Continued Family Services provider must consist of at least one adult, in addition to the individual receiving services, living in the home and no more than four non-related individuals living in the home. The Continued Family Services provider must have legal responsibility for the residence and either own or lease the residence. The home must be located in a typical residence within the community; and in a residence, neighborhood and community that meets the needs and choices of each individual. The residence must provide an environment that assures the community integration, health, safety, comfort, and welfare of the participant.

Continued Family Services adopts the same guidelines as described in “Habilitation – Residential Habilitation:”

The Continued Family Services agency will maintain responsibility for ensuring appropriateness of placement and monitoring of the family and environment. The Continued Family Services provider must provide care to the individual as appropriate and authorized on the service plan, including:

(1) Direct personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene);
(2) Assistance with meal planning and preparation;
(3) Securing and providing transportation;
(4) Assistance with housekeeping;
(5) Assistance with ambulation and mobility;
(6) Reinforcement of counseling, therapy, and educational activities;
(7) Assistance with medications and the performance of tasks delegated by a registered nurse;
(8) Supervision of individuals' safety and security;
(9) Facilitating inclusion in community activities, use of natural supports, social interaction, participation in leisure activities, and development of socially valued behaviors; and
(10) Habilitation.

The parents, the individual, and Continued Family Services provider continue to access non-waiver services, to include the independent school district and other community resources for the individual. The CLASS case management agency continues to provide case management services to ensure that services are accessed appropriately and timely. A separate payment will not be made for residential habilitation, meals, transportation, or emergency response services since these services are integral to and inherent in the provision of Continued Family Services.

Payments for Continued Family Services are not made for room and board, the cost of home maintenance, upkeep and improvement.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Continued Family Services are available to allow the individual to attend high school, a program leading to a high school diploma, a GED, or transition to independence, including attending college or vocational or technical training.

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	Continued Family Services Agency
Individual	Continued Family Services Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Continued Family Services

Provider Category:
Agency

Provider Type:
Continued Family Services Agency

Provider Qualifications

License *(specify):*
Appropriate Texas Department of Family and Protective Services (DFPS) Licensure or Certification as Child Placing Agency

Certificate *(specify):*
Appropriate Texas Department of Family and Protective Services (DFPS) Licensure or Certification as Child Placing Agency

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DFPS

Frequency of Verification:
DFPS enforces compliance of the following minimum standards:

a. conducts at least one annual, unannounced monitoring inspection of every main and branch office of a child-placing agency. DFPS conduct more inspections for child placing agencies that evidence problems complying with minimum standards.

b. conducts announced inspections every year of one-third of all agency foster homes. DFPS document

any deficiencies with minimum standards and cite the child placing agency if DFPS feel they have violated the minimum standards that govern their verification and oversight of foster homes.

c. investigates allegations of abuse, neglect, or exploitation. DFPS investigate all child deaths as alleged abuse or neglect.

d. investigate complaints of violations of minimum standards. Some complaints DFPS direct the child placing agency to investigate and report back to DFPS.

e. child placing agencies must report all serious incidents to DFPS to respond, often with an investigation. Reportable serious incidents are listed in Title 40, Part 19, Subchapter D, Division 1, §749.503

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Continued Family Services

Provider Category:
Individual
Provider Type:
Continued Family Services Provider
Provider Qualifications
License *(specify):*
Appropriate Texas Department of Family and Protective Services Licensure or Certification
Certificate *(specify):*
Appropriate DFPS Licensure or Certification
Other Standard *(specify):*
40 Texas Administrative Code, Part 19, Chapter 749, Child-Placing Agencies,
Contracted with either a Child Placement Agency or a CLASS Direct Services Agency that meets qualifications as a CLASS Support Family Agency or Continued Support Family. In addition to requirements found in regulations above, individual provider must be: Age 18 or older; Can be family member if not spouse or parent of minor child; Cardio-pulmonary resuscitation/First aid trained; client specific competencies; pass criminal background check, maintains current drivers license and insurance if transporting individual.
Verification of Provider Qualifications
Entity Responsible for Verification:
Continued Family Services Agency
DFPS
Frequency of Verification:
The Continued Family Services Agency must perform at a minimum quarterly supervisory visits of Continued Family Services Provider.

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
Service Definition *(Scope):*
Minor Home Modifications are those services that assess the need for, arrange for, and provide modifications and

improvements to, an individual's living quarters to allow for community living and ensure safety, security, and accessibility. Minor Home Modifications will be limited to those services identified by the service planning team, and approved by staff from DADS on the service plan as necessary to prevent institutionalization.
The home modifications listed are essential to provide safe access to and within the home while facilitating self-reliance and independence. Home modifications are cost-effective since greater individual access and greater overall independence allow the individual to perform more activities of daily living with less assistance. This decreases reliance on paid staff.
Supports, such as ramps, handrails, and grab bars reduce the risk of injury, thus saving costly hospital and other medical bills. Alarm and fire safety systems allow individuals with severe impairments to reside in community-based settings, while assuring their safety.
Safety flooring materials, including bath tile around floor mounted fixtures, vinyl or nylon carpeting, provide safe surfaces, and allow independent mobility for persons using crutches, wheelchairs, three-wheel scooters, and other aids which offer increased personal mobility. Floor leveling, of uneven surfaces to bridge multi-room levels, provides for safety and accessibility, and eliminates safety hazards, when the installation of a ramp is unworkable or inherently dangerous.
Safety glass, recess and protected lighting fixtures, window security devices and the fencing of residential areas further ensure the security and safety of persons with mental impairments.
Home modifications will be provided to meet the needs of the individual, which have been identified and approved in the individual service plan, as necessary to prevent institutionalization.
Minor Home Modifications consist of the following categories and include the installation, maintenance, and repair not covered by warranty
(1) Purchase or repair of wheelchair ramps;
(2) Protective awnings over ramps;
(3) Modifications to Bathroom Facilities;
(4) Modifications to Kitchen Facilities; and
(5) Specialized Accessibility/Safety Adaptations (Including repair and maintenance).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Minor Home Modifications are provided under this waiver when no other financial resource is available or when other available resources have been used. Minor Home Modifications will not be used to modify homes that are owned or leased by providers of waiver services. Direct service agencies are required to obtain specifications and bids from qualified contractors for modifications that are estimated to cost more than $1000. Direct service agency providers are also required to inspect all completed modifications for workmanship and compliance with the written specifications. All services shall be provided in accordance with applicable state and local building codes. Modifications must be for existing structures, and must not increase the square footage of the dwelling. Excluded are those adaptations or improvements to the home that are of general utility, and are not a direct medical or remedial benefit to the individual, such as carpeting (except to allow independent mobility for persons using crutches, wheelchairs, three-wheel scooters, and other aids which offer increased personal mobility), roof repair, central air conditioning, etc. If alternative solutions exist, modifications will be approved by staff from DADS based on considerations of cost and comparable functionality. The caregiver or individual is responsible for any enhancement costs, which exceed those approved by the department. Minor Home Modifications cannot exceed $10,000 lifetime maximum with $300 for repairs every year thereafter when such repair or replacement is not covered by warranty.
Waiver funds will not be used for the following residential modifications:
(1) Home security systems, including monthly services;
(2) Utilities;
(3) Electrical upgrades /or electrical outlets unless needed to power adapted equipment, or safety hazard exits;
(4) Elevators;
(5) Air duct cleaning and maintenance;
(6) Central air and heating systems, multiple individual air conditioners;
(7) Water filtration system;
(8) Carbon monoxide detector;
(9) Roof repair/replacement;
(10) Carpeting except to allow independent mobility for persons using crutches, wheelchairs, three-wheel scooters, and other aids which offer increased personal mobility;
(11) Building new carports, porches, patios, garages, porticoes or decks;
(12) Electric fences; and
(13) Landscaping or yard work, landscaping supplies, and pest exterminations.

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	Direct Service 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:
Direct Service Agency

Provider Qualifications

License *(specify):*
Home and Community Support Service Agency Agency Licensure 40 Texas Administrative Code, Part I, Chapter 97

Certificate *(specify):*

Other Standard *(specify):*
Product and work must meet applicable building codes. All items shall meet applicable standards of manufacture, design, and installation.

Verification of Provider Qualifications

Entity Responsible for Verification:
Direct Service Agency holding CLASS Medicaid Provider Agreement
DADS

Frequency of Verification:
Provider Agency prior to completing service agreement; prior to expiration of license.
DADS during biennial on-site reviews

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

Service Definition *(Scope):*
Massage Therapy
Massage Therapy is treatment given by stroking, kneading, and striking certain muscular parts of the body to improve

circulation, sooth the nerves, and stimulate the digestive organs. A massage therapist licensed by the Texas Department of State Health Services delivers the service. Massage therapy constitutes a health care service for therapeutic purposes where manual techniques are applied and may include adjunctive therapies with the intention of positively affecting the health and well-being of the individual. Massage increases the circulation of blood and flow of lymph. Massage helps loosen contracted, shortened muscles and can stimulate weak, flaccid muscles to improve posture and promote movement that is more efficient. Massage also helps with tissue elasticity to connective tissues that surround and support the muscles to improve range of motion and to reduce spasticity. Other benefits of the service may include decreased contractures, prevention of decubitis, decreased muscle spasms, improvement of posture and balance, and decreased fatigue.
Massage therapy may increase, or help sustain, an individual's ability to be more independent in the performance of activities of daily living; thereby, decreasing dependency upon others to perform or assist with basic daily activities.

Recreational Therapy
Recreational therapy helps to develop leisure time in ways that enhance health, independence, and well-being. A recreational therapist certified by the National Council of Therapeutic Recreation Certification delivers the service. 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.

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 maintenance or improvement of social or emotional functioning, mental processing, or physical health. A registered music therapist certified by the Certification Board for Music Therapy delivers the service.
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 an individual 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.

Hydrotherapy
Hydrotherapy consists of therapeutic modalities done in water to treat muscles, joints, and skin disorders and injuries. Any Texas state-licensed therapist may deliver the service when they have a background in hydrotherapy. Hydrotherapy will only be considered a specialized therapy if provided by a licensed therapist other than a physical, occupational, or speech therapist; otherwise, it is to be billed under the corresponding therapy service category.

Aquatic Therapy
Aquatic Therapy is a low-risk exercise medium done in water and offering a broad range of benefits including increased range of motion, flexibility, muscular strengthening and toning, cardiovascular endurance, fitness, and mobility. The service is delivered through any Texas state-licensed therapist who is also certified in emergency water safety (American Red Cross), water safety instruction, or lifeguarding. Aquatic Therapy will only be considered a specialized therapy if provided by a licensed therapist other than a physical, occupational or speech therapist (such as, a recreational therapist, massage therapist): otherwise, it is to be billed under the appropriate therapy service category.
Aquatic Therapy provides opportunities for improved range of motion, muscle strength, gait training, and sensory integration in a water medium. AT utilizes the unique properties of water to meet an individual's special needs. The therapy is used to improve function through the application of therapeutic exercises with the individual's active participation. The therapist provides activities within the scope of the single profession for which he is licensed or certified.

Hippotherapy
Hippotherapy is a physical, occupational, and speech-language therapy treatment strategy that utilizes equine movement as part of an integrated intervention program to achieve functional outcomes. The service is delivered by a North American Riding for the Handicapped Association certified riding instructor in a structured therapeutic riding program administered in cooperation with a licensed physical or occupational therapist that has an expertise in hippo-therapy. Hippotherapy applies multidimensional movement of a horse for individuals with movement dysfunction. Mobility is improved with increased range of motion. Contractures are decreased through hippotherapy by exercising those muscles

not used by non-ambulatory individuals and normalizing muscle tone. Mobilization of the pelvis, lumbar spine, and hip joints is achieved in strengthening the musculoskeletal system and increasing strength in postural muscles.
Hippotherapy requires that the individual use cognitive functioning, especially for sequencing and memory. Individuals with attention deficits and behavior problems are redirecting attention and behaviors by focusing on the activity. Improved confidence, self-esteem, and self-discipline are noted benefits of the therapy. Hippotherapy is an accepted mode for therapeutic exercise, neuromuscular education, kinetic activities, therapeutic activities, sensory integration activities, and for individual speech therapy. The activities also help improve respiratory function and assist with improved breathing and speech production. Hippotherapy cannot be authorized if the individual is receiving Therapeutic Horseback Riding.

Therapeutic Horseback Riding
Like hippotherapy, therapeutic horseback riding is a therapeutic modality that utilizes equine movement as part of an integrated intervention program to achieve functional outcomes. A riding instructor who is certified by the North American Riding for the Handicapped Association delivers the service through a structured riding program.
Therapeutic horseback riding provides gentle and rhythmic movements in a manner similar to a human gait. Individuals that are unable to ambulate are able to experience movement similar to ambulatory persons. Improvements are noted in flexibility, balance, and muscle strength. Many riders acquire a better range of hip and knee motion and improved sitting balance. The rider can also benefit from improved confidence, patience, and self-esteem through a sense of independence. Therapeutic Horseback Riding cannot be authorized if the individual is receiving Hippotherapy.

Auditory Integration Training/Auditory Enhancement Training
Auditory Integration Training/Auditory Enhancement Training is designed to help individuals to cope with hearing dysfunction by facilitating auditory processing skills. This training may be appropriate for a number of learning disabilities including, but not limited to, autism, dyslexia, and attention deficit disorders. The service is delivered by an Auditory Integration Training or Auditory Enhancement Training trainer who is certified by the Georgiana Organization Inc. of Westport, Connecticut, or BGC Enterprises of San Diego, California. A pre-requisite for Auditory Integration Training/Auditory Enhancement Training is for the individual to have an audiogram. In Texas, a licensed audiologist must perform an audiogram.

Nutritional Services
Nutritional Services assists individuals in meeting their basic and/or special therapeutic nutritional needs. Medically oriented nutritional services are especially important to ensure and maintain the health of persons on modified diets required by a disability and those requiring enteral or parenteral nutrition regimens.
For nutritional services, a dietician develops individual meal plans as appropriate for the individual. A registered, licensed, or provisionally licensed dietitian delivers the service. The Texas Board of Examiners of Dietitians licenses dietitians.
Through a nutritional assessment, the dietician evaluates the nutritional needs of an individual based on biochemical, anthropometric, physical and dietary data to determine nutrient needs and to recommend appropriate nutritional intake through counseling and/or in consultation with the physician.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The services identified as Specialized Therapies are provided under this waiver when no other financial resource is available or when all other available resources have been used.

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	Direct Service 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:
Direct Service Agency
Provider Qualifications
License *(specify):*
Home and Community Support Service Agency Agency Licensure 40 Texas Administrative Code, Part I, Chapter 97

Massage Therapist must be licensed by the Texas State Department of Health Services. Licensed Massage Therapist (Texas Occupations Code, Chapter 455)

Hippotherapy must be delivered by a Physical Therapist licensed by The Texas Board of Physical Therapy Examiners or by Occupational Therapist licensed by The Texas Board of Occupational Therapy Examiners.

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

Hydrotherapy must be delivered by any Texas state-licensed therapist, practicing within the scope of their licensure, with a background (education, training, and/or experience) in hydrotherapy. Hydrotherapy will only be considered a specialized therapy if provided by a licensed therapist other than a physical, occupational, or speech therapist: otherwise, it is to be billed under the corresponding therapy service category.

Aquatic Therapy must be delivered through any Texas state-licensed therapist, practicing within the scope of their licensure, who is also certified in emergency water safety, water safety instruction, or as a lifeguard by the American Red Cross.
Certificate *(specify):*
Recreational Therapist must be certified by the National Council of Therapeutic Recreation Certification.

Music Therapist must be certified by the Certification Board for Music Therapy.

Hippotherapy and Therapeutic Horseback Riding must be delivered by a North American Riding for the Handicapped Association certified riding instructor in a structured therapeutic riding program administered in cooperation with a licensed physical or occupational therapist who has an expertise in hippotherapy.

AIT/AET service provider must be Certified by the Georgiana Organization Inc. of Westport, Connecticut, or BGC Enterprises of San Diego, California.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Direct Service Agency holding CLASS Medicaid Provider Agreement
DADS
Frequency of Verification:
Direct Service Agency prior to completing service agreement; prior to expiration of license.
DADS during biennial On-site Reviews

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:

Support Family Services

Service Definition *(Scope):*

Support Family Services consists of those services that are required for a qualified waiver individual to reside within the home of a family other than the home of the natural or adopted parent(s). A support family agency must be contracted with DADS to provide Support Family Services. The support family agency will recruit, train, and certify the Support Family Services provider. The case manager, the support family agency, the natural family and the direct service agency, will coordinate placements into a Support Family Services provider.

The Support Family Services provider must consist of at least one adult living in the home and no more than four non-related individuals living in the home. The Support Family Services provider must have legal responsibility for the residence and either own or lease the residence. The home must be located in a typical residence within the community; and in a residence, neighborhood and community that meets the needs and choices of each individual. The residence must provide an environment that assures the community integration, health, safety, comfort, and welfare of the participant.

The Support Family Services provider must provide care to the individual as appropriate and authorized on the service plan, including:

(1) Direct personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene);
(2) Assistance with meal planning and preparation;
(3) Securing and providing transportation;
(4) Assistance with housekeeping;
(5) Assistance with ambulation and mobility;
(6) Reinforcement of counseling, therapy, and educational activities;
(7) Assistance with medications and the performance of tasks delegated by a registered nurse;
(8) Supervision of the individual's safety and security;
(9) Facilitating inclusion in community activities, by the use of natural supports, social interaction, participation in leisure activities, and development of socially valued behaviors;
(10) Habilitation.

The parents and Support Family Services provider continue to access non-waiver services, to include the independent school district and other community resources for the individual. The CLASS case management agency continues to provide case management services to ensure that services are accessed appropriately and timely.

Support Family Services adopts the same guidelines as described in "Habilitation – Residential Habilitation:" Payments for Support Family Services are not made for room and board, the cost of home maintenance, upkeep and improvement. Payment for Support Family Services does not include payments made, directly or indirectly, to members of the individual's immediate family. A separate payment will not be made for residential habilitation, meals, transportation, or emergency response services since these services are integral to and inherent in the provision of support family services.

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

Support Family Services are available to allow the individual to attend school, or participate in a program leading to a high school diploma or a GED.

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
Individual	Support Family Services Provider
Agency	Support Family Services Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Support Family Services

Provider Category:
Individual
Provider Type:
Support Family Services Provider
Provider Qualifications
License *(specify):*
Appropriate Texas Department of Family and Protective Services (DFPS) Licensure or Certification
Certificate *(specify):*
Appropriate DFPS Licensure or Certification
Other Standard *(specify):*
40 Texas Administrative Code, Part 19, Chapter 720, 24-Hour Care Licensing, and Chapter 749, Child-Placing Agencies
Contracted with either a Child Placement Agency or a CLASS Direct Services Agency that meets qualifications as a CLASS Support Family Agency or Continued Support Family. In addition to requirements found in regulations above, individual provider must be: Age 18+ Can be family member if not spouse or parent of minor child; Cardio-pulmonary resuscitation/First aid trained; client specific competencies; pass criminal background check, maintains current drivers license and insurance if transporting individual.
Verification of Provider Qualifications
Entity Responsible for Verification:
Support Family Agency
DFPS
Frequency of Verification:
40 Texas Administrative Code, Part 19, Chapter 720, 24-Hour Care Licensing, and Chapter 749, Child-Placing Agencies. The Support Family Agency must perform at a minimum quarterly supervisory visits of Support Family Services Provider.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Support Family Services

Provider Category:
Agency
Provider Type:
Support Family Services Agency
Provider Qualifications
License *(specify):*
Licensed by the Texas Department of Family and Protective Services (DFPS) as a Child Placing Agency: 40 Texas Administrative Code, Part 19, Chapter 720, 24-Hour Care Licensing, and Chapter 749, Child-Placing

Agencies
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
DFPS
Frequency of Verification:
DFPS enforces compliance of the following minimum standards:
a. conducts at least one annual, unannounced monitoring inspection of every main and branch office of a child-placing agency. DFPS conduct more inspections for child placing agencies that evidence problems complying with minimum standards.
b. conducts announced inspections every year of one-third of all agency foster homes. DFPS document any deficiencies with minimum standards and cite the child placing agency if DFPS feel they have violated the minimum standards that govern their verification and oversight of foster homes.
c. investigates allegations of abuse, neglect, or exploitation. DFPS investigate all child deaths as alleged abuse or neglect.
d. investigate complaints of violations of minimum standards. Some complaints DFPS direct the child placing agency to investigate and report back to DFPS.
e. child placing agencies must report all serious incidents to DFPS to respond, often with an investigation. Reportable serious incidents are listed in Title 40, Part 19, Subchapter D, Division 1, §749.503

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:
Transition Assistance Services
Service Definition *(Scope):*
Transition Assistance Services are services provided to a person living in an institutional setting to assist the person in transitioning from the institutional setting into the CLASS Program. Transition Assistance Services are one-time initial expenses required for setting up a household. The expenses must be included in the individual service plan approved by the case manager and DADS and the costs cannot exceed $2,500.

To be eligible to receive Transition Assistance Services the individual must:
(1) Be a resident of a Texas nursing facility or a Texas ICF/MR facility;
(2) Be Medicaid eligible; and
(3) Be determined eligible for CLASS services.

Examples of Transition Assistance Services include some or all of the following components:
(1) Security deposits that are required to obtain a lease on an apartment or home;
(2) Essential furnishings and moving expenses required to occupy and use a community domicile;
(3) Set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating); and
(4) Health and safety assurances, such as pest eradication, allergen control, or one-time cleaning prior to occupancy.

Essential furnishings in the above context would refer to necessary items for an individual to establish his basic living arrangement, such as a bed, table, chairs, window blinds, eating utensils, and food preparation items. CLASS does not consider essential furnishings to include diversional or recreational items such as televisions, cable television access, or

videocassette recorders.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Transiton Assistance Services are one-time initial expenses required for setting up a household. There is a $2,500 cost cap per participant for this service. There are no exceptions to this cost cap.

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	Transition Assistance Services Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Assistance Services

Provider Category:
Agency
Provider Type:
Transition Assistance Services Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The Transition Assistance Services provider employee must:
1) Be 18 years old; 2) Have a high school diploma or Certificate of High School Equivalency (GED credentials); 3) Not be the client's spouse, the parent of a minor child, have legal conservatorship of the client and not live in the client's household; 4) Be capable of providing the required services. The Transition Assistance Services provider must comply with the requirements for delivery of Transition Assistance Services, which include requirements such as allowable purchases, costs limits, and time frames for delivery. Transition Assistance Services providers must demonstrate knowledge of, and history in successfully serving individuals who require home and community based services.
Verification of Provider Qualifications
Entity Responsible for Verification:
DADS
Frequency of Verification:
Biennial On-site Reviews

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.*
  - ☐ **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:

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):

Providers and individual employers conduct a statewide criminal history check in compliance with the Texas Health and Safety Code (THSC), Chapter 250 by taking the following actions regarding applicants, employees, and contractors:
(1) Obtain criminal history record information from the Texas Department of Public Safety that relates to an unlicensed applicant, employee, or contractor whose duties involve direct contact with a consumer, and
(2) Refrain from employing or contracting with or immediately discharge, a person who has been convicted of an offense that bars employment under THSC, §250.006, or an offense that the program provider or individual employer determines is a contraindication to the person's employment or contract to provide services to the individual.

Employers are required to do criminal history checks on all new employees. During biennial on-site reviews of program providers, DADS monitors for completion of criminal history checks as required. Contract monitoring of providers are conducted biennially. Home and community support service agency providers must also comply with 40 Texas Administrative Code §97.247 by completing documentation of criminal history checks.

Each individual who chooses self-direction must choose a Consumer Directed Services Agency that provides guidance and assistance to the individual with employer-related tasks. The consumer directed services agency is required to have verification of the criminal history check prior to finalizing the hiring process on behalf of the individual. During on-site reviews of program providers and consumer directed service agencies, DADS Community Services Contracts monitors for completion of criminal history checks as required.

Regulatory boards conduct criminal background checks on licensed persons as a part of the licensing process. As part of their on-site reviews of providers, DADS Regulatory Services staff involved in licensure, survey and enforcement activities, monitor if criminal history checks are conducted as required.

Direct Service Agencies must be licensed to provide Licensed Home Health Services as a Home and Community Support Service Agency. DADS Regulatory Services licenses home and community support service agencies.

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):

Providers and individual employers must comply with THSC Chapters 250 and 253 regarding applicants, employees, and contractors by:
(1) Searching the Nurse Aide Registry in accordance with THSC Chapter 250, and refrain from employing or contracting with, or immediately discharge, a person who is designated in the registry as having abused, neglected, or mistreated a consumer of a facility or has misappropriated a consumer's property,
(2) Searching the Employee Misconduct Registry maintained by DADS in accordance with THSC, Chapter 253, and refrain from employing or contracting with or immediately discharge, a person whose duties would or do involve direct contact with a consumer, and who is designated in the registry as having abused, neglected, or exploited a consumer or has misappropriated a consumer's property.

Home and Community Support Service Agencies must also comply with 40 Texas Administrative Code §97.247 by completing and maintaining documentation of nurse aid registry and employee misconduct registry checks. Providers and individual-employers are required to maintain documentation of the nurse aid registry and employee misconduct registry checks performed. DADS Community Services Contracts monitors biennially for completion of required registry checks during on-site reviews.

As part of their reviews of Home and Community Support Service Agencies, DADS Regulatory Services staff involved in licensure, survey and enforcement activities, monitor if nurse aid registry and employee misconduct registry checks are conducted as required.

A billing and payment review for consumer directed service agencies is conducted biennially by DADS. DADS annually aggregates the data and reports to HHSC. HHSC discusses with DADS any significant findings and together with DADS prepares a remediation plan or improvement plan as needed.

The nurse aid registry and the employee misconduct registry are maintained by DADS.

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.*

Payment for habilitation and respite can be made to the parent/guardian of an individual who is over the age of 17. Payments will not be made for the routine care and supervision, which would be expected to be provided by a family member.
Documentation requirements are the same for relatives and guardians who are service providers as for all other service providers. Program providers must assure completion of required documentation and consumer directed service agencies require submission of required documentation before paying the provider of services and submitting a billing claim. DADS determines compliance with policies concerning eligibility of individual providers and completion of required documentation during biennial contract monitoring reviews of CLASS program providers and billing and payment reviews of consumer directed service agencies.

Services that can be provided by a relative/guardian are residential habilitation and respite. Residential habilitation schedules are developed based on assessed needs. The provider or the Consumer Directed Services Agency monitors this by reviewing documentation of hours worked compared to the residential habilitation schedule. Respite is also verified through records of hours worked.

- ( ) **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.

- ( ) **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:

The following processes 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:
In order to obtain a provider agreement as a case management agency, direct services agency, or a consumer directed services agency CLASS Program provider, a provider applicant must apply for such in accordance with 40 Texas Administrative Code Part 1, Chapter 49 relating to Enrollment of Medicaid Waiver Program Providers. DADS accepts new provider applications on a continuous and ongoing basis. As part of the provider enrollment process, new providers are required to complete new provider training on-line using a computer-based training (CBT) format. Once a provider submits a completed application and shows proof of appropriate licensure if applicable, the provider agreement is executed within 60 days. Qualified CLASS Program providers agree to provide all CLASS Program services as specified in the provider agreement. This model of service delivery accomplishes the following for CLASS Program individuals:
(1) ensures the availability of each service across the state, even in rural areas where without the use of our current definition of qualified provider not all services of the waiver would be readily accessible.
(2) recognizes that a vast majority of consumers are not single service users, but require supports across service disciplines that must be closely integrated and coordinated to achieve beneficial outcomes;
(3) promotes effective response to temporary or permanent changes in consumers' service needs as provider agencies are required to make all services available when and as they are needed by consumers;
(4) establishes a single point of accountability for provision of needed services;
(5) decreases administrative costs.
In addition to promoting efficient service delivery, the CLASS Program service delivery model does not compromise an individual's choice of qualified provider agencies or providers of individual service. Individuals have a choice between at least two of each type of provider agency.
Information for obtaining a CLASS Medicaid provider agreement is provided by contacting the DADS Community Services Contracts unit.

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**
   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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 Percent of new program providers that are licensed as required.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Approved contract (HCATS); Access Database

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 Percent of program providers in compliance with Medicaid provider agreement standards.

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: Biennially	

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.3 Percent of program providers surveyed and in substantial compliance with home and community support service agencies licensure standards.

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

Responsible Party for	**Frequency of data**	**Sampling Approach***(check*

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*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: Every 3 years	

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.4 Percent of program providers who have a current license.

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: Biennially	

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.5 Percent of Consumer Directed Services Agency monitoring reviews that do not result in any adverse action on Medicaid provider agreement.

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**	☐ **Weekly**	☑ **100% Review**

Agency		
☑ **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: Biennially	

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.6 Percent of program providers that demonstrate that personnel who provide services to individuals are qualified by licensing, certification, and state regulations.

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: Biennially	

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.7 Percent of Consumer Directed Services Agencies that demonstrate that personnel who provide services to individuals are qualified by licensing, certification, and state regulations.

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: Biennially	

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:

Percent of Case Management Agencies who ensure that case managers meet staff qualifications per program provider agreement.

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: Biennially	

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 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Percent of Direct Service Agencies compliant with training requirements.

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: Biennially	

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:
Percent of Case Management Agencies compliant with training requirements.

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: Biennially	

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:
Percent of on-site Consumer Directed Services Agency reviews that evidence service providers are trained as required by state rules and the waiver.

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: Biennially	

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.
During initial and biennial on-site contract monitoring reviews of CLASS Program providers, the State verifies that all minimum provider qualifications are met and required training has been accomplished.

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.
When DADS detects provider non-compliance with program requirements, DADS requires the provider to implement a correction action plan and can apply both financial and administrative sanctions. Following biennial on-site review, all providers receive a written report that details the specific areas of non-compliance found during the review and includes instruction regarding the provider's responsibility with regard to the areas of deficiency. DADS then conducts follow-up activities in accordance with CLASS Provider Review procedures and Consumer Directed Services Agency review procedures to ensure corrective action has been implemented.

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 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 set of services will be limited to a maximum of $10,000 per service plan year: Dental Services and Adaptive Aids. The individual or legally authorized representative can choose those services that will most support the individual's needs for that plan year. This limit is based on the adaptive aids cap of $10,000 in the current waiver. Since the current cost limit has not been fully utilized by most individuals as demonstrated by the most recent 372 cost report, the state is including dental services and adaptive aids under the $10,000 cap in order to provide a new service within the existing cost limit. The individual can prioritize their adaptive aid and dental needs for each plan year. The state will annually review the cost limit to determine if individual needs or funding resources allow for an increase to the cost limit. The service planning team will inform waiver participants and legally authorized representatives of the limit and will refer participants to other community and state resources as needed.
- ☐ **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 D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Individual 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)**
- [x] **Case Manager** (qualifications specified in Appendix C-1/C-3)
- [ ] **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

- [ ] **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:*

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.

The case manager selected by the individual or legally authorized representative educates the individual, legally authorized representative, or both about service delivery options and services available through the CLASS Program, including the consumer directed services option, that will contribute to goal achievement. The case manager must inform the individual, legally authorized representative or both, orally and in writing, of the eligibility criteria for participation in the CLASS Program; the services and supports provided by the CLASS Program and the limits on those services and supports; and the reasons an individual may be discharged from the CLASS Program.
The case manager assures that the individual and legally authorized representative participate in developing an initial service plan that meets the individual's identified needs and service outcomes. The service planning team that convenes to develop the service plan must consist of the individual or legally authorized representative , the case manager, and a representative from the direct service agency. Additionally, the individual or legally authorized representative has the authority to include any other persons they wish to invite to participate as a member on the service planning team. The case manager supports the

individual and legally authorized representative to set goals that address the needs identified during assessment.
The case manager must assure that the individual, legally authorized representative, or both, as appropriate, can contact the case manager to secure information regarding services, supports, and service delivery options; and can request to change the service plan due to changes in needs, goals or preferences.
At least annually, the case manager must present information to the individual or legally authorized representative regarding available waiver services and supports, and the available service delivery options, including the consumer directed services option.

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):

At enrollment and annually thereafter, the case manager presents information to the individual or legally authorized representative regarding available services and supports and the available service delivery options, including consumer directed services option. As part of the enrollment process, the initial service plan is developed with the service planning team. The case manager, the individual or legally authorized representative, the direct service agency representative and others (e.g., family, friends, or service providers) as chosen or designated by the individual or legally authorized representative comprise the service planning team. The service planning team coordinates the meetings to ensure they are held at times and locations convenient to the individual.

After the enrollment process is complete, the CLASS case manager initiates, coordinates and facilitates the service planning process to assure that the service plan addresses the desires and needs as identified by an individual and legally authorized representative. At least annually, the service planning team must review the service plan and initiate changes in the service plan in response to changes in the individual’s needs and identified outcomes as documented in the service plan. The individual and legally authorized representative must sign the plan to indicate understanding of and agreement with the plan. The case management agency assures an individual or legally authorized representative is informed of the name of the individual's case manager and how to contact the case manager. The CLASS case manager informs the individual or legally authorized representative that the case manager will assist in transferring the individual’s CLASS program services from one program provider to another program provider. The transfer will occur upon request from the individual or legally authorized representative.

The service planning team documents that the CLASS Program services in the service plan are necessary for the individual to live in the community and to prevent his or her admission to institutional services; and are sufficient, when combined with services or supports available from non-waiver resources, to assure the individual's health and welfare in the community.
At a minimum, both the initial and subsequent service planning processes and resulting plans must address the following:
(A) A description of the needs and preferences identified by the individual, legally authorized representative or both;
(B) A description of the services and supports the individual requires to continue living in a community-based setting;
(C) A description of the applicant’s or individual's current existing natural supports and non-CLASS Program services that will be or are available;
(D) A description of individual outcomes to be achieved through CLASS Program services and justification for each service to be included in the individual service plan;
(E) Documentation that the type, frequency, and amount of each service included in the applicant's or individual’s service plan do not replace existing natural supports or non-CLASS Program sources for the services for which the applicant/individual may be eligible; and
(F) A description of actions and methods to be used to reach identified service outcomes, projected completion dates, and person(s) responsible for completion.

The case manager supports individual and legally authorized representative participation in the process by encouraging the

expression of preferences, goals and ambitions and providing information about the services available through the CLASS Program, as well as through non-waiver resources for which the individual may be qualified. In addition, formal assessments regarding health, level of functioning and specialized therapeutic interventions are completed as the need is identified by the service planning team. The service plan identifies needs and specifies the type and frequency of waiver services and non-waiver services to be included in the individual service plan to address those needs as well as the individual's other needs, preferences and desired outcomes. The service planning team works together to develop a service plan that integrates CLASS services and supports and non-waiver services so that the individual's goals may be achieved and services are complementary and not duplicative.

The service planning process and plan must include a description of actions and methods to be used to reach identified service outcomes, projected completion dates, and entity or person(s) responsible for implementing the methodology. The service plan specifies the type and amount of each service to be provided to the individual, as well as services and supports to be provided by other, non-waiver sources during the service plan year.

The individual's case manager is responsible for monitoring the implementation of the service plans. The direct service agency is responsible for ensuring implementation of those CLASS services on the plan. The individual or legally authorized representative that elects to utilize the consumer directed services option is responsible for ensuring implementation of self-directed services.

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.

During the service planning process, the case manager, with support from appropriate professionals, uses assessment information in conjunction with input from the individual or legally authorized representative to determine any risks that might exist to health and welfare because of living in the community. The development of back-up plan is an integral part of the service planning process where the individual's needs and preferences are addressed by the service planning team. Key backup planning activities include use of informal supports, third party resources, and other community resources identified by the individual. The case manager incorporates back-up plans into the service plan. The direct service agency must implement back up plans that adequately prevent service interruptions or delays that may place the individual's health or safety at risk. The direct service agency provide agency specific after hours/emergency contact information to each individual.

The case manager also ensures that the individual is informed of the opportunity to change or transfer providers at any time during their plan year. This gives further options if one is not satisfied with the services they are receiving from their case manager, direct service agency, or provider for consumer directed services.

The DADS website provides case managers and other service planning team members, access to a "Person-directed Plan Discovery Tool," which includes the individual participation to determine a variety of risks such as risks related to health factors; abuse, neglect, or exploitation; and safety risks.

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.

When an individual is released from the Interest List, DADS sends a letter to inform them they are eligible to apply for the CLASS Program. A list of current direct service agencies and case management agencies is included with that letter. DADS posts an interview tool on its website for individuals and their families to use during the process of provider selection. Individuals complete a "Selection Determination" form indicating their selection of direct service agencies and

case management agencies annually.

The case manager must inform the individual or legally authorized representative that the case manager will assist in transferring the individual's CLASS program services from one program provider to another program provider. The transfer will occur upon request from the individual or legally authorized representative.

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):

The state Medicaid agency through its operating agreement delineates roles and responsibilities of each department. The operating agreement outlines the state Medicaid agency's monitoring and oversight functions. The state Medicaid agency has delegated the day-to-day approval of service plans to the Department of Aging and Disability Services (DADS), an operating agency within the state Medicaid agency. DADS approves all individual service plans. DADS also performs at least biennial reviews of each CLASS direct service agency and case management agency, during which they review the provider's compliance with the approved service planning requirements. DADS annually aggregates data and reports to HHSC. HHSC discusses with DADS any significant findings and together with DADS 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**
- ☑ **Operating agency**
- ☑ **Case manager**
- ☑ **Other**

Specify:

Direct Services Agency

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 implementation of individual service plans and assess how well services are meeting an individual's needs and enabling the individual to achieve the goals and outcomes described in the service plan. Case managers must complete at least one face-to-face contact with the individual every 90 days. Additional contacts may be completed in person or by telephone. The case manager must review and document the following:
(1) Whether waiver and non-waiver services and supports are implemented and provided in accordance with the service plan and continue to meet the individual's needs, goals, and preferences;
(2) Whether the individual and legally authorized representative are satisfied with implementation of services;
(3) Whether the individual's health and welfare are reasonably assured; and
(4) Whether the individual or legally authorized representative exercises free choice of providers and accesses non-waiver services including health services.

The case manager takes action to address identified problems by convening the service planning team to resolve problems or by advocating on the individual's behalf. When the case management agency or direct service agency identifies a change in the needs of the individual, the case manager convenes the service planning team. If there is an indication of a change in needs, a revision to the service plan is made with the assistance of the individual or legally authorized representative and the service planning team. At least annually, the case manager convenes the service planning team to plan services for the upcoming year.

The direct service agency is responsible for implementing the service plan and back up plans to protect the individual health and welfare. The direct service agency provides agency specific emergency contact number to individuals. The direct service program director is responsible for ensuring the service necessary are available to protect the health and welfare of the individual.

DADS conducts at least biennial reviews of CLASS Program direct service agencies and case management agencies. During the reviews, DADS ensures that the service plan developed and approved by the service planning team and DADS were implemented according to the plan. Review of back-up plans that have been implemented occurs during biennial reviews of direct service agencies to determine their effectiveness. DADS verifies that an individual or legally authorized individual is provided with agency specific emergency contact numbers for after hours service of the case management agency and direct service agency. DADS also ensures the case manager is monitoring service provision in accordance with the rules. Additionally, DADS interviews individuals and legally authorized representatives combined with record reviews to determine a provider's compliance with safeguarding the right of individuals and legally authorized representatives to exercise free choice of providers and the right to transfer to a new provider.

CLASS providers are required to inform individuals and legally authorized representatives of the process for filing a complaint with DADS Consumer Rights and Services, and must provide them with the phone number for Consumer Rights and Services. Evidence of provider compliance with this program requirement is assessed during all reviews conducted by DADS. DADS Consumer Rights and Services division follows up on all complaints to assure an individual or legally authorized representatives right to choose from among the list of qualified providers is protected. Employing a service planning team process to develop an individual's service plan and to evaluate changes in need offers a measure of objectivity in developing and monitoring an individual's service plan and delivery of program services.

The CLASS Program provider is responsible for ensuring that individuals' rights are protected, service plan monitoring occurs as stated in the individual's service plan, required documentation is completed, and follow-up action on contract monitoring findings is taken.
DADS annually aggregates the data and reports to HHSC. HHSC discusses with DADS any significant findings and together with DADS prepares a remediation plan or improvement plan as needed.

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:*

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**
   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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 Percent of service plans that are complete to include signature of individual, individual's family or legally authorized representative.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CLASS Access Database

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.a.2 Percent of people reporting that case managers asked about their preferences.

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators Survey

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 = 90% CI, +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Biennially	

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: Biennially

Performance Measure:
D.a.3 Percent of case management agencies that conduct quarterly reviews of service plans.

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: Biennially	

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.4 Proportion of individuals reporting that their case manager helped them get what they needed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators Survey

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 = 90% CI, +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Biennially	

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: Biennially

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 Percentage of service plans reviewed by the State.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CLASS Access Database

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**	☐ **Other**

	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:

Performance Measure:
D.b.2 Percent of service plans not remanded by the State.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CLASS Access Database

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 Percent of service plans that are reassessed and renewed annually prior to service plan expiration date.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CLASS Access Database

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 Percent of monitored providers who evidence that all program services are delivered in accordance with an individual's service plan.

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: Biennially	

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 Percentage of people reporting that needed services are available.

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators Survey

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 = 90% CI, +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Biennially	

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: Biennially

Performance Measure:
D.d.3 Percent of people using the consumer directed services option reporting that needed services are available.

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators Survey

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 = 90% CI, +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Biennially	

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: Biennially

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/indicator the State will use to assess compliance with the statutory assurance

complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 Percent of individuals' records evidencing at enrollment that individuals are afforded choice between waiver services and institutional care.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CLASS Access Database

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: Initial enrollment	

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 Percent of individuals' records evidencing that individuals are afforded choice between providers on an annual basis.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CLASS Access Database

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 Percent of people who make choices about their lives and are actively engaged in planning their services and supports.

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators Surveys

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 = 90% CI, +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Valid random sample
	☑ **Other** Specify: Biennially	

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: Biennially

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.
At the time of enrollment, the individual or legally authorized representative chooses a CLASS case management agency and direct service agency from all program providers serving their geographical area. The initial individual service plan is developed using a person-centered planning process. The case manager convenes a service planning team that must include the individual and, if applicable, the individual's legally authorized representative and, at the invitation of the individual or legally authorized representative, other individuals important in developing the individual service plan. The case manager, who is responsible for convening the individual's service planning team and assuring the plan, is reviewed and revised at least annually and whenever indicated by changes in the individual's service needs. Findings from the National Core Indicators survey can be used for trending and analysis.

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.
When DADS detects provider non-compliance with the program requirements, the agency requires the provider to implement a corrective action plan and can apply both financial and administrative sanctions. Following monitoring review, all providers receive a written report that details the specific areas of non-compliance found during the review and includes instruction regarding the provider's responsibility with regard to the areas of deficiency. DADS then conducts follow-up activities in accordance with CLASS Provider Review procedures and consumer directed services agency review procedures to ensure corrective action has been implemented. DADS provides technical assistance.

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)

a. **Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Participation in the consumer directed services option provides the individual or the legally authorized representative, the opportunity to be the employer of persons providing those waiver services chosen for self-direction. An individual, through the consumer directed service option, may direct habilitation services, respite services, nursing, physical therapy, occupational therapy, and speech/hearing therapy.
Each individual or legally authorized representative electing the consumer directed services option must receive support from a financial management service provider referred to as a consumer directed service agency, chosen by the individual or legally authorized representative . An individual or legally authorized representative may also self-direct support consultation, which is available only to individuals who choose the consumer directed services option.

By choosing to self-direct these services, the individual or legally authorized representative (employer) assumes and retains responsibility to: recruit; conduct criminal history checks; determine the competence of the provider; and hire, train, manage, and fire their employees.

The employer may appoint a designated representative to assist with or perform employer responsibilities to the extent approved by the employer. In addition, the employer has budget authority over the services he or she is directing. DADS will not pay the participant/employer's designated representative for serving as the designated representative or for providing and services to the individual.

The traditional agency option (provider-managed service delivery method) is available to provide any services not authorized for the consumer directed services option and any services authorized for the consumer directed services option that the individual or legally authorized representative elects not to self-direct. Under the traditional agency option, individuals choose a contracted direct service agency.

When choosing to self-direct authorized waiver services, the individual receiving those services or the legally authorized representative is the common-law employer of service providers and has decision-making authority over providers of those services. The employer or designated representative, with the assistance of the consumer directed services agency, budgets authorized funds for those services to be delivered through the consumer directed services option. DADS authorizes the funds for the services allocated for the consumer directed services option on the service plan.

The case manager informs the individual or legally authorized representative of the option to self-direct available waiver

services at the time of enrollment in the waiver and at least annually thereafter or upon request of the individual or legally authorized representative. The individual or legally authorized representative may elect at any time to choose the consumer directed services option, terminate participation in the consumer directed services option, or to change consumer directed services agencies.
Entities or individuals involved in supporting the individual receiving services or the individuals legally authorized representative who is directing services and supports, include:
(1) The individual's case manager provides information about the consumer directed services option and monitors service delivery through the option. The case management functions are global and apply to self-directed as well as agency-directed waiver services and non-waiver services;
(2) A consumer directed services agency, chosen by the individual or legally authorized representative, to provide financial management services. The consumer directed services agency must hold a Medicaid provider agreement (contract) with DADS on behalf of HHSC.
Supports may also include:
(3) A certified support advisor chosen by the individual or legally authorized representative employer if the individual or legally authorized representative has chosen to receive support consultation assists the individual or legally authorized representative employer in learning about and performing employer responsibilities; and
(4) A designated representative, if appointed by the individual or legally authorized representative employer, assists in meeting employer responsibilities to the extent directed by the employer;

To participate in the consumer directed services option, an individual or legally authorized representative must:
(1) Select a consumer directed services agency;
(2) Participate in orientation and ongoing training conducted by the consumer directed services agency;
(3) Perform all employer tasks that are required for self-direction or designate a designated represenative capable of performing some or all of these tasks on the individual's behalf; and
(4) Maintain a service backup plan for provision of services determined by the service planning team to be critical to the individual's health and welfare.

When an individual terminates the consumer directed services option, the CLASS case manager will assist the individual to begin services through the agency option with no gap in service coverage.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- **Waiver is designed to support only individuals who want to direct their services.**
- **The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Individuals receiving CLASS Program services are offered the opportunity to self-direct services when:
(1) The individuals live in their own homes or the homes of family members, and
(2) The service plan includes habilitation, respite services, nursing, physical therapy, occupational therapy or speech/hearing therapy.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The CLASS case manager provides each individual and legally authorized representative a written and oral explanation of the consumer directed service option at the time of enrollment in CLASS, at each annual review of the individual's service plan or at any time when requested by the individual or legally authorized representative.

Each individual or legally authorized representative is provided information sufficient to assure informed decision-making and understanding of the consumer directed service option and of the traditional agency-directed (provider-managed) service delivery option. The information includes the responsibilities and choices individuals can make with the election of the consumer directed service option.

Information provided orally and in writing to the individual and the legally authorized representative by the case manager includes:
(1) An overview of the consumer directed service option;
(2) An explanation of responsibilities in the consumer directed service option for the individual or individual's legally authorized representative, case manager, and the consumer directed service agency;
(3) An explanation of benefits and risks of participating in the consumer directed service option;
(4) A self-assessment for participation in the consumer directed service option;
(5) An explanation of required minimum qualifications of service providers through the consumer directed service option; and
(6) An explanation of employee/employer relationships that prohibit employment under the consumer directed service option.
consumer directed service materials are available in English and Spanish and can be provided upon request in other languages.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

- ○ **The State does not provide for the direction of waiver services by a representative.**
- ◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☑ **Waiver services may be directed by a legal representative of the participant.**
- ☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The individual or legally authorized representative employer may appoint a non-legal representative adult as a designated representative to assist in performance of employer responsibilities to the extent desired by the individual or legally authorized representative. Neither the designated representative nor the spouse of the designated representative may be employed by, receive compensation from, or be the provider of waiver services for the individual.

A legally authorized representative (LAR) is a person authorized or required by law to act on behalf of an individual with regard to a matter described in this chapter, including a parent, guardian, managing conservator of a minor, or the guardian of an adult.

A designated representative (DR) is willing adult appointed by the employer to assist with or perform the employer's required responsibilities to the extent approved by the employer. If a participant opts to have, or the case manager recommends, a designated representative, the participant completes an "Appointment of Designated Representative" form. The participant/employer documents the employer responsibilities that the designated representative (DR) may perform and those that the DR may not perform on the participant's/employer's behalf. The participant/employer provides this documentation to the CDSA. The CDSA monitors performance of employer responsibilities performed by the individual/employer and, when applicable, the DR in accordance with the individual's/employer's documented directions. The DR may not be the employee. Before a person can become a DR, the person must agree to and pass a criminal background check. An employer can also revoke the appointment of a designated representative.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Respite (In-Home and Out–of-Home)	☑	☑
Skilled Nursing	☑	☑
Residential Habilitation	☑	☑
Occupational Therapy	☑	☑
Speech, hearing, and language services		

	☑	☑
Support Consultation	☑	☑
Physical Therapy	☑	☑

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**
☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

◉ **FMS are covered as the waiver service specified in Appendix C1/C3**

The waiver service entitled:
Financial Management Services

○ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Private entities furnish financial management services. These entities are procured through an open enrollment process and the State has provider agreements with multiple entities to provide financial management services to individuals across the state.
Consumer directed services agencies are prohibited from providing case management or other waiver services, with the exception of Support Consultation, to an individual who has chosen the consumer directed services option. Consumer directed services agencies are entities that contract with the State to provide financial management services to the individual.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

Entities are compensated with a flat monthly fee per individual. Consumer directed services agencies provide Financial Management Services, not waiver administrative activities.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assists participant in verifying support worker citizenship status**
- [x] **Collects and processes timesheets of support workers**
- [x] **Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [ ] **Other**

Specify:

Supports furnished when the participant exercises budget authority:

- [x] **Maintains a separate account for each participant's participant-directed budget**
- [x] **Tracks and reports participant funds, disbursements and the balance of participant funds**
- [x] **Processes and pays invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [x] **Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

HHSC delegated to DADS the oversight of the FMS waiver service provider in their executions of the Medicaid provider agreement. DADS is responsible for the oversight of consumer directed services agencies. DADS conducts monitoring reviews of consumer directed services agencies to determine if the consumer directed services agency is in compliance with the provider agreement and with program rules and requirements. These reviews are conducted at the location where the consumer directed services agency is providing financial management services. Monitoring is based on a sample of individuals. DADS pulls 5 percent of all individuals receiving FMS from the CDSA using a random number generator. DADS assesses a consumer directed services agency's performance by:

(1) Measuring adherence to rules as described in Texas Administrative Code, Title 40, Part 1, Chapter 41;
(2) Reviewing individual satisfaction with financial management services services;
(3) Matching payroll, optional benefits and tax deposits to time sheets;
(4) Assessing adherence to state and federal tax laws;
(5). Ensuring that the hours worked and rate of pay are consistent with individual

budgets;
(6) Reviewing administrative payments; and
(7) Reviewing the provider agreements.

Monitoring of consumer directed services agencies occurs biennially. DADS report the results of the monitoring to HHSC.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Supported Employment	☐
Behavioral Support	☐
Minor Home Modifications	☐
Respite (In-Home and Out–of-Home)	☐
Adaptive Aids/Medical Supplies	☐
Transition Assistance Services	☐
Skilled Nursing	☐
Residential Habilitation	☐
Financial Management Services	☑
Specialized Therapies	☐
Support Family Services	☐
Prescriptions	☐
Case Management	☐
Occupational Therapy	☐
Speech, hearing, and language services	☐
Adult Day Health	☐
Support Consultation	

	☑
Dental Services	☐
Prevocational Services	☐
Continued Family Services	☐
Physical Therapy	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

An individual or legally authorized representative may voluntarily terminate participation in the Consumer Directed Services option at any time. The service planning team assists the individual in revising the service plan for the transition of services previously delivered through the consumer directed services option to be delivered by the direct service agency provider chosen by the individual or legally authorized representative. The service planning team assists the individual as necessary to ensure continuity of all waiver services through the traditional agency-directed service delivery option (provider-managed service delivery) and maintenance of the individual's health and welfare during the transition from the consumer directed services option. The consumer directed services agency closes the employer's payroll and payable accounts and completes all deposits and filings of required reports with governmental agencies on behalf of the individual.
This process ensures that no breaks in service occur and the participant's continuity of services and participant health and welfare is assured during the transition period.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Involuntary termination of the consumer directed services option may occur when:
(1) The individual's service planning team, in conjunction with the consumer directed services agency or DADS, determines that continued participation in the consumer directed services option would not permit the individual's health and welfare needs to be met; or
(2) The individual's service planning team, in conjunction with the consumer directed services agency or DADS, determines that the individual or the individual's representative, when provided with additional support from the consumer directed services agency, has not carried out employer responsibilities in accordance with requirements of the option.

The service planning team assists the individual to ensure continuity of all waiver services through the traditional provider-managed service delivery option and maintenance of the individual's health and welfare during the transition from the consumer directed services option. The consumer directed services agency closes the employer's payroll and payable accounts and completes all deposits and filing of required reports with governmental agencies on behalf of the individual.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		1740
Year 2		1840
Year 3		1940
Year 4 (renewal only)		2040
Year 5 (renewal only)		2140

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- [x] **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

- [x] **Recruit staff**
- [ ] **Refer staff to agency for hiring (co-employer)**
- [ ] **Select staff from worker registry**
- [x] **Hire staff common law employer**
- [x] **Verify staff qualifications**
- [x] **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Funds available in the individual's consumer directed services budget are used for this purpose. An individual may use up to a maximum of $600 of the consumer directed budget for employer related support activities, including criminal background checks. The consumer directed service rates account for both direct service costs and those costs necessary for the individual to be an employer. The cost of criminal background checks is necessary for the individual to be an employer, and is included in the consumer directed service rate.

- [x] **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [x] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. **Participant - Budget Authority** *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. **Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [x] **Reallocate funds among services included in the budget**

- [x] **Determine the amount paid for services within the State's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [x] **Authorize payment for waiver goods and services**
- [x] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The amount of funds included in a service plan is calculated by the service planning team based on the planned waiver services and the adopted reimbursement rate. The service plan is developed in the same manner for the individual who elects the consumer directed services option as it is for the individual who elects to have services delivered through the traditional provider-managed option. DADS must authorize the service plan and the estimated cost of waiver services. The consumer-directed services budget is composed of those authorized services and estimated costs that will be directed by the individual and itemized in the individual service plan authorized by DADS.

Employer related costs are paid for through the consumer directed service rates and are costs for equipment, supplies, or activities that will provide direct benefit to the individuals who self-direct services to support specific outcomes related to being an employer including: recruiting expenses, fax machine for sending employee time sheets to the consumer directed services agency, criminal conviction history checks from the Texas Department of Public Safety, acquiring other background checks of a potential service provider, purchased employee job-specific training, and Hepatitis B vaccination, if elected by an employee. An individual may use up to a maximum of $600 of the consumer directed budget for employer-related support activities.

Support Consultation has a specific reimbursement rate and is a component of the individual's service budget. In conjunction with the service planning team, individuals or legally authorized representatives determine the level of support consultation necessary for inclusion in each individual's service plan.

The amount of funds included in the service plan for each service to be self-directed is budgeted by the individual or legally authorized representative with assistance from the consumer directed services agency. The budget for each service, and any revisions, must be approved by the consumer directed services agency prior to implementation. The consumer directed services agency must ensure that projected expenditures are within the authorized budget for each service, are allowable and reasonable, and are projected over the effective period of the plan to ensure that sufficient funds will be available to the end date of the service plan. With approval of the consumer directed services agency, the individual or LAR may make revisions to a specific service budget that does not change the amount of funds available for the service in the approved service plan.

Revisions to the service plan amount available for a particular service, or a request to shift funds from one self-

directed waiver service to another, must be justified by the individual's service planning team and authorized by DADS. With assistance of the consumer directed services agency, the individual or legally authorized representative revises the consumer directed services budget to reflect a revision in the service plan.

Information concerning budget methodology for the Participant Directed Budget is contained in rule and available to the public online at the following site:
http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=5&ti=40&pt=1&ch=41&sch=E&rl=Y

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The individual or the legally authorized representative participates as a member of the service planning team that develops the individual's service plan. Individuals using the CDS option are involved in the service planning development process. They are apprised of the budget as it is developed. The individual develops the CDS budget based on the finalized service plan and authorized budget.

The Consumer Directed Services Agency and the case manager inform the individual of the amount authorized for the particular service before the budget is finalized and the total budget once finalized.

The individual may request an adjustment to the budget at anytime, subject to the individual cost limit of 200% of the institutional costs. When DADS denies an individual's request for an adjustment to the budget or reduces the budget, the individual is entitled to a fair hearing. The procedures for a fair hearing are provided in Appendix F, Participant Rights.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

An individual's consumer directed services budget is calculated and monitored based on projected utilization and frequency of the service as determined by the service planning team. The consumer directed services agency is required to monitor payroll every pay period (2 weeks) and expenditures (as processed for payment) and report over- and under-utilization to the employer and the case manager. When an over- or under-utilization is not corrected by the individual or legally authorized representative, the consumer directed services agency notifies the individual's case manager and the employer. The case manager and the individual identify the cause of continuing deviation from projected utilization and develop a plan to correct the deviation or revise the service plan.

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.

An applicant whose request for enrollment in the CLASS program is denied or is not acted upon with reasonable promptness is entitled to a fair hearing in accordance with 1 Texas Administrative Code, Part 15, Chapter 357, Subchapter A and 40, Texas Administrative Code §48.2104. If an applicant is denied enrollment into the CLASS program, DADS sends written notification to the applicant stating the right to a fair hearing and the process to follow to request a fair hearing. The CLASS case manager explains the fair hearing procedure, the applicant's right of appeal, and the right for others to represent the applicant, including legal counsel. CLASS case managers provide information to applicants concerning available legal services in the community.

At the time of enrollment the CLASS case manager reviews the rights and responsibilities with the individual or legally authorized representative and obtains the individual's or legally authorized representative's signature acknowledging receipt of the information. These rights include the right to participate in decisions and to be informed of the reasons for decisions regarding plans for enrollment, service termination, reduction, transfer, or denial of services.

If it is determined that an individual is not eligible for CLASS services, the person may appeal. In rare cases if a provider cannot meet the health and safety needs of a consumer due to extensive nursing needs, the consumer is given an opportunity to choose another provider to obtain needed services. Since services are not being suspended, reduced or terminated a fair hearing is not offered.

If services are reduced, denied or terminated, the case manager sends a letter to the individual or legally authorized representative that outlines the fair hearing procedure. This letter informs the individual of the opportunity to request a fair hearing. The notification explains the person's right of appeal, and the rights to have others represent the individual, including legal counsel. The case manager may provide information to individuals concerning available legal services in the community. An individual has ninety days to request a fair hearing. If a fair hearing is requested within 10 days of the notice, then services already authorized in the service plan will continue while the appeal is under consideration.

The case manager retains in the individual's record a copy of the notice of adverse action and the notice to the individual of the opportunity to request a fair hearing. If an individual or his authorized representative elects to request a fair hearing, a copy of the written request for a hearing is retained in the record.

When an applicant or individual makes a request for a fair hearing, the case manager completes Petition for Fair Hearing form and sends it to DADS to prepare notification to the hearing officer. The form must be sent to DADS within five days after the date the

applicant or the individual requests an appeal. The individual is provided the Acknowledgement and Notice of Fair Hearing that serves as a notice of the hearing. The HHSC hearing officer sends the form to the appellant, the case manager, the direct services agency, and to DADS staff to acknowledge the request for a hearing and to set a time, date, and place for the hearing. The Petition for Fair Hearing Addendum, along with copies of all relevant documentation, is sent to all known parties and required witnesses within five days of receiving the form. The HHSC hearing office files the decision on the Update after Fair Hearing form in the appeal file. DADS staff notifies the case manager and direct service agency to implement the decision of the HHSC hearing officer within ten days of the date of the decision and sends the DADS Action Taken on Hearing Decision form to the HHSC hearing office documenting that the decision has been implemented.

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:

DADS, the operating agency, operates the grievance and 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).

The State acknowledges all complaints received from applicants seeking enrollment or individuals enrolled in the CLASS Program or their families and representatives. The state advises complaintants that the formal filing of a complaint is not a substitute or required in order for the individual to request a fair hearing if enrollment or services are denied, suspended, or reduced.

Grievances or complaints can be submitted by telephone by calling a toll-free line, by e-mail, or by written correspondence. In-office employees answer the toll-free line from 8 a.m. to 5 p.m. Monday through Friday. Voice mail is available 24 hours a day and is monitored by in-office employees from 8 a.m. to 5 p.m. every day including Saturday, Sunday, and holidays. Complaints may be anonymous. The identity of all complainants and individuals is protected by law. DADS Consumer Rights and Services unit investigates the complaint and attempts resolution within 14 days of the initiation of the

investigation, unless the complaint involves abuse, neglect, or exploitation of an individual receiving services. Complaints involving allegations of abuse, neglect, or exploitation are referred immediately to the Texas Department of Family and Protective Services (DFPS), the agency with statutory responsibility for investigation of such allegations. Resolution of complaints not referred to DFPS are tracked and recorded in the Consumer Rights and Services complaint database. The status of all complaints unresolved in 90 days are documented in follow-up letters to the complainant unless doing so places the complainant in jeopardy.

HHSC's Office of the Ombudsman assists the public when the State's normal complaint process cannot or does not satisfactorily resolve an issue. The Office of the Ombudsman's services include:
(1) Conducting independent reviews of complaints concerning agency policies or practices;
(2) Ensuring policies and practices are consistent with the goals of HHSC;
(3) Ensuring individuals are treated fairly, respectfully and with dignity; and
(4) Making referrals to other agencies as appropriate
The Office of the Ombudsman process to assist with complaints and issues is as follows:
(1) A member of the public, individual, or provider makes first contact with the State to request assistance with an issue or complaint.
(2) If Consumer Rights and Services is not able to resolve the issue or complaint, the HHSC Office of the Ombudsman may be contacted.
(3) The Office of the Ombudsman provides an impartial review of actions taken by the program or department.
(4) The Office of the Ombudsman seeks 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 follows up with the complainant to determine if a resolution has been achieved or refers the complainant to other available known resources.

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).

Every direct service agency is licensed as a home and community support services agency and is required to self-report allegations of abuse, neglect, and exploitation to both the Department of Family and Protective Services (DFPS) and the Department of Aging and Disability Services (DADS) under Texas Health and Safety Code §142.018 and 40 Texas Administrative Code §97.249. DFPS investigates allegations of abuse, neglect, and exploitation of individuals receiving services from providers under Texas Human Resources Code Chapter 48. Texas defines abuse, neglect, and exploitation in §48.401. "Reportable conduct includes:
(A) Abuse or neglect that causes or may cause death or harm to an individual receiving agency services;
(B) Sexual abuse of an individual receiving agency services;
(C) Financial exploitation of an individual receiving agency services in an amount of $25 or more; and
(D) Emotional, verbal, or psychological abuse that causes harm to an individual receiving agency services."

All program provider personnel, individuals and legally authorized represenatives and consumer directed services agencies are provided the DFPS toll-free number in writing and are instructed to report to DFPS immediately, but not later than one hour after having knowledge or suspicion that an individual has been or is being abused, neglected, or exploited. Providers must report any instances of abuse, neglect, and exploitation immediately upon suspicion of such activities to DFPS and DADS Consumers Rights and Services. Individuals may report suspected instances of abuse, neglect, and exploitation using DFPS telephone hotline number or to DADS' Consumers Rights and Services. Phone calls to both agencies are available 24 hours a day.

DFPS investigates reports and makes a determination as to whether abuse, neglect, and exploitation is substantiated. DADS Regulatory Division monitors reported incidents and complaints related to abuse, neglect, and exploitation for licensed home and community service support agencies.

Out-of-Home Respite facilities are also required to immediately report abuse, neglect, and exploitation to DADS Consumers Rights and Services under DADS licensure rules. Those reports are investigated by DADS regulatory staff.

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 an individual is enrolled in CLASS or at the time an individual's legal status changes, and annually thereafter, all case management agencies and direct service agencies must ensure that the individual is informed orally and in writing of the processes for reporting allegations of abuse, neglect, or exploitation. The toll free numbers for DADS and DFPS must be provided. Facilities must post the information in a conspicuous place. Evidence supporting compliance with these requirements is reviewed during DADS' on-site licensure surveys and contract monitoring reviews of the program provider.

In addition to information provided to all individuals in the waiver, a consumer directed services agency provides individuals electing the consumer directed services option with training and written information related to reporting allegations of abuse, neglect, and exploitation.

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.

The Texas Department of Family and Protective Services (DFPS) is responsible for receiving and investigating reports of abuse, neglect, and exploitation for all individuals. DFPS assigns a priority level to complaint at the time of intake based on the perceived threat level to the individual. DFPS must initiate a case by contacting a person with current and reliable information within 24 hours of intake. The investigator may change the priority level because of based on information from the contact. DFPS must make the initial face-to-face contact with the alleged victim based on the priority level. The results of the investigation are reported within 30 days by generating a letter from their automated system.

Texas Human Resources Code Chapter 48 requires that DFPS investigates persons thought to have knowledge of the circumstances regarding abuse, neglect, and exploitation. Texas Human Resources Code also provides certain laws to assist with investigations including access to records and a prohibition against interference with investigation or services.

DADS is responsible for receiving and reviewing reports of abuse, neglect, and exploitation from DFPS. All providers reporting abuse, neglect, and exploitation must provide appropriate contact information. Pursuant to 40 Texas Administrative Code §49.17, upon completion of a complaint investigation, provider agencies must notify the individual of the results. Provider agencies must investigate and resolve complaints not related to abuse, neglect, and exploitation within five workdays from the receipt of the complaint report. Evidence supporting compliance with these requirements is reviewed during DADS' on-site licensure surveys and contract monitoring reviews of the program provider.

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.

The Texas Department of Family and Protective Services (DFPS) is responsible for handling all reports of abuse, neglect, and exploitation related to individuals receiving services in the community. As required by Human Resources Code §48.103, upon completion of an investigation in which abuse, neglect, and exploitation is validated against an employee of a direct service agency after due process has been completed, the DFPS caseworker releases the investigation findings to DADS. DADS reviews all investigation reports provided by DFPS. Based on the content of the report, DADS may conduct an on-site survey of the provider or require the provider to submit evidence of follow-up action on the incident. The investigative findings and DADS' follow up on those findings is entered into the abuse, neglect, and exploitation database by

DADS staff.

Reports of abuse, neglect, and exploitation incidents are compiled on an annual basis for each program provider. In preparation for on-site reviews of providers, DADS staff compiles data related to all abuse, neglect, and exploitation incidents reported by or involving the program provider. DADS may use this information in selecting the sample of individuals whose records will be reviewed and who may be interviewed to ensure the program provider conducted appropriate follow-up. This information may also be used in the risk assessment by DADS to determine contract monitoring frequency. DADS provides oversight on a continuous basis and aggregates the data annually for reporting to HHSC.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. *(Select one)*:

- **The State does not permit or prohibits the use of restraints or seclusion**

  Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

  Complaints concerning use of restraint can be made to DADS or DFPS. The case manager and the provider must ensure that an individual or legally authorized representative is informed orally and in writing of the processes for filing complaints about the provision of services including: the toll-free telephone number of DADS Consumer Rights and Services to file a complaint; and the toll-free telephone number of DFPS to file a complaint of abuse, neglect, or exploitation.

  All direct service agencies are licensed as a home and community support services agency and are required to report allegations of abuse, neglect, and exploitation to both the Department of Family and Protective Services (DFPS) and the Department of Aging and Disability Services (DADS) under Texas Health and Safety Code §142.018 and 40 Texas Administrative Code §97.249. DFPS investigates allegations of abuse, neglect, and exploitation of individuals under Texas Human Resources Code Chapter 48.

- **The use of restraints or seclusion 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 or Seclusion.** 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 or 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 restraints or 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-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

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:

Complaints concerning use of restrictive intervention can be made to DADS or DFPS. The case manager and the provider must ensure that an individual or legally authorized representative is informed orally and in writing of the processes for filing complaints about the provision of services including: the toll-free telephone number of DADS Consumer Rights and Services to file a complaint; and the toll-free telephone number of DFPS to file a complaint of abuse, neglect, or exploitation.

All direct service agencies are licensed as a home and community support services agency and are required to self-report allegations of abuse, neglect, and exploitation to both the Department of Family and Protective Services (DFPS) and the Department of Aging and Disability Services (DADS) under Texas Health and Safety Code §142.018 and 40 Texas Administrative Code §97.249. DFPS investigates allegations of ANE of individuals receiving services from providers under Texas Human Resources Code Chapter 48. Texas defines Abuse, Neglect, and Expolitation in §48.401. "Reportable conduct includes:

(A) Abuse or neglect that causes or may cause death or harm to an individual receiving agency services;
(B) Sexual abuse of an individual receiving agency services;
(C) Financial exploitation of an individual receiving agency services in an amount of $25 or more; and
(D) Emotional, verbal, or psychological abuse that causes harm to an individual receiving agency services."

DFPS investigates reports and makes a determination as to whether abuse, neglect, and exploitation occurred. DADS Regulatory Division monitors reported incidents and complaints related to abuse, neglect, and exploitation for licensed home and community support services agencies.

Out-of-Home Respite facilities are also required to immediately report abuse, neglect, and exploitation to DADS Consumer Rights and Services under DADS licensure rules. Those reports are investigated by DADS regulatory staff.

- **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-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.

Department of Family and Protective Services (DFPS) monitors medication management and administration of Child Placing Agencies who oversee Support Family Services and Continued Family Services as indicated in Title 40, Part 19, Chapter 749, Subchapter J of the Texas Administrative Code.

Support Family and Continued Family providers are monitored through on-site quarterly visits by the licensed Child Placing Agencies.

DFPS performs annual on-site licensure visit of the child placing agencies.

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.

Caregivers must maintain a cumulative record of all prescription medication dispensed to a child and all nonprescription medication, excluding vitamins, dispensed to a child under five years old. Caregivers must maintain the medication record during the time that they provide services to the child. This record must include the:
(1) Child's full name;
(2) Prescribing health-care professional's name, if applicable;
(3) Medication name, strength, and dosage;
(4) Date (day, month, and year) and the time the medication was administered;
(5) Name and signature of the person who administered the medication;
(6) Child's refusal to accept medication, if applicable; and
(7) Reasons for administering the medication, including the specific symptoms, condition, and/or injuries of the child that the caregiver is treating, for PRN prescriptions and nonprescription medications (excluding vitamins) for children under five years old.
(b) Identification of any prohibited prescription medication, nonprescription medication, and vitamins for each child must be maintained in the medication record, which must be incorporated into the child's record.
(c) The medication records of prescription and nonprescription medication dispensed to the child must be incorporated into the child's record.

If a caregiver finds a medication error regarding a prescribed medication, the caregiver must contact a health-care professional immediately, and follow the health-care professional's recommendations.
(b) If a caregiver finds a medication error regarding a nonprescription medication, the caregiver must take the appropriate and necessary actions as required by the circumstances.
(c) For all medication errors, a caregiver must document the following within 24 hours:
(1) The time and date of the error;
(2) The medication error;
(3) The time and date of the call(s) to the licensed health-care professional, if applicable;
(4) The name and title of the health-care professional contacted, if applicable; and

Child placing agency is responsible for the home's ongoing compliance with rules and must evaluate the home as follows:
(1) When there is an allegation of a deficiency, you must evaluate the rule and any rules related to the deficiency;
(2) When a change in the conditions of the verification or a major life change occurs, you must evaluate the rules related to the conditions or change;
(3) You must document the rules that were evaluated and the determination of the evaluation;
(4) During any contact with the foster family, including routine supervisory contacts and investigations, you must cite and address any deficiencies noted;
(5) Your documentation of deficiencies must include plans for achieving compliance; and
(6) You must also document a plan for follow-up to ensure compliance was achieved.

DFPS is the agency responsible for follow and oversight as outlined in Title 40, Part 19, Chapter 749, Subchapter J of the Texas Administrative Code. DFPS monitors child placing agencies annually and identifies harmful practices and uses that information to improve quality, using methods specific to the agency, including technical assistance or corrective action plans. Annually, DADS will obtain data from DFPS on child placing agencies serving individuals in CLASS. DADS will share this information with HHSC and review DFPS' actions regarding violations.

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).

The Department of Family and Protective Services (DFPS) monitors the performance of Support Family Agencies and Continued Family Agencies regarding medication administration.

Title 40, Part 19, Chapter 749, Subchapter J, Division 3, §749.1501 states:
For a child to be on a self-medication program:
(1) The child's health-care professional must give written authorization for the child to be on the program;
(2) The child's service plan must include the self-medication program and any requirements for caregiver supervision; and
(3) Child Placing Agency (Support Family or Continued Family Agency) must notify the parent and the person legally authorized to give medical consent that the child is on the program.

Title 40, Part 19, Chapter 749, Subchapter J, Division 3,§749.1503 states:
When a child who is on a self-medication program takes a dosage of the medication, the child may:
(1) Record the dosage if you have a system for reviewing the child's medication each day; or
(2) Report the medication to a caregiver, who must then do the actual recording.

Title 40, Part 19, Chapter 749, Subchapter J, Division 3, §749.1463 states:
a) To the best of their knowledge, caregivers must inform the person legally authorized to give medical consent of the benefits, risks, and side effects of all prescription medication and treatment procedures used and the medical consequences of refusing them, and/or provide the name and telephone number of the prescribing health-care professional for more information.
(b) Caregivers must:
(1) Be informed about possible side effects of medications administered to the child;
(2) Store all medication in the original container unless you have an additional container with the same label and instructions;
(3) Administer all medications according to the instructions on the label or according to a prescribing health-care professional's subsequent signed orders;
(4) Administer each child's medication immediately after preparation;
(5) Ensure the child has taken the medication as prescribed;
(6) Ensure a person trained in and authorized to administer prescription medication administers the medication to a child in care unless the child is on a self-medication program;
(7) Maintain any documentation provided by the health-care professional on the administration of current prescription medication;
(8) Not physically force a child to take prescription medication;
(9) Ensure that your employees do not provide any prescription medication or treatment to a child except on written orders of a health-care professional;
(10) Not borrow or administer prescription medication to a child that is prescribed to another person; and
(11) Not administer prescription medication to more than one child from the same container. Only the child for whom the prescription medication was prescribed may use the medication.
Title 40, Part 19, Chapter 749, Subchapter J, Division 3, §749.1469, states:
(a) Caregiver must follow the label and ensure the nonprescription medication is not contraindicated with any other medication prescribed to the child or the child's medical conditions.
(b) Caregiver may give nonprescription medication or vitamins to more than one child from one container.

Pre-service training requirements for a caregiver that administers psychotropic medication ensures that each caregiver that administers psychotropic medication receives training on:

(1) Identification of psychotropic medications;
(2) Basic pharmacology (the actions and side effects of, and possible adverse reactions to, various psychotropic medications);
(3) Techniques and methods of administering medications;
(4) Who is legally authorized to provide consent for the psychotropic medication; and
(5) Any related policies and procedures.

Child placing agencies are required to ensure caregivers are trained on the following aspects of administering medications:

(1) Be informed about possible side effects of medications administered to the child;
(2) Store all medication in the original container unless you have an additional container with the same label and instructions;
(3) Administer all medications according to the instructions on the label or according to a prescribing health-care professional's subsequent signed orders;
(4) Administer each child's medication immediately after preparation;
(5) Ensure the child has taken the medication as prescribed;
(6) Ensure a person trained in and authorized to administer prescription medication administers the medication to a child in care unless the child is on a self-medication program;
(7) Maintain any documentation provided by the health-care professional on the administration of current prescription medication; (8) Not physically force a child to take prescription medication;
(9) Ensure that your employees do not provide any prescription medication or treatment to a child except on written orders of a health-care professional;
(10) Not borrow or administer prescription medication to a child that is prescribed to another person; and
(11) Not administer prescription medication to more than one child from the same container. Only the child for whom the prescription medication was prescribed may use the medication.

DFPS monitors child placing agencies annually and reviews both the child placing agencies' records and the records kept by the support family. Additionally, child placing agencies meet with the support family at least quarterly to oversee all aspects of the child's care.

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:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the State:

◉ **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:

Title 40, Part 19, Chapter 749, Subchapter J, Division 3, §749.1561 states:
A medication error includes, but is not limited to, the following:
(1) A child receives the wrong medication;
(2) A child receives medication prescribed to someone else;

(3) A child receives the wrong dosage of medication;
(4) A child receives medication at the wrong time;
(5) A medication dose is skipped or missed;
(6) A child receives expired medication;
(7) Not following the medication administration instructions, such as giving a child medication on an empty stomach when the medication should be given with food; and
(8) A child receives medication that was not stored as required to maintain the effectiveness of the medication, such as refrigerating or not refrigerating the medication or exposing the medication to heat or sunlight.

Title 40, Part 19, Chapter 749, Subchapter J, Division 3, §749.1563 states:
(a) If a caregiver finds a medication error regarding a prescribed medication, the caregiver must contact a health-care professional immediately, unless the error is the type described in paragraph (4) or (5) of §749.1561 of this title (relating to What is a medication error?), and follow the health-care professional's recommendations.
(b) If a caregiver finds a medication error regarding a nonprescription medication, the caregiver must take the appropriate and necessary actions as required by the circumstances.
(c) For all medication errors, a caregiver must document the following within 24 hours:
(1) The time and date of the error;
(2) The medication error;
(3) The time and date of the call(s) to the licensed health-care professional, if applicable;
(4) The name and title of the health-care professional contacted, if applicable; and
(5) The health-care professional's medical recommendations for ensuring the child's safety, if applicable.

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.

The Department of Family and Protective Services (DFPS) monitors the performance of Support Family Agencies and Continued Family Agencies.
(1) DFPS conducts at least one annual, unannounced monitoring inspection of every main and branch office of a child-placing agency (CPA).
(2) DFPS conducts announced inspections every year of one-third of all agency foster homes. DFPS documents any deficiencies with minimum standards and cites the CPA if DFPS feels they have violated the minimum standards that govern their verification and oversight of foster homes.
(3) DFPS investigate allegations of abuse, neglect, or exploitation. DFPS investigates all child deaths as alleged abuse or neglect.
(4) DFPS investigates complaints of violations of minimum standards.
CPA's must report all serious incidents to us and DFPS responds.

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, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.
i. **Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 Percent of all program providers required to submit plans of correction related to abuse, neglect and exploitation per home and community support service agencies licensure standards.

Data Source (Select one):
Other
If 'Other' is selected, specify:
On-site Program Provider Reviews, desk reviews,

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: Reviews conducted 1x first year, then 18 mos., then every 3 yrs and on an individual basis as they come in.	

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 Percent of all non-deemed home and community support services agency (direct service agency)program providers found to be substantial compliance with regulations related to abuse, neglect and 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: At least every 3 years.	

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 Percent of consumer directed services agency reviews that evidence compliance with the requirement to maintain records of criminal history, nurse-aid registry and the employee misconduct registry checks conducted by employer.

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: Biennially	

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 Percent of home and community support services agency (direct service agency) program provider reviews that evidence the program provider has informed all individuals how to report allegations of abuse, neglect and exploitation in accordance with program rules.

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: Biennially	

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 Percent of consumer directed services agency reviews that evidence the consumer

directed services agency has informed all individuals and individuals' families or legally authorized representatives how to report allegations of abuse, neglect, and exploitation in accordance with program rules.

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: Biennially	

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.6 Percent of case management agencies reviewed evidencing the participant or legally

authorized representative was informed orally and in writing of the process for filing complaints.

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: Biennially	

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.7 Percent of direct service agencies reviewed evidencing the participant or legally authorized representative was informed orally and in writing of the process for filing

complaints.

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: Biennially	

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.8 Percent of case management agencies who have conducted staff criminal history checks per provider agreement.

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: Biennially	

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.9 Percent of direct service agencies who have conducted staff criminal history checks per provider agreement.

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

Responsible Party for data	**Frequency of data**	**Sampling Approach***(check*

collection/generation*(check each that applies):*	**collection/generation***(check each that applies):*	*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: Biennially	

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.10 Percent of licensed home and community support services agencies (direct service agencies) surveyed that were cited for failure to conduct criminal history checks, employee misconduct registry, and nurse aid registry for unlicensed personnel that have face to face contact with individuals per home and community support services agencies licensure standards.

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

Responsible Party for data	**Frequency of data**	**Sampling Approach***(check*

collection/generation*(check each that applies):*	**collection/generation***(check each that applies):*	*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: Reviews conducted 1x first year, then 18 months, then every 3 years	

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.11 Percent of consumer directed service agencies evidencing that the employer has a service back-up plan in place.

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

Responsible Party for data	**Frequency of data**	**Sampling Approach***(check*

collection/generation*(check each that applies):*	**collection/generation***(check each that applies):*	*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: Biennially	

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.12 Percent of consumer directed services agencies reviewed evidencing the participant or legally authorized representative was informed orally and in writing of the process for filing complaints.

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: Biennally	

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.13 Percent of case management agency and direct service agency staff who have taken the CLASS Individual Rights and Safeguards (includes abuse, neglect, and exploitation) training annually.

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: Biennially	

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 Department of Family and Protective Services (DFPS) is statutorily responsible for investigating allegations of abuse, neglect, or exploitation of individuals enrolled in the CLASS Program. In accordance with State law, the State maintains an Employee Misconduct Registry that includes the names of persons DADS or DFPS has confirmed to have abused, neglected, or exploited an individual receiving services in a licensed ICF/MR or through the CLASS Program or other home and community-based services programs. In addition, in accordance with federal law, the State maintains a Nurse Aide Registry that lists certified nurse aides. The Nurse Aide Registry indicates if an aide has been confirmed to have abused, neglected, or exploited a resident of a licensed nursing facility. Program providers must consult these registries prior to offering employment to a non-licensed service provider and refrain from employing that person if either registry indicated the person was confirmed to have abused, neglected, or exploited an individual receiving services.

The Quality Assurance and Improvement unit of DADS will continue its National Core Indicators survey project with the individuals who participate in home and community-based service programs operated by the State. As a part of

the National Core Indicators survey, individuals who receive services in the CLASS program may respond to indicators regarding health, welfare and rights. Discovery findings from the National Core Indicators survey project will be routinely evaluated to assess the status of remediation and improvement activities. In addition, the State will use findings to update the CLASS QMS as necessary. Reports on each of the following assurances will be provided annually to the State. HHSC may accompany DADS staff on selected provider and consumer directed service agency reviews and assess for quality and effectiveness.

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.
When DADS detects provider non-compliance with the program requirements, the agency requires the provider to implement a corrective action plan and can apply both financial and administrative sanctions. Following monitoring review, all providers receive a written report that details the specific areas of non-compliance found during the review and includes instruction regarding the provider's responsibility with regard to the areas of deficiency. DADS then conducts follow-up activities in accordance with CLASS Provider Review procedures and Consumer Directed Services Agency review procedures to ensure corrective action has been implemented. DADS provides technical assistance. When appropriate a referral will be made to Department of Family and Protective Services.

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 QMS 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 QMS* 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 QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

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.

The Quality Review Team consists of representatives from several agencies within the HHS enterprise. In addition to directing the improvement activities for each waiver, the Quality Review Team will oversee implementation of the Quality Oversight Plan and related processes. This includes making recommendations for new or revised quality measures, identifying and facilitating access to new data sources, identifying new intra and interagency processes impacting any and all phases of the quality program, and other actions needed to assure continued improvement of Texas' Home and Community-Based Services waiver programs.

Additionally, the Quality Review Team will review the Quality Oversight Plan at least every three years. Revisions to the plan will be approved by HHSC leadership.

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 Quality Review Team meets quarterly and reviews comprehensive quality reports from each waiver program at least annually. These reports are generated from the Policy Quality Assurance and Improvement Data Mart that includes data on all of the waiver's quality improvement strategy measures. These reports also include remediation activities and outcomes. HHSC and DADS staff present the reports and recommendations to the Quality Review Team. Priorities are established by the Quality Review Team.
Improvement plans are developed as issues are identified and the Quality Review Team reviews, modifies, if needed, and approves all improvement plans. All active improvement plans for all waivers are monitored at each quality review team meetings, to include updates on data to determine whether or not improvement activities have had the intended effect.
The Center for Policy and Innovation maintains the Policy Quality Assurance and Improvement Data Mart which compiles data currently collected in multiple automated systems. The Data Mart produces standardized reports and provides capability for ad-hoc reporting. The areas covered by the reports include: individual demographics; service utilization; enrollments; levels of care; service plans; consumer-direction; critical incidents; provider compliance and oversight; transfers; and discharges. This system has the capability to provide management reports at the individual level or any level of aggregation needed.
To facilitate communication with external stakeholders, the agency has implemented Texas Quality Matters, which is a web-based medium that provides external stakeholders with an increased ability to access quality reporting information. Texas Quality Matters provides the State with the ability to conduct online surveys related to quality improvement.
Stakeholders have the opportunity to provide testimony on policies and rules governing the delivery of services in the CLASS program in writing and at meetings of the Medical Care Advisory Committee, the DADS Advisory Council, and the HHSC Advisory Council.
The Promoting Independence Advisory Committee is comprised of member representatives from all departments of the State Medicaid agency and external stakeholders. The PIAC studies and makes recommendations to the State regarding appropriate care settings for persons with disabilities.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

At least every three years, state staff will evaluate the processes and indicators of the Quality Oversight Plan. State staff will examine issues such as whether or not the indicators are providing substantive information about each sub-assurance and whether the Quality Review Team composition is inclusive of key agency stakeholders. If areas for improvement exist, state staff will make recommendations for changes to the Quality Review Team , and the Quality Review Team will approve or reivse staff's recommended changes.

Appendix I: Financial Accountability

F1. 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).

Providers are not required to obtain independent financial audits.
The Department of Aging and Disability Services (DADS) uses a fiscal review process to ensure that providers for the Community Living Assistance and Support Services (CLASS) program are complying with program requirements. The methods used in the fiscal review process include examination of financial and service records as well as plans of care and other records and comparison of provider billings to service delivery and other supporting documentation.

DADS' procedures provide for on-site fiscal reviews of each CLASS provider at least biennially to examine the provider agency's service delivery and financial records and verify that payments made to the provider agency were supported by documentation. New providers must be reviewed within the first 12 months of the contract period before moving to a 24-month review schedule. DADS typically reviews a three-month sample of the provider's records, and may increase the review period if deemed necessary. Examples of records reviewed include assessment documents, service delivery documents, and complaints.

The provider must maintain documentation that supports the claims. If the provider fails to maintain the required documentation, DADS recovers improper payments. DADS also recoups payments when it verifies the provider was overpaid because of improper billing. DADS may take adverse action against the provider's contract or require corrective action for any fiscal review finding.

Texas State Auditor's Office audits the CLASS program as required under the provisions of the Single Audit Act. The Texas Health and Human Services Commission (HHSC) Office of Inspector General is responsible for performing audits of contracts between DADS 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.
   i. **Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 Percentage of direct service agencies who have claims correctly coded and reimbursed per financial findings according to reimbursement methodology.

Data Source (Select one):
Other

If 'Other' is selected, specify:
Contracts database

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: Biennially	

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 Percentage of direct service agencies who have claims correctly coded and reimbursed per administration findings according to reimbursement methodology.

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

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: Biennially	

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.3 Percent of dollars recouped over total billings based on direct service agency provider reviews.

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: Biennially	

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.4 Percent of consumer directed services agencies reviewed evidencing that quarterly budget reports were sent to employers.

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: Biennially	

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.5 Percentage of consumer directed services agencies who have claims correctly coded and reimbursed according to the consumers budget.

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: Biennially	

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: Biennially

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.

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.
When DADS detects provider non-compliance with the program requirements, the agency requires the provider to implement a corrective action plan and can apply both financial and administrative sanctions. Following monitoring reviews, all providers receive a written review report that details the specific areas of non-compliance found during the review and includes instruction regarding the provider's responsibility with regard to the areas of deficiency. DADS then conducts follow-up activities in accordance with CLASS Monitoring Review procedures and consumer directed services agency review procedures to ensure corrective action has been implemented. DADS recoups funds when claims for services to individuals were found in error.

ii. Remediation Data Aggregation

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

	Frequency of data aggregation and analysis

Responsible Party *(check each that applies):*	*(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 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 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. The rates for the CLASS program are available on the Rate Analysis' webpage.

HHSC uses cost reports to determine rates for the following services: residential habilitation services; respite care; skilled nursing; physical therapy; occupational therapy; speech, hearing, and language therapy; case management; behavioral support, adult day health, and auditory integration training/auditory enhancement training and nutritional services (included in the waiver as specialized therapies.) Providers of these services are required to submit annual cost reports to the HHSC Rate Analysis Department. 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 reviewed 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 provider's total allowable costs are projected from the historical cost reporting period to the prospective reimbursement period; 4) payroll taxes and benefits are allocated to each salary item; 5) total projected allowable costs are divided by the number of units of service to determine the projected cost per unit of

service; 6) 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 7) the median cost per unit of service for each waiver service is multiplied by 1.044.

When historical costs are unavailable, such as in the case of changes in program requirements, payment rates may be based on a pro forma approach. This approach involves using historical costs of delivering similar services, where appropriate data are available, and determining the types and costs of products and services necessary to deliver services meeting federal and state requirements. The rates for transition assistance services, continued family services, support family services, and support consultation are modeled using a pro forma approach.

Supported employment services, pre vocational services, specialized therapies (other than auditory integration training/auditory enhancement training and nutritional services) and prescriptions are paid at cost.

Minor home modifications and adaptive aids/medical supplies are paid at cost. The CLASS providers are given additional payments for the cost of acquiring adaptive aids and minor home modifications for consumers; these payments are called requisition fees. The rates for the requisition fees are modeled using a pro forma approach.

In setting the rates for Financial Management Services provided under the Consumer Directed Services Option, the reimbursement rate to the Financial Management Services provider, the Consumer Directed Services Agency, is a flat monthly fee, determined by modeling the estimated cost to carry out the financial management responsibilities of the Consumer Directed Services Agency. The payment rate available for the individual's budget for the self-directed service is modeled based on the payment rate to the traditional agency less an adjustment for the traditional agency's indirect costs.

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.

Providers of residential habilitation services have the option of participating in the Attendant Compensation Enhancement Rate. The 76th Texas Legislature directed the Texas Department of Human Services (a legacy agency for DADS) to provide incentives for increased wages and benefits for community care attendants. In response, HHSC adopted rules at Title 1, Texas Administrative Code §355.112 to establish procedures for community care providers to obtain additional funds for increased attendant wages, benefits, insurance, and mileage reimbursement. As per these rules, community care providers who choose to participate in Attendant Compensation Enhancement Rate and receive additional funds must demonstrate compliance with enhanced spending requirements. For providers who choose not to participate in Attendant Compensation Enhancement Rate, the attendant compensation rate will remain constant over time, except for adjustments necessitated by increases in the federal minimum wage.

Participation in the Attendant Compensation Enhancement Rate is voluntary. Providers may choose to participate in Attendant Compensation Enhancement Rate by submitting to HHSC a signed Enrollment Contract Amendment choosing to enroll and indicating the level of enhanced add-on rate they desire to receive. Requested add-on rate levels will be granted beginning with the lowest level and granting successive levels until requested enhancements are granted within available funds. Funding for the enhancement add-on rate levels is limited by appropriations. Enrollment in Attendant Compensation Enhancement Rate is held in July prior to the rate year.

Providers participating in the Attendant Compensation Enhancement Rate agree to spend approximately 90 percent of their total attendant revenues, including their enhanced add-on rate revenues, on attendant compensation. Attendant compensation includes salaries, payroll taxes, benefits, and mileage reimbursement. Participating providers must submit reports to HHSC documenting their spending on attendant compensation.

Determination of each provider's compliance with the attendant compensation spending requirement will be made on an annual basis from reports submitted to HHSC. Participants failing to meet their spending requirement for the reporting period will have their enhanced add-on revenues associated with the unmet spending requirements recouped. At no time will a participating provider's attendant care rate after their spending recoupment be less than the rate paid to providers not participating in receiving the enhanced add-on rates.

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:

For services delivered through the agency option and consumer directed services option, providers send claims for reimbursement for waiver services provided to individuals to Texas' MMIS claims processing system. Providers may submit claims electronically or may submit paper claims.

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:

Texas' Medicaid Management Information System claims processing system verifies that the participant was Medicaid-eligible on the date of service delivery specified in a request for reimbursement and allows payment only on claims for services provided within the eligibility period.
Prior to processing claims, the automated claims management system edits claims for the validity of the information and compliance with business rules for the service and program, and calculates the payment amount and applicable reductions for claims approved for payment. For example, unless the system verifies that a participant's current authorized service plan has sufficient units in the service plan to cover amounts claimed or that an authorized Level of Care is registered in the claims management system, the claim will be rejected.
As noted in the Financial Integrity and Accountability section above, DADS staff conducts on-site reviews to determine a provider's compliance with standards pertaining to fiscal accountability and to verify the services billed were actually

rendered.

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:

- ( ) **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.**
- [x] **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: *Complete item I-3-e.*

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*:

- [ ] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [x] **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:

The State share of the federal funds is appropriated to DADS for the CLASS program. The non-federal share of CLASS funds are appropriated by the Texas State Legislature to DADS, the department designated by the Texas Health and Human Services Commission, the single state Medicaid Agency, as the Medicaid operating agency for the CLASS program. There are no Inter-Governmental Transfers (IGTs) or Certified Public Expenditures (CPEs).

The non-federal share is exclusively from state general revenue appropriations. There are no local sources of funds. There are no CPEs. CLASS non-federal share funds are appropriated to DADS as a specific line item for the provision of CLASS services. DADS CLASS appropriations remain in the state comptroller's account designated for the CLASS program. Once the Medicaid Agency has approved a claim via the Health and Human Services Accounting System, federal funds are drawn and combined with the state appropriation to make payments to the provider.

☐ **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:
Do not complete this item.

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-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: ICF/MR

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	41708.11	14198.80	55906.91	78671.58	3536.89	82208.47	26301.56
2	39093.50	13603.78	52697.28	78671.58	3640.41	82311.99	29614.71
3	44694.78	15438.54	60133.32	81480.16	3745.58	85225.74	25092.42
4	44738.27	15794.38	60532.65	81480.16	3850.40	85330.56	24797.91
5	46344.40	16174.13	62518.53	84446.04	3958.16	88404.20	25885.67

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 Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/MR
Year 1	4804	4804
Year 2	6165	6165
Year 3	6201	6201
Year 4 (renewal only)	6210	6210
Year 5 (renewal only)	6219	6219

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 average length of stay for an individual is calculated based on historical data in the Service Authorization System Online system regarding the length of time all individuals remain in the program.

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:

We have seen significant changes in utilization of certain services since the latest CMS 372 report (Waiver Year September 2006-August 2007). Therefore, we used claims payment data through September 2009 to update utilization by service as well as units of service per user to better reflect current utilization patterns. We used actual payment rates established for Renewal Year One and Two, and inflated the rates forward for Years Three through Five using the chain-weighted General Implicit Price Deflator-Personal Consumption Expenditures index (PCE-IPD).

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:

Based upon the latest CMS 372 D' values. Adjusted the amount to remove Adult Day Health expenditures, since Adult Day Health is now a Waiver (D) service. Inflated the adjusted amount forward using the PCE-IPD "Medical Care" Index for all services except drugs, and used the PCE-IPD "Drugs" index for drug expenditures were included. No payments for prescription drugs covered under Medicare Part D were included.

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:

Although the CMS 372 report requires us to report the G value from the latest approved amendment, at the time we run the data used to prepare the CMS 372 report we also obtain information to calculate what the G value actually was for the reporting period. We used this actual value and inflated it forward based upon the actual increase in ICF/MR costs based upon actual ICF/MR payment rates established for Renewal Years One and Two, and then inflated the rates forward for Years Three through Five using the chain-weighted General Implicit Price Deflator-Personal Consumption Expenditures index (PCE-IPD). We have changed the comparison population from people with related

conditions in ICFs-MR (level of care 8) to all individuals in ICFs-MR because the number of individuals, 106, at LOC 8 in ICFs-MR has become too small to be reliable.

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:

Although the CMS 372 report requires us to report the G' value from the latest approved amendment, at the time we run the data used to prepare the CMS 372 report we also obtain information to calculate what the G' value actually was for the reporting period. We used this actual value and inflated it forward using the PCE-IPD "Medical Care" Index for all services except drugs, and used the PCE-IPD "Drugs" index for drug expenditures. We have changed the comparison population from people with related conditions in ICFs-MR (level of care 8) to all individuals in ICFs-MR because the number of individuals, 106, at LOC 8 in ICFs-MR has become too small to be reliable.

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
Adult Day Health
Case Management
Prevocational Services
Residential Habilitation
Respite (In-Home and Out–of-Home)
Supported Employment
Adaptive Aids/Medical Supplies
Dental Services
Occupational Therapy
Physical Therapy
Prescriptions
Skilled Nursing
Speech, hearing, and language services
Financial Management Services
Support Consultation
Behavioral Support
Continued Family Services
Minor Home Modifications
Specialized Therapies
Support Family Services
Transition Assistance 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
Adult Day Health Total:						**530111.40**
Adult Day Health	Per Half-Day	91	399.00	14.60	**530111.40**	
Case Management Total:						**8640954.80**
Case Management	Per Month	4804	10.00	179.87	**8640954.80**	
Prevocational Services Total:						**671409.62**
Prevocational Services	Per Hour	101	461.00	14.42	**671409.62**	
Residential Habilitation Total:						**136932464.20**
Residential Habilitation	Per Hour	4715	2014.00	14.42	**136932464.20**	
Respite (In-Home and Out–of-Home) Total:						**9627032.80**
Respite (In-Home and Out–of-Home)	Per Day	2882	14.00	238.60	**9627032.80**	
Supported Employment Total:						**33238.10**
Supported Employment	Per Hour	5	461.00	14.42	**33238.10**	
Adaptive Aids/Medical Supplies Total:						**2668470.96**
Adaptive Aids/Medical Supplies	Per Item	1102	4.00	605.37	**2668470.96**	
Dental Services Total:						**421056.00**
Dental Services	Per Item	288	2.00	731.00	**421056.00**	
Occupational Therapy Total:						**297873.00**
Occupational Therapy	Per Hour	138	30.00	71.95	**297873.00**	
Physical Therapy Total:						**1006735.96**
Physical Therapy	Per Hour	356	37.00	76.43	**1006735.96**	
Prescriptions Total:						**2939986.80**
Prescriptions	Per Rx	2010	12.00	121.89	**2939986.80**	
Skilled Nursing Total:						**1787928.00**
Skilled Nursing	Per Hour	3239	16.00	34.50	**1787928.00**	
Speech, hearing, and language services Total:						**176178.60**
Speech, hearing, and language services	Per Hour	78	30.00	75.29	**176178.60**	
Financial Management Services Total:						**5137264.00**
Financial Management Services	Per Month				**5137264.00**	

		2312	11.00	202.00		
Support Consultation Total:						**53303.16**
Support Consultation	Per Hour	578	6.00	15.37	**53303.16**	
Behavioral Support Total:						**233818.20**
Behavioral Support	Per Hour	28	105.00	79.53	**233818.20**	
Continued Family Services Total:						**21814.52**
Continued Family Services	Per Day	1	338.00	64.54	**21814.52**	
Minor Home Modifications Total:						**1635435.36**
Minor Home Modifications	Per Item	459	1.00	3563.04	**1635435.36**	
Specialized Therapies Total:						**27494541.27**
Specialized Therapies	Per Hour	3199	111.00	77.43	**27494541.27**	
Support Family Services Total:						**43629.04**
Support Family Services	Per Day	2	338.00	64.54	**43629.04**	
Transition Assistance Services Total:						**12523.50**
Transition Assistance Services	Per Item	6	1.00	2087.25	**12523.50**	
			GRAND TOTAL:			**200365769.29**
			Total Estimated Unduplicated Participants:			**4804**
			Factor D (Divide total by number of participants):			**41708.11**
			Average Length of Stay on the Waiver:			338

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
Adult Day Health Total:						**635450.40**
Adult Day Health	Per Half-Day	117	372.00	14.60	**635450.40**	
Case Management Total:						**11088985.50**
Case Management	Per Month	6165	10.00	179.87	**11088985.50**	

Prevocational Services Total:						**806078.00**
Prevocational Services	Per Hour	130	430.00	14.42	**806078.00**	
Residential Habilitation Total:						**163838598.00**
Residential Habilitation	Per Hour	6050	1878.00	14.42	**163838598.00**	
Respite (In-Home and Out–of-Home) Total:						**11470456.40**
Respite (In-Home and Out–of-Home)	Per Day	3698	13.00	238.60	**11470456.40**	
Supported Employment Total:						**31003.00**
Supported Employment	Per Hour	5	430.00	14.42	**31003.00**	
Adaptive Aids/Medical Supplies Total:						**3476319.12**
Adaptive Aids/Medical Supplies	Per Item	1413	4.00	615.06	**3476319.12**	
Dental Services Total:						**540940.00**
Dental Services	Per Item	370	2.00	731.00	**540940.00**	
Occupational Therapy Total:						**356584.20**
Occupational Therapy	Per Hour	177	28.00	71.95	**356584.20**	
Physical Therapy Total:						**1222497.85**
Physical Therapy	Per Hour	457	35.00	76.43	**1222497.85**	
Prescriptions Total:						**3579853.20**
Prescriptions	per Rx	2580	11.00	126.14	**3579853.20**	
Skilled Nursing Total:						**2153317.50**
Skilled Nursing	per Hour	4161	15.00	34.50	**2153317.50**	
Speech, hearing, and language services Total:						**212920.12**
Speech, hearing, and language services	Per Hour	101	28.00	75.29	**212920.12**	
Financial Management Services Total:						**5993340.00**
Financial Management Services	Per Month	2967	10.00	202.00	**5993340.00**	
Support Consultation Total:						**57022.70**
Support Consultation	Per Hour	742	5.00	15.37	**57022.70**	
Behavioral Support Total:						**283444.92**
Behavioral Support	Per Hour	36	99.00	79.53	**283444.92**	
Continued Family Services Total:						**20330.10**
Continued Family Services	Per Day	1	315.00	64.54	**20330.10**	
Minor Home Modifications Total:						**2132209.45**

Minor Home Modifications	Per Item	589	1.00	3620.05	2132209.45	
Specialized Therapies Total:						33056415.60
Specialized Therapies	Per Hour	4105	104.00	77.43	33056415.60	
Support Family Services Total:						40789.28
Support Family Services	Per Day	2	316.00	64.54	40789.28	
Transition Assistance Services Total:						14844.55
Transition Assistance Services	Per Item	7	1.00	2120.65	14844.55	
				GRAND TOTAL:		241011399.89
				Total Estimated Unduplicated Participants:		6165
				Factor D (Divide total by number of participants):		39093.50
				Average Length of Stay on the Waiver:		315

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
Adult Day Health Total:						735073.92
Adult Day Health	Per Half-Day	118	412.00	15.12	735073.92	
Case Management Total:						12707027.19
Case Management	Per Month	6201	11.00	186.29	12707027.19	
Prevocational Services Total:						923868.40
Prevocational Services	Per Hour	130	476.00	14.93	923868.40	
Residential Habilitation Total:						189087942.38
Residential Habilitation	Per Hour	6086	2081.00	14.93	189087942.38	
Respite (In-Home and Out–of-Home) Total:						12870009.60
Respite (In-Home and Out–of-Home)	Per Day	3720	14.00	247.12	12870009.60	
Supported Employment Total:						35533.40
Supported Employment	Per Hour	5	476.00	14.93	35533.40	

Adaptive Aids/Medical Supplies Total:						**3559605.00**
Adaptive Aids/Medical Supplies	Per Item	1421	4.00	626.25	**3559605.00**	
Dental Services Total:						**563282.40**
Dental Services	Per Item	372	2.00	757.10	**563282.40**	
Occupational Therapy Total:						**413511.48**
Occupational Therapy	Per Hour	179	31.00	74.52	**413511.48**	
Physical Therapy Total:						**1420130.40**
Physical Therapy	Per Hour	460	39.00	79.16	**1420130.40**	
Prescriptions Total:						**4437164.55**
Prescriptions	per Rx	2595	13.00	131.53	**4437164.55**	
Skilled Nursing Total:						**2540188.62**
Skilled Nursing	per Hour	4182	17.00	35.73	**2540188.62**	
Speech, hearing, and language services Total:						**244155.38**
Speech, hearing, and language services	Per Hour	101	31.00	77.98	**244155.38**	
Financial Management Services Total:						**6869410.35**
Financial Management Services	Per Month	2985	11.00	209.21	**6869410.35**	
Support Consultation Total:						**71257.92**
Support Consultation	Per Hour	746	6.00	15.92	**71257.92**	
Behavioral Support Total:						**326185.20**
Behavioral Support	Per Hour	36	110.00	82.37	**326185.20**	
Continued Family Services Total:						**23327.16**
Continued Family Services	Per Day	1	349.00	66.84	**23327.16**	
Minor Home Modifications Total:						**2185756.49**
Minor Home Modifications	Per Item	593	1.00	3685.93	**2185756.49**	
Specialized Therapies Total:						**38077018.65**
Specialized Therapies	Per Hour	4129	115.00	80.19	**38077018.65**	
Support Family Services Total:						**46788.00**
Support Family Services	Per Day	2	350.00	66.84	**46788.00**	
Transition Assistance Services Total:						**15114.75**
Transition Assistance Services	Per Year	7	1.00	2159.25	**15114.75**	
			GRAND TOTAL:			**277152351.24**
			Total Estimated Unduplicated Participants:			**6201**

Factor D (Divide total by number of participants):	44694.78
Average Length of Stay on the Waiver:	349

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 *(renewal only)*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**735073.92**
Adult Day Health	Per Half-Day	118	412.00	15.12	**735073.92**	
Case Management Total:						**12725469.90**
Case Management	Per Month	6210	11.00	186.29	**12725469.90**	
Prevocational Services Total:						**930975.08**
Prevocational Services	Per Hour	131	476.00	14.93	**930975.08**	
Residential Habilitation Total:						**189336497.02**
Residential Habilitation	Per Hour	6094	2081.00	14.93	**189336497.02**	
Respite (In-Home and Out–of-Home) Total:						**12890767.68**
Respite (In-Home and Out–of-Home)	Per Day	3726	14.00	247.12	**12890767.68**	
Supported Employment Total:						**35533.40**
Supported Employment	Per Hour	5	476.00	14.93	**35533.40**	
Adaptive Aids/Medical Supplies Total:						**3630585.28**
Adaptive Aids/Medical Supplies	Per Item	1423	4.00	637.84	**3630585.28**	
Dental Services Total:						**564796.60**
Dental Services	Per Item	373	2.00	757.10	**564796.60**	
Occupational Therapy Total:						**413511.48**
Occupational Therapy	Per Hour	179	31.00	74.52	**413511.48**	
Physical Therapy Total:						**1420130.40**
Physical Therapy	Per Hour	460	39.00	79.16	**1420130.40**	

Prescriptions Total:						**4632535.57**
Prescriptions	per Rx	2599	13.00	137.11	**4632535.57**	
Skilled Nursing Total:						**2544440.49**
Skilled Nursing	per Hour	4189	17.00	35.73	**2544440.49**	
Speech, hearing, and language services Total:						**244155.38**
Speech, hearing, and language services	Per Hour	101	31.00	77.98	**244155.38**	
Financial Management Services Total:						**6878615.59**
Financial Management Services	Per Month	2989	11.00	209.21	**6878615.59**	
Support Consultation Total:						**71353.44**
Support Consultation	Per Hour	747	6.00	15.92	**71353.44**	
Behavioral Support Total:						**326185.20**
Behavioral Support	Per Hour	36	110.00	82.37	**326185.20**	
Continued Family Services Total:						**23327.16**
Continued Family Services	Per Day	1	349.00	66.84	**23327.16**	
Minor Home Modifications Total:						**2226193.16**
Minor Home Modifications	Per Item	593	1.00	3754.12	**2226193.16**	
Specialized Therapies Total:						**38132349.75**
Specialized Therapies	Per Hour	4135	115.00	80.19	**38132349.75**	
Support Family Services Total:						**46788.00**
Support Family Services	Per Day	2	350.00	66.84	**46788.00**	
Transition Assistance Services Total:						**15394.40**
Transition Assistance Services	Per Item	7	1.00	2199.20	**15394.40**	
				GRAND TOTAL:		**277824678.90**
				Total Estimated Unduplicated Participants:		**6210**
				Factor D (Divide total by number of participants):		**44738.27**
				Average Length of Stay on the Waiver:		349

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 *(renewal only)*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**761812.72**
Adult Day Health	Per Day	118	412.00	15.67	**761812.72**	
Case Management Total:						**13207725.63**
Case Management	Per Month	6219	11.00	193.07	**13207725.63**	
Prevocational Services Total:						**964647.32**
Prevocational Services	Per Hour	131	476.00	15.47	**964647.32**	
Residential Habilitation Total:						**196474306.21**
Residential Habilitation	Per Hour	6103	2081.00	15.47	**196474306.21**	
Respite (In-Home and Out–of-Home) Total:						**13371000.72**
Respite (In-Home and Out–of-Home)	Per Day	3729	14.00	256.12	**13371000.72**	
Supported Employment Total:						**36818.60**
Supported Employment	Per Hour	5	476.00	15.47	**36818.60**	
Adaptive Aids/Medical Supplies Total:						**3703721.28**
Adaptive Aids/Medical Supplies	Per Item	1426	4.00	649.32	**3703721.28**	
Dental Services Total:						**585356.36**
Dental Services	Per Item	373	2.00	784.66	**585356.36**	
Occupational Therapy Total:						**428549.27**
Occupational Therapy	Per Hour	179	31.00	77.23	**428549.27**	
Physical Therapy Total:						**1478196.72**
Physical Therapy	Per Hour	462	39.00	82.04	**1478196.72**	
Prescriptions Total:						**4822057.50**
Prescriptions	Per Rx	2603	13.00	142.50	**4822057.50**	
Skilled Nursing Total:						**2641423.96**
Skilled Nursing	per Hour	4196	17.00	37.03	**2641423.96**	
Speech, hearing, and language services Total:						**253047.42**
Speech, hearing, and language services	Per Hour	101	31.00	80.82	**253047.42**	
Financial Management Services Total:						**7138694.09**
Financial Management Services	Per Month	2993	11.00	216.83	**7138694.09**	
Support Consultation Total:						**74052.00**

Support Consultation	Per Hour	748	6.00	16.50	**74052.00**	
Behavioral Support Total:						**338065.20**
Behavioral Support	Per Hour	36	110.00	85.37	**338065.20**	
Continued Family Services Total:						**24175.23**
Continued Family Services	Per Day	1	349.00	69.27	**24175.23**	
Minor Home Modifications Total:						**2270083.86**
Minor Home Modifications	Per Item	594	1.00	3821.69	**2270083.86**	
Specialized Therapies Total:						**39578228.65**
Specialized Therapies	Per Hour	4141	115.00	83.11	**39578228.65**	
Support Family Services Total:						**48489.00**
Support Family Services	Per Day	2	350.00	69.27	**48489.00**	
Transition Assistance Services Total:						**15394.40**
Transition Assistance Services	Per Item	7	1.00	2199.20	**15394.40**	
				GRAND TOTAL:		**288215846.14**
				Total Estimated Unduplicated Participants:		**6219**
				Factor D (Divide total by number of participants):		**46344.40**
				Average Length of Stay on the Waiver:		349