

*The Texas
Money Follows the Person Demonstration
Operational Protocol*

Texas Health and Human Services Commission
Texas Department of Aging and Disability Services and
Texas Department of State Health Services

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Section I, Part A – Project Introduction

Introduction to the Texas MFP Demonstration

Texas was one of the first of four states to have a comprehensive working plan in response to the Supreme Court's *Olmstead* decision (June 1999). Then Governor George W. Bush issued an immediate response to the *Olmstead* decision with Executive Order (GWB-99, September 1999) which began Texas' Promoting Independence Initiative (Initiative). The Executive Order mandated a high-level report that analyzed Texas' long term services and supports system and required that policy and financing recommendations be made to the Governor and the Texas legislature in 2001, in order to be in compliance with the *Olmstead* decision.

The 77th Texas Legislature (2001) codified the report's recommendations in Texas law through Senate Bills (SB) 367 and 368; the report, itself, became Texas' original *Promoting Independence Plan* (Plan). This first Plan had approximately one hundred recommendations impacting all individuals who are aging and/or with a disability (physical, intellectual, developmental, behavioral) across Texas' health and human services system.

Every two years prior to Texas' legislative session (biennial), the human services system submits a revised Plan based on new recommendations from a stakeholders' oversight committee (the Promoting Independence Advisory Committee [Committee] – which meets quarterly). There have been three revisions to the original plan which now encompasses more than a hundred initiatives for change. The Plan has and continues to impact the state development of its long term services and supports policy to provide individual choice and self-determination.

As part of the original Initiative and legislative action by 77th Texas Legislative Session (2001), two of the more major policy initiatives began, which have had lasting impact on state and national policy: (1) "Money Follows the Person" for individuals residing in nursing facilities (NF); and (2) the Promoting Independence priority populations for individuals with intellectual and developmental disabilities (IDD) residing in large (fourteen-plus bed) community Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR) and state mental retardation facilities (state supported living centers).

These accomplishments were the result of strong advocacy from consumers and advocate organizations, informed providers, and strong governmental leadership. This coalition continues in its efforts to meet goals of the state's Promoting Independence Plan while the Promoting Independence Advisory Committee aggressively provides its advisory function.

Money Follows the Person

Texas is one of the originators of the "Money Follows the Person" (MFP) financing policy and as of June 30, 2007 has transitioned 13,337 individuals from nursing facilities to community-based services. Texas' MFP policy began on September 1, 2001 as a result of a rider to then-Texas Department of Human Services' appropriations (DHS –

this part of DHS is now part of the Texas Department of Aging and Disability Services). This rider allowed Medicaid-certified individuals who reside in a NF to access 1915 (c) waiver and other community services without being placed on an interest (waiting) list. Subsequent legislatures continued the rider and the 79th Texas Legislature (2005) codified the policy into law with House Bill 1867. Since the beginning of the policy, the state has understood the importance of a supportive infrastructure to assist individuals in their personal transition. These support programs and policies include:

- Transition to Life in the Community (TLC) funds: general revenue funds to assist an individual to pay for household and moving expenses that are not available under Medicaid.
- Transition Assistance Services (TAS): a \$2500 one-time capped allowable expense under the adult nursing facility 1915 (c) service array to assist an individual in paying housing down payments and the purchasing of household items in order to establish a community residence.
- Community Transition Teams (Teams): these are public-private regional community resource coordinating groups who work with individual and systematic barriers to community relocation; these Teams were established with the assistance of a 2002 Real Choice Grant.
- Relocation Contractors: this is a statewide network of contracted organizations who hire relocation specialists to help identify individuals in NFs who want to relocate back into their communities. Relocation specialists provide outreach, identification, facilitation, and housing navigation services to assist in the relocation, as well as post-transition follow-up activities.
- Housing Voucher Program: this program is administered through Texas' housing financing agency (Texas Department of Housing and Community Affairs) to provide Section 8 Project Access Vouchers for individuals leaving NFs.

As June 30, 2007, 13,337 individuals have successfully transitioned from NFs accessing 1915 (c) waiver services – the actual number of NF residents has decreased from 61,678 in 2001 to a projected 56,832 in Fiscal Year 2008.

Promoting Independence Priority Populations

The original Promoting Independence Plan (2001) mandates that individuals in state supported living centers or in medium (nine to thirteen) large (fourteen-plus) community ICFs/MR have expedited access to Texas' Home and Community-based Services (HCS) 1915(c) waiver. Individuals residing in a state supported living center may access HCS waiver services within six months of referral, while individuals residing in large community ICFs/MR may access community-based services within twelve months. Since these programs began, 1,031 individuals have moved from the state supported living centers and another 796 individuals have moved from large community ICFs/MR into HCS.

Individuals in large community ICFs/MR and state supported living centers must go through an annual "Community Living Options" (CLO) process to inform those residents

of their rights and community options. This extensive process engages the individual and/or their legal guardian in a face-to-face meeting with facility staff to review their current status, and to help identify those individuals who want an alternative living arrangement to the institutional setting. The 80th Texas Legislature (2007) mandated that the CLO process be administered to state supported living center residents by the local Mental Retardation Authority (see Glossary).

Key Demonstration Objectives

MFP is not a new concept for Texas. Our extensive history with nursing facility MFP and relocation for individuals with IDD gives Texas both the knowledge and the infrastructure to successfully implement this *Operational Protocol* and to enhance the state's current efforts. Texas has six years of experience working with individuals in institutional settings, providing them with the information and assistance they need in order to make an informed choice on where they want to receive their long term services and supports. Texas has demonstrated its willingness to rebalance its system and has successfully pioneered many of the national efforts in community transition.

There have been many lessons learned during the past six years, which have provided the data on which to base this OP. The state has identified many of the barriers to a successful relocation. Texas will use the MFP Demonstration to respond to those identified barriers and to provide the necessary additional supports; those new initiatives include:

- Community behavioral health cognitive Adaptation training and substance abuse services
- Overnight support services
- Post-transitional services; and
- Voluntary closure of nine-plus bed community ICFs/MR.

As significantly, Texas understands the importance of a robust regulatory and quality management process. The state has implemented policies and procedures to ensure a safe environment so that individuals will receive quality community services. The state also understands, however, that an individual or their guardian may want to take certain risks in order for that individual to relocate back to the community. Texas strongly supports the principles of self-determination and that an individual with capacity or their guardian should have the final decision in the delivery of their services

The following are Texas' statements of fact that it will meet the four key demonstration objectives as outlined in statute. The statements of fact are categorized under three headings: *Ongoing Public Policy; Recent Legislative/Policy Action; and Demonstration Activity(ies)*.

The state must address the four key demonstration objectives as outlined in statute in their project introduction. These objectives are to:

- 1) Increase the use of home and community-based, rather than institutional, long-term care services;***

Increase in Use of Home and Community-Based Services

Texas has and will increase its use of home and community-based services by:

Ongoing Public Policy

- Assisting relocation contractors to help identify individuals who want to relocate and facilitate that transition (see above).
- Proposing the continuation of the budgetary line item within the Texas Department of Aging and Disabilities' appropriation for MFP.
- Allocating 1915(c) waiver slots for individuals with intellectual and developmental disabilities who want to leave the state supported living center system or large (fourteen-plus bed) community ICFs/MR.
- Dedicating line items in both the DADS' and Health and Human Services Commission's appropriations to help support community services and relocation activities (\$2.6 million).
- Contracting activities to help children relocate back to the community by supporting their biological parents or if that is not possible, establishing alternative families to assist the biological parents (Family-based Alternative program).
- Mandating through Senate Bill 368 (77th Legislature, 2001) the process of permanency planning for children in institutional settings to establish plans for relocation to the community and for subsequent six month reviews.
- Passing flexible nursing delegation rules.
- Maintaining the nation's only 1929(b) program, as part of its state plan entitlement services, which provides individuals with up to 300% of SSI with attendant services.

Recent Legislative/Policy Action

- Expanding the MFP policy to allow children (0-21) with intellectual and developmental disabilities who are in NFs to access a HCS 1915(c) waiver.
- Increasing the individual cost cap for (c) waiver programs from 100 to 200 percent of the NF cost, and from 80 to 200 percent of the ICF/MR cost.
- Dedicating HCS 1915(c) waiver slots for children (0-21) who are aging out of Texas' Foster Care system.
- Dedicating NF 1915(c) waiver slots for children (0-21) who are aging out of Texas' EPSDT program.
- Implementing new legislation that will improve Texas' outreach and information process to individuals within its state supported living center system to inform them of their community options (this is known as "Community Living Options," an annual process, which will be conducted by the Texas' Mental Retardation Authorities).
- Expanding the long-term services and supports managed care system to include five services areas; individuals who meet the Supplemental Security Income (SSI)

eligibility criteria will have access to 1915(c) nursing facility waiver services without having to be on an interest (waiting) list.

- Funding a special nursing rate to assist individuals with ventilator needs to be able to relocate/remain in the community.

Demonstration Activities

- Introducing two new Demonstration services within the MFP Demonstration to provide additional community supports for individuals with behavioral health needs and for those who require overnight assistance.
- Including as part of the MFP Demonstration the activity of working with providers of nine-plus bed community ICFs/MR who want to close their facilities, take their Medicaid-certified beds off-line, and possibly become HCS waiver providers, which will offer those residents community options.
- Piloting, as part of the Demonstration, an Overnight Support Service, which will allow more individuals with complex needs and without informal supports, to relocate back into the community to receive long term services and supports.

2) Eliminate barriers or mechanisms, whether in the State law, the State Medicaid plan, the State budget, or otherwise, that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice;

Elimination of Barriers and Flexible Use of Medicaid Funds

The Texas Legislature has done the following to eliminate barriers that prevent or restrict the flexible use of Medicaid funds.

Ongoing Public Policy

- Codified Texas' response to the *Olmstead* decision (Senate Bill 367, 77th Legislature, 2001) and acceptance of the Promoting Independence Plan, which provides among its many initiatives: (1) expedited access to HCS 1915 (c) waiver slots for individuals with IDD (and provided additional funding for those slots), and (2) requires intensive community mental health services for individuals with three more admissions within a six month period into a state mental health facility in order to avoid further hospitalization.
- Codified (House Bill [HB] 1867, 79th Legislature, 2005) the MFP policy and established a dedicated line item in the DADS' appropriations for MFP funding. The law states that all individuals who meet the eligibility criteria may relocate back into the community without having to be placed on a 1915 (c) waiver interest (waiting) list.

Recent Legislative/Policy Action

- Attached the following Riders to DADS' appropriation (80th Legislature, 2007):
 - Rider 37 dedicates 120 HCS 1915(c) waiver slots for Fiscal Years 2008-2009 for children aging out of foster care and 180 slots for individuals leaving fourteen-plus bed community ICFs/MR;
 - Rider 41 will provide HCS 1915(c) waiver slots for children (0-21) who reside in NFs;
 - Rider 43 will provide IDD 1915 (c) waiver slots for fifty children residing in eight-bed or less ICFs/MR; and
 - Rider 45 will increase individual (adult) cost caps for NF 1915 (c) waiver services from 100 percent of the NF costs to 200 percent and for individuals with IDD who are accessing the HCS 1915(c) waiver from 80 percent of the ICF/MR cost to 200 percent.

Demonstration Activity

- Attached Rider 7 to the Special Provisions of the Health and Human Services Commission's (state Medicaid agency) appropriation which will allow enhanced matching dollars from the MFP Demonstration to be utilized to enhance community services and supports.

3) Increase the ability of the State Medicaid program to assure continued provision of home and community-based long-term care services to eligible individuals who choose to transition from an institution to a community setting; and

Continued Provision of Community-Based Services

The following actions increase the ability of the state Medicaid program to assure continued provision of community-based services.

Ongoing Public Policy

- Submittal of the biennial Promoting Independence Plan (Plan) to the Governor and the Texas Legislature, which states the need for reduction and ultimate elimination of Texas' community interest lists in addition to scores of other recommendations to enhance the community-based long term services and supports system.
- Scheduled quarterly meetings of the Promoting Independence Advisory Committee (PIAC), which oversees the hundreds of initiatives within the Plan, makes additional recommendations for new initiatives, and provides overall oversight on the state's compliance to the *Olmstead* decision. Codification of the MFP policy into statute (see above discussion on HB 1867).

- Settlement of a lawsuit that requires the Health and Human Services Commission to request in its LAR a twenty percent reduction of the community interest (waiting) lists for the next two biennia (Fiscal Years 2010-2011 and 2012-2013).
- Codification of the MFP policy into statute (79th Legislature, 2005 – see above discussion on House Bill 1867).

Recent Legislative/Policy Action

- Increased coverage within the long term services and supports managed care system which allows all individuals who are aging and/or with physical disabilities on SSI, and who meet the eligibility criteria, to receive 1915(c) waiver services.
- Inclusion of additional HCS 1915 (c) slots to address enhanced efforts to provide community options for individuals who want to leave the state supported living center system.

Demonstration Activity

- Inclusion of Rider 7 to the Special Provisions of the Health and Human Services Commission's (state Medicaid agency) appropriation which will allow enhanced matching dollars from the MFP Demonstration to be utilized to enhance community services and supports.
- Inclusion of all individuals in Demonstration as part of the baseline information that is utilized in the development of the agency's Legislative Appropriation Request (LAR) which is used in building the state's two-year budget.
- Inclusion within this *Operational Protocol* that the state assures it will continue services to individuals who transition.
- Inclusion of an assurance within this *Operational Protocol* that the state will evaluate the success of the behavioral health and the overnight support services demonstration services to determine their inclusion in current state 1915(c) waivers for statewide services.

4) Ensure that a strategy and procedures are in place to provide quality assurance for eligible individuals receiving Medicaid home and community-based long term care services and to provide for continuous quality improvement in such services.

Texas has always had a strong commitment to quality for all its recipients of services. This commitment was enhanced through a three-year Real Choice Systems Change Grant awarded by CMS in 2003 to improve quality in community-based programs. Two of the major accomplishments of the grant were the development of a systematic approach to gathering information on the experiences of individuals receiving services in the community and the first phase of the development of a Quality Assurance and Improvement (QAI) Data Mart.

Quality Strategies and Continuous Quality Improvement (Ongoing Public Policy)

Annual Face-to-Face Surveys

Each year, Texas conducts face-to-face consumer surveys to obtain information directly from the individuals receiving community-based services, and measure achievement of their goals and aspirations. Depending upon the characteristics of the individuals being surveyed, two different survey instruments are utilized.

Texas is a member of the National Core Indicators (NCI) project developed by the Human Services Research Institute. The NCI project is designed to assist member states (22 states) with developing performance and outcome measurement strategies for their programs. The project provides a nationally recognized survey instrument, the NCI Consumer Survey, which was designed specifically for people with intellectual and developmental disabilities. The survey contains multiple questions to calculate specific indicators that are grouped by four different domains: consumer outcomes, system performance, health, welfare and rights, and self-determination.

The second survey instrument Texas uses is the Participant Experience Survey (PES) developed by MEDSTAT Group, Inc. for CMS. The PES was designed to collect information directly from elderly and non-elderly adults with physical disabilities and divides questions into five domains: access to care, choice and control, respect/dignity, community integration/inclusion, and self-determination.

The results of these surveys are shared with internal and external stakeholders to identify experiences of the individuals receiving services, to develop intervention strategies and, to assist in program improvement activities.

Continuous Quality Management

Texas also employs the process of continuous quality management (CQM) to determine whether its programs operate in accordance with CMS' approved design and meet statutory and regulatory assurances and requirements. CQM is one of the mechanisms to ensure individuals achieve desired outcomes, identify opportunities for program and service improvement, and ensure that public funds are spent efficiently and for the benefit of the people of Texas. The major activities are conducted by the following divisions:

- Regulatory Services (RS) Division. This division is responsible for the licensure and/or certification of nursing facilities, intermediate care facilities for persons with mental retardation, assisted living, adult day care facilities, and home health and hospice agencies. Surveyors monitor the performance of these providers by conducting routine surveys, inspections and complaint/incident investigations and require a corrective action plan if state violations and federal deficiencies are found. Follow-up surveys and inspections are conducted to ensure that the provider has effectively implemented any required corrective action plan. All surveys and inspections are unannounced and include an observation of the care of the individual.

- Provider Services (PS) Division. This division is responsible for conducting on-site contract monitoring visits to ensure providers are in compliance with program rules and to verify service delivery and payment. Provider complaint and payment histories are collected from a DADS database and reviewed prior to conducting the monitoring visits.
- Consumer Rights and Service (CRS) Unit. This unit maintains a complaint data base and receives complaints from applicants, individuals enrolled in Medicaid programs, or their families and representatives. Staff from the CRS unit will investigate the complaint and attempt resolution of it 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 CRS Complaint Data Base.
- Adult Protective Services (APS). APS is a division of Texas Department of Family and Protective Services within the Texas Health and Human Services Enterprise. APS is responsible for investigating allegations of abuse, neglect, and exploitation of adults who are elderly or those with disabilities, including cases in which a provider is alleged to have abused, neglected or exploited a participant. APS assigns one of four priority levels to complaints at the time of the complaint intake. APS complaint investigators must contact the alleged victim by phone within 24 hours of intake. The investigator may change the priority level as a result of the phone contact. APS must make the initial face-to-face contact with the alleged victim based on the priority level.

DADS is responsible for abuse, exploitation, and exploitation investigations of persons who are elderly and persons with disabilities or other residents living in facilities licensed by DADS.

Demonstration Activities

QAI Data Mart. Texas is advancing its work on its QAI Data Mart which will be a primary source of data for filing MFP Demonstration reports. The QAI Data Mart will compile data currently collected in multiple automated systems. Consultants have designed the data mart to produce standardized reports, as well as provide capability for ad hoc reporting. The areas covered by the reports will include: participant demographics; services utilization; enrollments; levels of care; plans of care; consumer-directed options, critical incidents; abuse, neglect, and exploitation incidents; long-term services and support (LTSS) provider compliance and oversight; transfers; discharges; complaints, and recoupments. The system will have the capability to provide management reports at the participant level.

At least quarterly, Texas will compile reports regarding performance of the MFP Demonstration and provide them to program staff for review and appropriate action. Additionally, these reports will be presented to the MFP Demonstration Advisory Committee for their review and comment on the status of the MFP demonstration and program improvement activities.

- Quality of Life surveys: Texas will comply with the Demonstration's Quality of Life surveys as prescribed by CMS.

1. Case Studies

Provide a detailed description, from a demonstration participant's perspective, of the overall program and the interventions for transition and rebalancing that the State proposes to use under the demonstration. The case study should walk the reader through every step of the proposed processes. These steps include, but are not limited to, the initial process of participant identification, processes that will occur prior to transition, those processes employed during the actual transition into community life and those processes that will be utilized when the individual has been fully transitioned into a home and community-based program.

Before the Case Studies are presented, it should be noted that the issues/processes impacting the transition process for individuals who are aging and for those with physical disabilities are, for the most part, the same. Major relocation activities include: securing housing, establishing community supports, choosing the appropriate provider of functional supports, and helping the individual to (re)establish social networks. The different services/supports that an aging individual may require are: training on fall prevention; lack of many social or community supports because of the death of a spouse/friends; increased need of medical supports because of deteriorating health/disease progression; increased attention because of an initial fear of living alone after extended institutionalization; depression and other behavioral issues as a result of the aging process; supports for dementia and/or Alzheimer's disease; securing appropriate eyeglasses and/or hearing aids.

Texas will be utilizing existing 1915 (c) waivers as its community-based system and will employ current rules, policies, procedures, and assurances to CMS as program criteria. The transition from the MFP Demonstration back to the State Medicaid program should be relatively seamless for the individual unless he/she was receiving a demonstration service – however, the main service array should not vary.

Each individual enrolled in the MFP Demonstration will be re-assessed on an annual basis in order to determine ongoing eligibility. This renewal process is good for a year unless there is a significant change in the individual's condition. For the significant majority of MFP Demonstration participants this re-assessment will occur just prior to the end of the Demonstration period. For those individuals who left the Demonstration due to a hospitalization or other institutional placement, this re-assessment may occur somewhat off-cycle to the movement from the Demonstration to the regular state Medicaid program.

Nursing Facility Case Study

Client Characteristics

- *Name:* Milton Jones
- *Sex:* Male

- *Age:* 54
- *Diagnoses:* Broken Back with Paralysis of Lower Extremities
- *Date of Nursing Facility Admission:* January 20, 2005
- *Legal Status:* Legally Competent Adult
- *Current Residence:* STU Nursing Care, a 256 bed large nursing facility located in Amarillo, Texas

Background

Milton is 54 years-old and resided in a nursing facility for nearly two years. Milton had been a long-haul truck driver for about ten years when he had an accident on an interstate highway during a winter blizzard in the Texas Panhandle. He sustained a broken back with paralysis in the lower extremities, and after a six week stay in a rehabilitation hospital, he was transferred to a nursing facility in Amarillo.

Before the accident, Milton rented a home in a small town outside of Marble Falls, Texas, a city approximately 600 miles from Amarillo. Milton had no immediate family and was also estranged from his ex-wife. Before the accident, he had monthly phone calls with his 22-year-old son who lived in Dallas.

After about eighteen months in the nursing facility, Milton felt he was too young to be in a nursing facility and desperately wanted return to Marble Falls or at least live closer to the community where his son could visit him more frequently.

Learning about Community Options

When Milton first arrived at the nursing facility in Amarillo, he remembered hearing from a DADS eligibility worker about some community options that may be available. However, at that point, he had been in pain, and because he thought he was going to receive rehabilitation services in the nursing facility and then leave, he did not pay much attention. So after a year and a half, he started asking the nursing facility staff about leaving. This seemed difficult because he appeared to need 24-hour care and he could not walk or transfer himself very well.

One of his friends in the nursing facility who was getting ready to move suggested that Milton speak with the Ombudsman from the Area Agency on Aging (AAA) and the relocation specialist, both of whom frequently visited the nursing facility. He had seen the Ombudsman talking with other residents and asked to speak with him. The Ombudsman gave Milton a brochure called "*Money Follows the Person to Community Living*" and contact information for the local relocation specialist, who is contracted by the state to specifically assist nursing facility residents, who want to relocate, and the Department of Aging and Disability Services (DADS) case manager.

In Texas, consumers are informed about community options when they apply for Medicaid. Nursing facility social workers, AAA Ombudsman, and relocation specialists are direct sources of information about services in the community.

Assessment for Transition Services

Relocation specialists routinely check the Minimum Data Set (MDS) Q1A information provided to them by DADS to see who has expressed an interest in moving to the community. In this case, the referral came from the AAA Ombudsman's Office. Within a week of this referral, the relocation specialist went to the nursing facility to meet with Milton to verify his request, discuss his relocation needs, and conduct a relocation assessment. The relocation specialist also provided Milton with a brief description of the types of 1915(c) waiver services available and told him that a DADS case manager would provide more detailed information when the two met in the near future; the relocation specialist helped to facilitate that meeting.

The relocation specialist then began talking with Milton about the types of transition support he might want during and after his transition to the community. The relocation specialist said that they could re-visit the transition assessment as frequently as needed after relocation. The relocation specialist told Milton that this ongoing process was intended to support him through the transition; however, Milton would be making the decisions. He could use as much or as little relocation support as he wanted.

The relocation assessment identifies the following information:

- Personal data
- Medical conditions and professional care needs such as the need for physical therapy
- Previous home care arrangements (if any)
- Housing and neighborhood preferences
- Financial situation which would be important in securing housing
- Family supports that can be provided
- Transportation needs
- Public and private supports needed
- Assistive technology needs

During the relocation assessment, Milton requested to be able to live in a place where his son could visit and stay with him for several days. Milton also requested to be close to a grocery store, a bookstore because he enjoys reading, and would need transportation to medical appointments. The relocation specialist assisted Milton with contacting the local DADS office so he could request community-based services and begin the enrollment process.

A couple of days later, the DADS case worker contacted Milton to schedule a visit at the nursing facility to begin the application process for community-based services. The case manager discussed program guidelines, medical and financial eligibility criteria, and services for the various programs that were available to Milton. The case manager also informed Milton that he had several options for directing his services. He could select the consumer directed services (CDS) option where he is the employer of his attendant

and could set the wages for his attendant within the rate set by the state. If he selected CDS, he would need to work with a financial management agency. Alternatively, Milton could select an option called the Service Responsibility Option (SRO) where he could select, train, and supervise his attendant but the direct service (home health) agency remained the employer of record. The final option discussed with Milton was one in which he could rely on the home health agency to find his attendant. The case manager discussed the advantages and disadvantages of each option. While Milton liked the idea of hiring his own attendant, he decided to start with the agency option and then check into CDS later.

Milton chose the Community-based Alternatives (CBA) program as it offered everything he needed including nursing services, personal attendant services, minor home modification, adaptive aids, transportation to medical appointments, and professional therapies like physical therapy and occupation therapy (see Glossary).

The case manager then provided Milton with a list of providers and asked him to choose a home health agency to complete the rest of the assessment. She told Milton that the next step was to meet with the home health agency and that she would fax the referral to the home health agency he selected so that they could complete the *Level of Care Assessment* for community services.

Milton met with his chosen home health agency to complete his *Level of Care Assessment* for community-based services and to develop his service plan. Three activities then had to occur: (1) the home health agency had to accept Milton's referral; (2) the DADS case manager had to verify that he had met all the eligibility criteria including medical necessity, financial eligibility, medical effective date, and (3) the services had to be identified in the service plan. Once these activities were accomplished, the DADS case manager notified Milton, the relocation specialist and the social worker at the nursing facility to finalize discharge plans and arrange transportation to Marble Falls.

Service Coordination

Prior to the move, Milton met with his DADS case manager, relocation specialist and others to develop a plan to ensure the success of his transition. Together they revisited Milton's goals and objectives for living in the community as well as the respective responsibilities of Milton, his community support and the staff supporting his transition.

Because of Milton's extensive functional and support needs, the DADS case manager also let Milton know that there are a number of community-based organizations that might help him resolve problems that might arise during the transition and throughout his enrollment in the CBA program. This additional community support comes through the regional Community Transition Teams (Team) that DADS originally established as part of a 2002 CMS Real Choice grant.

There is one Team in each of the DADS regions and they are comprised of public-private partners with representatives from: DADS, consumers, AAAs, Adult Protective Services, advocacy groups, housing organizations, long term services and supports providers, nursing facility staff, AAA Ombudsman, Mental Retardation Authorities,

Mental Health Authorities, and other not-for-profit and for-profit organizations. The Team meets monthly to address specific barriers that prevent a nursing facility resident from relocating into the community, to ensure continued success, and promote effective transitions from nursing facilities back to the community. The Team also addresses systematic barriers within their communities.

One of the major barriers to Milton's relocation was his lack of community housing. In Texas, there are three sources of housing assistance that can help with making monthly rent payments: HOME rental vouchers; Tenant Based Rental Assistance (TBRA); and the Texas' Housing Voucher Program (HVP), which provides *Project Access* vouchers to persons leaving nursing facility settings. Each of these sources of housing assistance is from the U.S. Department of Housing and Urban Development to the state housing finance agency and local public housing authorities. Because of limited housing resources, relocation contractors help individuals fill out the paperwork for placement on waiting lists for every type of housing assistance program.

Because of the limited resources for housing assistance, it took several months to find housing to meet Milton's preference for enough space so his son could visit and that was also in the para-transit service area. Also, he did not realize that it would take so long to find a place to live that could accommodate his physical disabilities and that he could afford. Many of the housing options were not wheelchair accessible and did not have the kind of shower he needed. Everything was on hold until Milton could find a place to live. During this time, his relocation specialist visited him every few weeks to give Milton an update on the housing situation.

While the relocation specialist was working to secure housing for Milton, the MFP Demonstration Project Director was meeting with the local public housing authority (PHA) to explain the Demonstration and need for dedicated housing vouchers for nursing facility residents who wanted to relocate. The Project Director provided training and educational materials on Medicaid and the availability of long term services and supports. He also discussed the opportunities provided through the Demonstration and how the Demonstration could benefit clients of the PHA. The state agency and the PHA signed a Memorandum of Understanding (MOU) detailing how the state agencies and the PHA would work together and the commitment of the PHA to dedicate ten vouchers specifically for Demonstration participants.

After three months, the relocation contractor was able to obtain one of these ten new tenant-based rental assistance vouchers for Milton.

Texas also offers two types of community transition supports to individuals who reside in nursing facilities and want to receive their long-term services and supports in a community setting. These services can be used for setting up a household in the community. Transitional Assistance Services (TAS) is provided under the Medicaid 1915(c) waiver and will provide one-time start-up funds of up to \$2500 to help an individual establish a community residence. Start-up funds available through TAS are not allowed for individuals relocating to Adult Foster Care or Assisted Living facilities. The start-up funds can be used for expenses directly related to moving, including but not limited to paying for moving expenses; housing deposits; utility deposits; cooking utensils; other moving-related expenses and household start-up costs.

Also, DADS administers a general revenue program named Transition to Life in the Community (TLC). The TLC program can provide funds for expenses that are not covered by Medicaid through TAS or other long-term services programs. TLC funding is considered a wrap-around activity to TAS.

Milton, the DADS case manager, the home health agency, and the relocation specialist, determined a discharge date from the nursing facility once the residence was established. During the intervening time, the DADS case manager helped Milton identify any household items, such as furniture, dishes, towels and bedding, and/or security deposits that he required to be bought through TAS/TLC. Finally, even though his new apartment was accessible, Milton needed to have a special shower chair before he could move; the home health agency provided the chair.

Post-Transition

On the day of discharge and relocation, Milton's relocation specialist met him when he arrived at the apartment. Milton noticed that the kitchen was stocked with groceries and he had a few sets of clothing in his bedroom. The DADS case manager and home health agency made sure that Milton's personal assistance worker reported to work at the same time Milton showed up at his new apartment.

Milton initially had difficulty with his nurse making visits on a regular basis. Concerns like this made him wonder if he could survive alone in his apartment. He discussed this with his DADS case manager, and the home health agency was able to meet his nursing needs on a regular basis. Before leaving, the relocation contractor gave Milton his telephone number. The DADS case manager also gave Milton her telephone number and the number of the home health agency in case Milton had any problems or questions that needed attention before her next contact; he was also told who to call in case of an emergency.

As indicated in his service plan, the direct services staff attends to Milton a few times a week as required, and the case manager periodically checks on Milton to ensure that he is adjusting to his new living arrangement and that the services authorized in his plan of care are being delivered.

However, one day, his direct service worker failed to show up as scheduled. When Milton tried to get himself in his wheelchair to go to the phone, he began to feel very dizzy and had to lie back down. For a few minutes he panicked and then remembered his Emergency Response System (ERS) device he received through the CBA program as part of his back up system. Milton followed the directions given to him by his service provider, and punched the button on the ERS device which was programmed to go to: (1) the home health agency emergency number and to (2) a neighbor downstairs who had volunteered to be unpaid support for Milton in an emergency. As part of the emergency backup plan, the neighbor had a key to his apartment. Within the next five minutes, he heard the neighbor unlock his apartment door and announce herself. Then the phone rang and the neighbor handed it over to Milton. It was the home health agency. Milton said that his worker had not shown up and that he needed the agency to send a back-up immediately. Within the next hour another attendant from the agency arrived.

The home health agency filed the incident on their complaint log and indicated the actions taken to remedy the situation and steps taken to prevent a reoccurrence. The complaint log was reviewed by DADS in their next on-site inspection.

Over the next three month period, the relocation specialist will visit Milton four times in the first month, two times during the second month and once during the third month. In between these visits, the relocation specialist will talk to Milton over the telephone on an as needed basis. Finally, the DADS case manager will visit Milton at least every six months unless circumstances warrant more frequent contacts.

MFP ICFs/MR Case Study

Client Characteristics

- *Name:* John Brown
- *Sex:* Male
- *Age:* 36
- *Diagnoses:* Moderate MR, Seizure disorder (controlled w/ medications), Schizophrenia (unspecified)
- *Level of Need:* LON 8
- *Date of Last Staffing (IDT):* August 16, 2006
- *Date of Last Community Living Options:* August 16, 2006
- *Legal Status:* Legally Competent Adult (Mother is actively involved in decision-making process.)
- *Current Residence:* ABC Place, a 90 bed large Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) facility located in Austin

Background

John resided at ABC Place since graduating high school in 1990. At John's request, his mother is actively involved in his life, but is not his Legally Authorized Representative (LAR) or guardian. His mother was unable to control John's behavioral outbursts by herself, and sought a long-term care option that would provide John the structure, active treatment and behavioral support that she believed he needed. John participated in workshop activities where he earned money helping to assemble barbeque pits for a large local manufacturer. The workshop was located on the campus of his residence. His behavioral episodes of physical and verbal aggression were minimized over the years with the structure of the institutional setting. He received medication to control his seizure disorder, as well as to treat his schizophrenia.

Learning About Community Options

At the time someone moves into a community ICF/MR or a State Mental Retardation Facility (state supported living center) and at least each year thereafter, the resident is presented with information about community living alternatives. This is done through the Community Living Options (CLO) process that will be discussed in greater detail later in this *Operational Protocol*. The CLO process identifies the following factors:

- The person's personal preferences for living arrangements.
- The LAR/family preferences for living arrangements.
- Identification of medical, behavioral/psychiatric issues.
- Quality of life issues.

- The recommendation of the Mental Retardation Authority (MRA) if an alternative living arrangement has been requested (see Glossary for definition of MRA).

John and his mother indicated through the annual CLO process that John wanted to move into the community with one of his friends at his annual staffing. His Qualified Mental Retardation Professional (QMRP), who was an employee of the community ICF/MR, contacted the local MRA in late August 2006 to refer him for community placement. John wanted to live in a house with his friend and maybe one other person. John's mother was concerned about his safety and well-being and therefore they agreed that John would need staff with him 24 hours. John and his mom wanted to be involved in hiring the staff in his home. Also, he was interested in having a yard because he likes plants and wanted to grow a garden. In addition, John indicated that he wanted to have a job where he could earn more money. He indicated he is interested in wood working and taking care of animals.

Once it was determined that John was interested in moving out of his current home, John asked his QMRP to invite a staff from the MRA to his planning meeting. At the meeting, the MRA service coordinator provided John and his mother with an *Explanation of Services and Supports* (Appendix F). Based on the preferences of John and his mother, his name was registered on the Home and Community-based Services (HCS) waiver interest (waiting) list. Under the Texas Promoting Independence Plan, individuals living in large community ICFs/MR have expedited access to the HCS 1915(c) waiver within a twelve month period.

Choosing a Provider

On February 1, 2007 DADS notified the Austin/ Travis County MRA that a HCS slot was available for John. Concurrently, DADS faxed ABC Place a courtesy notification that John would be offered an HCS slot soon. On February 3, 2007 Austin/Travis County MRA mailed a letter to John, in care of his mother, at his local address and his mother's home in Austin, Texas. John's mother responded by phone to the MRA that she and John were ready to pursue living options in the HCS program. Because the case manager at the MRA had already been involved in the planning process for John, she was aware of his desires for his life and scheduled an appointment with John and his Mother.

On the day the meeting was held, many of John's and his mother's questions were answered regarding how to work with providers to develop his needed supports and services. The contact names and telephone numbers of local area HCS providers were furnished to John's mother and they both co-signed a *Verification of Freedom of Choice* form that establishes their choice of the HCS Medicaid 1915(c) waiver program rather than the ICF/MR program. It was at this meeting that John and his mother were informed about the MFP Demonstration and presented with the *Informed Consent* document which they signed.

John's mother emphasized that this decision was contingent on locating a provider that would develop the services and supports that were contained in John's plan. John and his mother also wanted to make sure they would be involved in choosing the staff that supported him. Because John had developed some long-term relationships with staff

that had worked with him at ABC Place, he was interested in having these staff members come and work for him in his new home.

John and his mother reviewed available options and over the next couple of weeks they visited with three different providers of HCS services in the Austin area. John's mother had no problem with contacting each provider by calling the local numbers provided, and setting appointments to meet the provider's representative in person. In two instances, John and his mother were able to actually visit the home that was being considered for John and his friend.

One of the issues that developed over this period was the need for coordination between John's team and his friend's team so that they could live together. John's friend Tim was receiving his HCS slot two weeks after John got his slot. In two of the homes that were considered, John and Tim needed to choose a third roommate in order to afford the rent. In the third instance, there was no home to visit but the provider was helpful in describing how services might be provided in an apartment setting or in a foster/companion setting. John's mother indicated to the MRA service coordinator that she preferred for John to live outside her home, and the providers all assured her this was possible with the proper structure and support to meet his needs.

Transition Process

After meeting with HCS provider XYZ Inc., John and his mother determined that he wanted to receive HCS services from this provider. John's mother notified the MRA service coordinator who then scheduled a time to meet with John, his mother and the provider to put a plan in place for John's move. The person centered plan was updated and a proposed Individual Plan of Care (IPC) was developed and reviewed by John and his Mother. In the meeting John and his mother signed a *Documentation of Provider Choice* form and then, with XYZ Inc.'s case manager, once again reviewed his needs and desires for successful community living. This information was recorded on the IPC which is the instrument that identifies all formal Medicaid 1915(c) waiver and informal services and supports that an individual wants and needs to live in the community. The IPC was signed by all parties to indicate agreement.

John and his mother were informed that there were three different types of living arrangements under the HCS 1915(c) waiver: (1) one's own home or family home, (2) a foster/companion care setting, or (3) a residence with no more than four individuals who receive similar services. John chose to go into a three-person Residential Support Services (RSS) residence with his friend Tim and another person. John was also referred to the Department of Assistive and Rehabilitative Services (DARS) for supported employment. At the request of John and his mother, the HCS service coordinator facilitated the development of services that addressed John's needs and desires once the enrollment was approved by the state office. The HCS service coordinator then helped implement the services in John's plan, and continued to be a part of John's team by participating and monitoring the plan to ensure all of the agreed upon services were being provided.

Post-Transition

Following admission into the HCS program, XYZ's case manager became responsible for ongoing coordination of John's services and needs. John's IPC included the 24-hour residential supervision and support inherent in a residential supportive services 3-bed residential living arrangement. The big difference for John was that he was able to interview and participate in the hiring of all the staff that worked with him, including the nursing services that are used to supervise his medication administration, the psychological services to address behavioral needs, and the supported employment services to assist him on the job at the local cabinet shop.

In addition to John receiving twenty-four hour residential supervision, his XYZ case manager ongoing contact with him to see how he is getting along at the residence and to respond any of his issues with his relocation.

After two months, John's attendant began arriving late and one day did not show up as scheduled. The group home staff notified his program provider because they are contractually required to maintain a system of service planning and service delivery that is continuously responsive to changes in the individual's condition, abilities, needs, and personal goals as identified by the individual or the individual's LAR. Additionally, the program provider must ensure the continuous availability of trained and qualified employees or contractual service providers to deliver the required services as determined by the individual's needs. Once notified of the situation, John's back-up service provider arrived quickly.

This situation was reported to the Texas Department of Aging and Disabilities' (DADS) complaint hotline number by his mother. DADS intake desk reviewed the information, made a priority assessment on its risk to health and welfare, and used the information during its onsite inspection.

Managed Care/Behavioral Health Case Study

Client Characteristics

- *Name:* Gloria Cox
- *Sex:* Female
- *Age:* 46
- *Diagnoses:* Chronic Deep Vein Thrombosis, Type II Diabetes Mellitus, Schizoaffective Disorder
- *Date of Last Nursing Facility Admission:* August 3, 2007
- *Date of Last Living Options:* August 16, 2006
- *Legal Status:* Legally Competent Adult
- *Current Residence:* HIJ Nursing Facility, a 168 bed nursing facility located in San Antonio, Texas

Background

Gloria Cox is a 46-year-old female with a diagnosis of Schizoaffective Disorder, Bipolar type, who was on psychotropic medication since she was 20 years old. Prior to admission to a nursing facility, Ms. Cox lived with her boyfriend Milan, who had Schizophrenia for approximately 20 years. Ms. Cox relied on Milan to help her with daily activities since she began to have difficulty ambulating due to chronic deep vein thrombosis in both of her legs, and Type II diabetes mellitus. Milan also assisted her by doing laundry, grocery shopping, housekeeping and cooking.

Ms. Cox required insulin injections twice a day and took other medications, but needed assistance with her daily insulin injections as well as filling her pillbox each week. Ms. Cox required some assistance transferring to and from bed, or bath, to her walker and assistance with appropriate toileting. She was able to bathe, feed and groom herself with prompting, although she often dressed inappropriately before entering the nursing facility (e.g., wore several shirts or dresses at once, wore a parka in hot weather, wore stained or unwashed clothing). Ms. Cox also needed assistance dressing herself and in particular putting on shoes.

Ms. Cox was placed in the nursing facility by her mental health caseworker and Adult Protective Services after Milan was admitted to the psychiatric hospital approximately eight months ago. She had bouts of depressed mood that was intensified with her inability to ambulate well. Ms. Cox had no family members or friends who remained involved in her life, other than Milan, who came to visit her at the nursing facility once a week. Milan attended church regularly and attempted to get Ms. Cox to go with him, but she refused to go saying that she was uncomfortable around crowds. Ms. Cox also had a history of self-medicating with alcohol and street drugs before entering the nursing facility.

DADS uses Minimum Data Set 2.0 (MDS) data to help determine who might want to transition from a nursing facility back into the community. Item Q1A of Ms. Cox's initial MDS screen indicated that she wanted to leave the nursing facility to live in the community and also indicated that she had prior behavioral health issues.

Learning About Community Options

The MDS data is transmitted to the local relocation contractor which triggers a visit by the relocation specialist. The relocation specialist verified that Ms. Cox wanted to move back into the community, and that she had a prior history of mental health and substance abuse issues. Ms. Cox indicated that her goal was to live with Milan again some day, but feared that he could be hospitalized again, thus causing her to return to the nursing facility. Ms. Cox also indicated that she wanted Milan involved in her life, and wanted him to take part in helping her with her decisions about the move.

After the visit, the relocation specialist obtained her informed consent and referred Ms. Cox to the local DADS Star+PLUS Support Unit (SPSU) to begin her relocation to community services (see Glossary). The SPSU was contacted rather than a DADS case manager because San Antonio is in a managed care catchment area where long term services and supports are provided through the Star+PLUS Medicaid 1915(c) waiver.

Ms. Cox was informed that Star+PLUS is a Texas Medicaid managed care program designed to provide health care, acute and long-term services and support through a managed care system. The 1915(c) waiver program provides a continuum of care with a range of options and flexibility to meet individual needs. The program increases the number and types of providers available to Medicaid clients.

Participants of Star+PLUS select a managed care organization (MCO) from those available in their county, and receive Medicaid services through the managed care health plan. Through these managed care health plans, the Star+PLUS program combines traditional health care (such as doctor visits) and long-term services and support, such as providing help in the individual's home with daily activities, home modifications, respite care (short-term supervision) and personal assistance.

Service coordination is a main feature of Star+PLUS. Medicaid clients, their family and providers work together to help clients coordinate health, long-term and other community support services.

Choosing a Service Provider

The SPSU provided Ms. Cox with information so that she could select a Star+PLUS MCO. Concurrently, the relocation specialist assisted Ms. Cox in transitioning her Supplemental Security Income (SSI) benefits to the community setting. She chose a MCO who assigned a service coordinator who assisted her in developing a service plan.

The service coordinator also convened a staffing by the transition team. The transition team included representatives from: Ms. Cox, the local mental health authority, the relocation contractor, the Organization for Screening, Assessment and Referral (OSAR

– the substance abuse services provider), the public housing agency and local advocates. The transition team helped to initiate all the supporting activities to make Ms. Cox’s relocation to the community a reality.

The service coordinator visited Ms. Cox in order to have assessed her needs, and discuss the types of home and community-based services that were available. Shortly after the assessment, the service coordinator and Ms. Cox agreed on her individual plan of care. The plan included peer support, home and community-based 1915(c) waiver services through the Star+PLUS 1915(c) waiver program, Cognitive Adaptation Training (CAT) and screening/assessment for substance abuse services through the OSAR.

The CAT services were selected because of the unique behavioral health needs of Ms. Cox. CAT services are rehabilitation services that address the cognitive deficits of the individual, and assist the person to establish their environment and provide tools to support skill acquisition including improvement in medication adherence, personal care and activities of daily living, social skills, and integration into the community.

The service coordinator also discussed the three types of consumer directed service options available to Ms. Cox (see discussion under the Nursing Facility Case Study). Ms. Cox did not feel she was ready to select consumer directed services but wanted to reconsider the option at a later date

While Ms. Cox wanted to move back with Milan, who was now living in the community again, she realized that to increase the success of the transition that she would need support in maintaining her sobriety and independence. After discussing possible living arrangements with the relocation specialist, she chose to live in a licensed adult foster care home until she is ready to live in an apartment of her own with Milan. Ms. Cox visited the foster home where the foster care provider explained where she was to sleep, the types of activities available and the meal options such as joining the family in the dining room or eating her meal in her room. Ms. Cox indicated that she was pleased with the living arrangement, the foster family and the family pets.

Post Transition

As part of her individual plan, Ms. Cox received personal care assistance, adaptive aids, physical health care and counseling through Star+PLUS. Ms. Cox was assisted in locating a local pharmacy that delivers medication. Her service coordinator helped her arrange for dental services through the local Health District, assisted Ms. Cox in completing an application to a local transportation provider in order to receive transportation to and from her medical appointments, and assisted her in learning how to use the public transportation system to attend a support group for individuals recovering from addiction. She also received CAT from the CAT provider to assist her in organizing her environment and learning to perform daily activities, such as how to do her own laundry, dressing appropriately for the season, and managing her medications.

The CAT provider worked closely with Ms. Cox’s personal care provider to ensure that cognitive adaptation is understood and supported by her personal care attendants. The relocation specialist helped Ms. Cox understand how to work with the members of her support team and to advocate for herself. The service coordinator ensured that Ms.

Cox's continued to receive the health, long-term services and supports, and behavioral health services she required.

After training and assistance from the CAT provider, Ms. Cox was ready to move from the group home setting to her own apartment. The relocation specialist monitored Ms. Cox's progress over the training period and when she was ready to move, identified suitable, accessible and subsidized housing for Ms. Cox's consideration. Ms. Cox decided at this time to live with Milan, so they were shown three available apartments and they selected a furnished apartment which was closer to a grocery store and her physician's office. The relocation specialist assisted Ms. Cox in relocating, and visits her and Milan periodically to ensure that they are getting along well.

Ms. Cox continued to receive her acute and long term services and supports through the Star+PLUS program, and once she was settled and functioning on a day to day basis in her new home, Ms. Cox began receiving psychosocial rehabilitative services through the local mental health authority to help maintain and further her independence.

Ms. Cox's Star+PLUS service coordinator periodically monitors her situation to ensure that she is receiving the health and long term care services described in her plan of care and that these services are working for her. When changes are required, or once every 12 months (whichever is less) the Star+PLUS service coordinator revises the plan of care, with the active involvement of Ms. Cox, her providers and Milan, to reflect Ms. Cox's evolving needs and preferences. The local mental health provider reviews and updates Ms. Cox's psychosocial rehabilitation plan every 90 days, coordinating their activities and services with the individual plan developed by the Star+PLUS service coordinator. Finally, the relocation specialist visits Ms. Cox periodically both in person and by telephone. Ms. Cox is provided with phone numbers for each of these organizations/individuals and told what to do in an emergency.

Loss of Medical Necessity

Ms. Cox significantly improved during the Demonstration period as the result of better coordinated care through the managed care organization and being the recipient of CAT services. Ms. Cox became a compliant individual and took her medications in a timely manner. Both her behavioral and medical health improved to such a degree that upon her annual reassessment, as she prepared to transition from the Demonstration to regular STAR+PLUS services, she was denied medical necessity (MN). The decision to deny MN was appealed to a Fair Hearing judge who upheld the decision.

The STAR+PLUS service coordinator worked with Ms. Cox and Milan, and evaluated her for attendant services. Ms. Cox met the functional eligibility criteria for that service, and the service coordinator worked with her and the attendant care provider agency to develop a service plan. It was determined that Ms. Cox would receive fifteen hours per week of attendant services. The consumer directed services (CDS) option was offered but declined. Ms. Cox continues to receive her acute care services through STAR+PLUS, while the local mental health provider continues to review and updates her psychosocial rehabilitation plan every ninety days coordinating activities with the managed care service coordinator.

Ms. Cox is thriving in the community and increasingly is becoming more engaged in social interactions. She is considering re-entering the workforce and has requested information about Texas' Medicaid Buy-In program, and has contacted the Texas Department of Assistive and Rehabilitative Services about vocational training.

ICFs/MR Voluntary Closure Case Study

Client Characteristics

- *Facility Name:* ABC Place
- *Facility Owner:* Texas Concepts
- *Facility Type:* 90 bed Intermediate Care Facility for Persons with Mental Retardation (ICF/MR)
- *Location:* Austin, TX
- *Year Built:* 1957
- *Client Name:* Jim Johnson
- *Sex:* Male
- *Age:* 52
- *Diagnoses:* Profound mental retardation, cerebral palsy, and diabetes
- *Legal Status:* Mother is legal guardian

Background

ABC Place was built in 1957 and was converted to a large (fourteen-plus bed) community ICF/MR in 1976. It is owned and operated by Texas Concepts who also owns several six bed ICFs/MR in the Austin area and operates Home and Community-based Services (HCS) 1915(c) waiver service programs. ABC Place serves all persons diagnosed with an intellectual or developmental disability, but specializes in medically fragile/medically complex individuals. The facility had a current census of 67 and over the past several years has found it increasingly difficult to meet their goal of a census with of at least ninety percent capacity. This decreasing census, combined with the increasing cost of maintenance for a fifty year old building, has resulted in ABC Place operating with a deficit for three consecutive years.

Jim moved to ABC Place in 1982. He was mobile in a manual wheelchair with assistance from a helper. Due to severe contractures, Jim required total physical assistance with dressing, grooming, meals, hygiene, and other activities of daily living. Jim's mother, Eunice, his legal guardian, was and continues to be active in his life.

ABC Place's parent company, Texas Concepts, approached DADS in October 2007 to discuss the feasibility of a voluntary closure of ABC Place due to severe financial hardships associated with continued operation. Texas Concepts indicated that rather than just close their doors and relocate their current residents, they wanted to follow the voluntary closure protocol associated with the Money Follows the Person Demonstration (MFP Demonstration).

Representatives from Texas Concepts and the Administrator of ABC Place met with DADS State Office representatives on November 21, 2007, to discuss the closure process.

In Texas, the cost of operating a HCS residential facility is more expensive than operating a large community ICF/MR. This higher cost has been an obstacle to the overall reduction of beds in the large community ICF/MR program through voluntary closure. To minimize this obstacle, Texas will use its enhanced Federal Medical Assistance Annual Percentage (FMAP) to help off-set the costs associated with the closure of a large ICF/MR.

Texas Concepts indicated to DADS that the largest barriers to voluntarily closing this facility were: 1) meeting the requirement of overall cost-neutrality to the state; and 2) maintaining operations (utilities, mortgage, staff salaries, etc.) during the closure period as the census and revenue declined.

DADS advised Texas Concepts to begin contacting all ABC Place residents/ guardians/ legally authorized representative (LAR) to inform them of the possibility of a facility closure, and to complete an updated *Community Living Options* (CLO) instruments on all current residents (as described elsewhere in the Operational Protocol, the CLO is a formal mechanism where the individuals and/or family member or legal guardian and the facility have a meeting to discuss the individual's current status and review all community options).

Learning about Community Options

Management of ABC Place invited all residents and their family members/LARs to a meeting on November 14, 2007 to discuss the possibility of closing ABC Place and what the impact would be for the residents. Upon receiving this notification, Eunice Johnson, Jim's mother, was extremely distressed and resistant to the thought of uprooting Jim from his home of 26 years and feared there would be negative physical and emotional consequences for Jim in a new environment.

At the November 14, 2007 meeting, the administrator described the proposed process for closure and how it would impact the residents. She presented the following information:

- Residential living options available to the residents.
- Community Living Options (CLO) process to be conducted prior to the closure which included the:
 - Updating of the CLO documentation.
 - Identification of the proposed timelines for the closure and relocation of residents.
 - Overview and scheduling of visits to the various living arrangement options and various providers
 - Documenting informed choice related to living arrangement and choice of service provider.
 - Description of the relocation assistance to be furnished by the provider.

- Provider assurances that the facility would remain in compliance with regulations during the closure process and ensure appropriate and adequate staffing during the closure.
- Provider intention to continue as a provider of ICF/MR services and whether the provider's plan included the conversion of ICF/MR services to Home and Community-based Services (HCS).
- Provider assurance to furnish written and verbal notice to each individual and the individual's legally authorized representative (LAR) or family at least thirty calendar days prior to the facility closure. The notice included a description of assistance that was available from the provider and the local Mental Retardation Authority (MRA) during the relocation process, along with contact information. In addition, the provider assured all residents that they would cooperate with the applicable MRA to assist individuals in making an informed choice.

At the conclusion of the meeting, the residents and/or their family members/LARs had the ability to meet with their Qualified Mental Retardation Professional (QMRP) to discuss any additional issues or concerns. Shortly after the meeting, Jim's mother/guardian was contacted by Jim's QMRP and an updated CLO instrument was completed which provided information of possible residential options. Ms. Johnson indicated at that time that she was most comfortable with Jim residing in a large community ICF/MR and was very angry about the closure.

Final DADS – Texas Concepts Negotiation

On January 20, 2008, representatives from Texas Concepts and ABC Place met again with DADS Central Office staff to discuss voluntary closure of the facility. DADS requested that Texas Concepts present preliminary information regarding where their residents would relocate and a budget for closure.

The following information was presented at this meeting:

- ABC Place's census was 67 and 48 of those individuals indicated that if ABC Place should close, they wanted to pursue HCS residential placement.
- Forty-eight of these individuals chose the Residential Support Services (RSS) or Supervised Living (SL) model available in HCS due to medical complexity and need for intense supervision.
- Twelve individuals indicated that they were aware of their options and chose to live in a different large community ICF/MR facility.
- Seven individuals expressed interest in a small (six-bed) ICF/MR group home placement.
- ABC Place provided DADS with potential Individual Plans of Care (IPCs) for those individuals interested in HCS residential placement so that cost neutrality considerations of the closure could be determined.

DADS and Texas Concepts were able to successfully negotiate an agreement on the terms for voluntary closure of ABC Place in order to safely and properly discharge all

residents, transition the residents, and cease operations. The state would use part of its enhanced funding to support residents in their relocation to community services. In addition, facility closure would occur on May 1, 2008 with all services, including appropriate staffing, to be provided by the facility until all residents had relocated.

On February 1, 2008, ABC Place formally notified all residents/ guardians/ LARs that ABC Place would be closing effective May 1, 2008. The local MRAs for all affected residents were also notified. The MRAs began contacting residents/ guardians/ LARs to complete *Verification of Freedom of Choice* forms and ensure education of all living options.

Choosing a Provider

During the months of February, March and April 2008, provider agencies were chosen by the residents, and living arrangements were secured. This was a very difficult time for Jim and his mother and their anger about the closure continued to grow.

One of the QMRP's scheduled a follow-up meeting with Jim and his mother in order to gain a better understanding of their concerns, and provide further information on the various living options available for Jim. The QMRP: (1) provided a list of residential housing options available under the HCS waiver program; (2) provided a listing of ICFs/MR options; (3) explained the services available under each of these living arrangements; and (4) offered to help to set up appointments to visit any of these facilities. Jim and his mother finally began to feel that someone was listening to them.

After this meeting, Jim's mother wanted to know more about the Residential Support Services (RSS) option under HCS. RSS allows the individual to live in a three-bed or less group home with twenty-four hour on-site staff. The QMRP met with Jim and his mother again, and discussed the RSS model with them; they agreed to visit a number of places. Ms. Johnson indicated that she was pleased with the services provided by the staff at ABC Place and requested that Jim be able to do an overnight visit at one of Texas Concepts' RSS homes. Jim's QMRP arranged for this visit to occur.

Following this visit, Jim and his mother decided that his needs could be met in an HCS environment, and requested RSS placement with Texas Concepts. A case manager for Texas Concepts met with the family and Jim's IDT from ABC Place to create his Individual Program Plan. Over the course of the next two months, Jim was encouraged and assisted to make numerous visits to HCS group homes to become more acclimated to the setting prior to his move. On April 16, 2008, Jim was officially discharged from ABC Place and admitted to his new home in the community.

The QMRP further reassured Jim's mother by telling her that if Jim desired to return to the ICF/MR program, the request would be made to Jim's case manager. The case manager would notify the local Mental Retardation Authority (MRA) of the request so that Jim's level of care/level of need assessment would be updated, and submit that request. On acceptance to an ICF/MR, the service coordinator would provide assistance and direction for Jim's transition from waiver program services back to an ICF/MR.

Please refer to the *Transition Process* portion of the MFP ICFs/MR case Study as the process is exactly the same.

Transition Process

As per agreement with DADS, the majority of resident discharges occurred during a one month period (April 2008) to lessen the fiscal impact associated with a declining census. Direct service staff from ABC place was offered employment with Texas Concepts ICF/MR group homes and HCS programs. Thirty nine individuals who chose HCS services selected HCS programs affiliated with Texas Concepts. These residents and their families indicated that familiarity and long-standing relationships with staff members were important factors in choosing Texas Concepts' programs.

During the transition process, ABC Place kept the residents/LAR/Guardians informed of the closure process and advised them that their staff were available to answer questions and offer assistance. Please refer to the transition process portion of the *MFP ICF/MR Case Study*, as previously described because the process is exactly the same.

Post-Transition

Please see the *MFP ICF/MR Case Study* for a description of the post-transition process. The only difference between that case study and the voluntary closure case study is that many of the employees of ABC Place were chosen by the individuals transitioned to provide their services in the new living arrangement. The reason for this is because many of the direct services staff from ABC Place chose to work for Texas Concept's HCS program.

2. Benchmarks

Provide a list of proposed annual benchmarks that establish empirical measures to assess the State's progress in transitioning individuals to the community and rebalancing its long-term care system. The first two benchmarks were specifically required under the MFP Demonstration.

Required Benchmark One – Persons Transitioned

The projected number of eligible individuals in each target group of eligible individuals to be assisted in transitioning from an inpatient facility to a qualified residence during each fiscal year of the demonstration.

From FY 2011 forward, Texas will assist 1362 individuals to relocate from the following types of qualified institutions:

- Nursing facilities
- Community ICFs/MRs that voluntarily choose to close
- *Medium and Large Community ICFs/MR*
- *State Supported Living Centers (SSLCs)*

MFP Target Groups FY 08 – FY 11

MFP Demonstration Enrollment	Target Group	FY08	FY09	FY10	FY11	Total
Number of individuals relocating from medium and large community ICFs/MR and SSLCs, including children under the age of 22	MRDD	200	325	375	375	1275
Number of individuals relocating from ICFs/MR because of closure	MRDD	42	94	94	237	467
Number of individuals relocating from nursing facilities	Elderly	157	157	157	388	859
	Physical Disability	118	118	118	292	646
	Sub-Total	275	275	275	680	1505
Number of individuals relocating from nursing facilities with behavioral	Elderly	29	29	29	29	116
	Physical Disability	21	21	21	21	84

health needs	Sub-Total	50	50	50	50	200
Number of individuals relocating from a nursing facility and receive Overnight Companion Services	Elderly	11	11	11	11	44
	Physical Disability	9	9	9	9	36
	Sub-Total	20	20	20	20	80
Total MFP Demonstration Enrollment		587	764	814	1362	3527

Amendment No. 3 revisions for this benchmark have increased the number of relocations for each target group, include all community ICFs/MR that close regardless of size, and add children under the age of 22, a Texas Promoting Independence Priority Population, as an eligible person for the Money Follows the Person Demonstration. The changes to enrollment estimates in years 2008-2010 are to correct mathematical errors (i.e. in year 2008 the total was reported as 572 individuals but should have been 587).

Texas has been very successful with the ICF/MR voluntary closure target group but at the time of Amendment #3 of the OP, there are no new applicants. Accordingly, the revised estimate is based on 237 individuals relocated through the voluntary closure target group in 2011 and another 100 in 2012. After 2012, Texas will revise these estimates annually during the supplemental funding request.

The original application estimated that there would be a total of 2616 individuals participating in the MFP demonstration. The original Operational Protocol estimated that 3135 individuals would participate in the MFP demonstration. This is because the 80th Texas Legislature (2007) directed the Texas Department of Aging and Disability Services to enhance its efforts in communicating community options with residents (intellectual and developmental disabilities) of the state supported living center system. This renewed effort is known as the “Community Living Option Information Process” and was legislated through Senate Bill 27 (80th Legislature, Regular Session, 2007). Texas believes that this renewed effort will increase the number of individuals with IDD who will want to participate in the MFP Demonstration.

Finally, after the CMS review of the Operational Protocol regarding question number 8, number of ICF/MR beds taken off-line, the estimate was reduced to 2999 because DADS’ original voluntary closure benchmark did not take into consideration that approximately thirty percent of people leaving a ICF/MR will choose to move to another ICF/MR rather than community services.

Initial MFP Proposal. The original application estimated that 2,616 individuals would transition over the five year demonstration period. Of this total, it was estimated that

1,400 individuals would transition from nursing facilities and 1,216 would transition from ICFs/MR.

Operational Protocol Submission. For reasons identified in the preceding question, the Operational Protocol was increased to 3,135 individuals (a 519 increase). The estimated nursing facility transitions remained the same (1,400) while the ICFs/MR transitions increased to 1,735 (which include the dual diagnosis of 70 individuals).

Revised Submission. As Texas was reviewing CMS' responses to the Texas Operational Protocol, the State found a few other areas that it wanted to clarify/revise. First, the number of individuals transitioning as a result of voluntary closure of an ICF/MR was reduced by thirty percent (see response to the previous question). The next change pertains to the number of individuals transitioning from nursing facilities. The total remains the same at 1,400. However, review of historical program information reveals that 42.9 percent of nursing facility relocations are by individuals under the age of 65. Accordingly, the "physical disability" nursing facility population was increased from 537 to 600 individuals while the number of 65+ decreased from 1007 to 800.

For clarification purposes, the "Mental Illness" target population remains the same at 200 individuals and is included within the nursing facility transition target population. The "Dual Diagnosis" population of seventy individuals should have never been listed as a separate category because it is part of the category of individuals with intellectual and developmental disabilities. These seventy have been combined with the ICF/MR population that will move into the Home and Community-based Services (HCS) waiver.

Texas will be using the additional dollars allocated in the initial CMS grant award. The revised budget to reflect the revisions in the number of people estimated to be in the MFP Demonstration can be found at Appendix I.

Required Benchmark Two – Qualified Expenditures for HCBS

Qualified expenditures for HCBS during each year of the demonstration program.

The following benchmarks document Texas' projected expenditures for fiscal years 2008-11 for community-based long-term services and supports programs. These are Medicaid expenditures and do not include Title III, IV, XX or state general revenue programs. These projected expenditures are shown in the table below. Program descriptions for state entitlement services are provided in the glossary and descriptions for 1915(c) waiver services are provided in the *Benefits and Services* section of this *Operational Protocol*.

Texas' legislature meets on a biennial basis beginning the second Tuesday in January of odd-numbered years. The Legislature appropriates a two-year budget with the fiscal year beginning on September 1st.

The state agencies can not predict what the Legislature will appropriate beyond the current biennium (FYs 2008-2009). Therefore, that is why the figures for FY 2010 and FY 2011 are the same as for FY 2009. The FY 2009 figures will be the base numbers for the FY2010-11 biennium. The new budget-writing cycle will begin in the spring of

the even-years prior to the start of a new Legislative session. Staff will present information during the preparation of the new Legislative Appropriations Request (LAR).

The appropriations, built on forecast and case load models, are expected to be expended on Texas' home and community-based programs and, therefore, should be considered "qualified expenditures" for the purposes of the MFP Demonstration. The Texas Legislature only appropriates dollars that it believes will be qualified expenditures based on the state agencies Legislative Appropriation Request (LAR). Texas will prepare to build its Fiscal Years 2010-2011 biennial LARs in the spring 2008 for the consideration of the 81st Texas Legislature (January 2009 – May 2009). Again, the state agencies will utilize historical data, demographic growth, caseload projections and forecasting models to build the LARs. The dollars in chart provided are our best estimations on proposed qualified expenditures.

At a minimum, the DADS and the Health and Human Services Commission will be requesting a 20% increase in (c) waiver appropriations for SFY 2010-2011 and 2012-2013 per a lawsuit settlement. However, the ultimate amount of the final appropriations is the sole decision of the Texas Legislature.

Texas HCBS Appropriations

Texas HCBS Appropriations (X000)	FY2007 Baseline	FY2008	FY2009	FY2010	FY2011
Managed Care Entitlement HCBS (Star Plus)	\$ 190,932	\$304,003	\$317,136	\$317,136	\$317,136
Primary Home Care (PHC)	\$ 450,356	\$409,608	\$418,350	\$418,350	\$418,350
Community Attendant Services (CAS)	\$ 312,930	\$344,412	\$350,324	\$350,324	\$350,324
Day Activity & Health Services (DAHS)	\$ 99,886	\$95,484	\$96,871	\$96,871	\$96,871
Community-Based Alternatives Waiver (CBA)	\$ 415,252	\$417,836	\$429,497	\$429,497	\$429,497
Home and Community-Based Services Waiver (HCS)	\$ 455,182	\$533,150	\$603,821	\$603,821	\$603,821

Community Living Assistance and Support Services Waiver (CLASS)	\$ 103,805	\$132,291	\$142,600	\$142,600	\$142,600
Deaf-Blind Multiple Disabilities Waiver (DBMD)	\$ 6,339	\$7,703	\$8,088	\$8,088	\$8,088
Medically Dependent Children Program Waiver (MDCP)	\$ 21,464	\$41,744	\$46,554	\$46,554	\$46,554
Consolidated Waiver Program (CWP)	\$ 3,798	\$4,214	\$4,214	\$4,214	\$4,214
Texas Home Living Waiver (TxHml)	\$ 7,488	\$8,201	\$8,201	\$8,201	\$8,201
Money Follows the Person (MFP) Promoting Independence (PI) Initiative	\$ 72,268	\$75,341	\$82,097	\$82,097	\$82,097
Managed Care (Star Plus) Waiver	\$ 114,141	\$190,146	\$197,880	\$197,880	\$197,880
Program of All-Inclusive Care for the Elderly (PACE)	\$ 25,749	\$29,779	\$29,806	\$29,806	\$29,806
Total	\$ 2,279,588	\$2,593,913	\$2,735,440	\$2,735,440	\$2,735,440

The figures presented in all of the Benchmarks for capitated programs indicate the long term services and supports expenditures; they do not include the acute portion. The long term services and supports portion of the capitated rate is based on historical and encounter data for long term services and supports. Furthermore, all information regarding the (c) waivers is for community-based long term services and supports.

Benchmark Three – Individuals Served through Behavioral Health

Texas is proposing two new demonstration services for individuals who have co-occurring behavioral health issues (a mental illness or substance abuse) and want to relocate from a nursing facility (NF) to a community residence of their choice. The demonstration services will provide additional community supports during the pre-transition and post-transition phase of an individual's overall relocation. The two new supportive services will be *Cognitive Adaptation Training (CAT)* and *Adult Substance Abuse Treatment Services (ASATS)*; each service will be explained in more detail in the

Demonstration Services section of this *Operational Protocol*. These services will be provided in the nursing facility when appropriate, and in the community upon transition.

These demonstration services are being proposed as a pilot project within the larger context of the overall Demonstration. The pilot will be limited up to fifty individuals per year who are current NF residents in the San Antonio service delivery area. If this pilot is successful, then Texas will consider an amendment to the 1915(c) waivers to make these demonstration services available statewide.

An additional benefit of this pilot will be the extensive training of community direct care and professional workers in CAT skills. This training will be generalized to populations at-large, thereby assisting individuals not in the official Demonstration pilot.

MFP Demonstration Service	FY 2008	FY 2009	FY 2010	FY 2011
Number of Individuals Receiving Cognitive Adaptation Training and/or Substance Abuse Treatment Services	20	35	40	50

The benchmark number of 145 is less than the maximum we hope to serve because, given the complexity of the population and care delivery systems which must be coordinated and the delay in grant implementation due to receiving CMS OP approval, there may be less individuals served in the initial years. However, the MFP demonstration budget is based on serving 200 individuals, which is our goal.

Benchmark Four – Annual Change in the Number of Licensed ICFs/MR Facilities and Certified Beds Taken Off-Line.

Texas will work with providers of nine-plus bed community ICFs/MR who voluntarily want to close their facilities. Texas will work with these providers to take those certified beds off-line and provide HCS 1915(c) waiver community service options. Those residents will be given several options on where they want to move.

Based on previous DADS’ experience, over seventy-five percent of individuals in nine-plus bed community ICFs/MF choose a small group home as their preferred HCS waiver living arrangement. This living arrangement is more expensive than residing in a nine+ bed ICF/MR. This cost differential has always been an obstacle for some providers who want to downsize or close their facilities and become HCS providers; Texas currently requires that any conversion not exceed the cost of community-based services. For purposes of this Demonstration, Texas will utilize the Demonstration’s enhanced matching funds to assist with the transition infrastructure costs (non-room and board) from institutional to community-based services. Additionally, the term “cost-neutral” does not have the same connotation as used by CMS for its 372 reports.

Licensed Medium and Large	FY 2008	FY 2009	FY 2010	FY 2011
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Community ICFs/MR's				
# Beds at End of Fiscal Year (FY 07 end of year = 2368)	2308	2175	2042	1908
Accumulated % Decrease In Certified Beds	2.53%	8.15%	13.77%	19.43%

Benchmark Five – Public Housing Authorities and Housing Related Issues

The Texas Department of Housing and Community Affairs (TDHCA) is the state housing finance agency and a public housing authority. TDHCA allocates funding of federal housing funds/programs to local Public Housing Authorities (PHA) in non-participating jurisdictions throughout the state. PHAs in larger communities receive funding directly from the U.S. Department of Housing and Urban Development (HUD); there are 475 PHAs in Texas. There is no central state oversight authority and PHAs develop their own programs and priorities through their local Consolidated Housing Plans.

Until recently, Texas' health and human service agencies and PHAs have had very little interaction on housing issues. Governor Rick Perry's Executive Order RP-13 established TDHCA as a member of the Promoting Independence Advisory Committee (PIAC), which oversees Texas' response to the Olmstead decision. In 2002, TDHCA began administering approximately thirty-five "Project Access" housing vouchers for individuals who transition from institutions to a community living arrangement. It was at this time that DADS and TDHCA began the process of collaborating on a number of housing issues.

One result of this collaboration materialized last year when the PIAC approached TDHCA to request an increase in funding for housing assistance during the development of their Consolidated Housing Plan. TDHCA responded favorably by increasing annual funding for Tenant-Based Rental Assistance (TBRA) vouchers from \$800,000 to \$2,000,000.

These recent activities of the PIAC and TDHCA have brought attention to the continued need for health and human service agencies and advocates to work closely with the state and local PHAs. The efforts necessary to increase the stock of affordable and assessable housing and rental assistance must come through mutual cooperation, identification of housing need and education by all parties involved. Because of the increased attention of preparing this *Operation Protocol*, TDHCA is preparing a request to its Board to increase the number of Project Access vouchers from thirty-five to fifty.

The MFP Demonstration Project Director will act as the housing liaison for the Health and Human Services Enterprise's housing related issues; the Enterprise is comprised of the Health and Human Services Commission and its four operating agencies: the Department of Aging and Disability Services, the Department of State Health Services, the Department of Assistive and Rehabilitative Services, and the Department of Family and Protective Services. Furthermore, Texas will build upon its recent preliminary

successes to establish more comprehensive working relationships with its state housing finance agency and its PHAs. Texas will begin this process with the following activities:

Development of a Housing Inventory/Registry

DADS will work with the TDHCA, the Texas Council on Developmental Disabilities, United Cerebral Palsy of Texas, and the Texas Low-Income Housing and Information Services to develop a housing inventory that will be linked on each agency's website. Individuals interested in looking for affordable housing will be able to search these websites. These activities will begin in 2007 and will be an ongoing effort to provide the following information from state and local PHAs and public and private owners of rental stock. The inventory/registry will include:

- Number of affordable housing units in their inventory and accessible units.
- Number of housing vouchers currently available and the number dedicated to individuals with disabilities.

Training Activities

DADS, in conjunction with its partners, will:

- Collect and distribute basic information on housing and housing plans. Information collected and shared will include: the most recent Consolidated Housing Plan and Annual Action Plan to identify priorities for HOME, Low Income Housing Tax Credit, Community Development Block Grant and other programs used to develop affordable housing.
- Develop a Computer Based Training (CBT) curriculum for PHAs regarding the HHS Enterprise home and community-based services. This project will begin in state fiscal year 2008.
- Create a Housing Advocacy E-mail Distribution list to distribute housing related information. As an example, federal Notice of Funds Availability (NOFA) and draft housing/action plans will be distributed in a more expedient manner.
- Provide linkages to the DADS Promoting Independence website for individuals who want more information about Texas' Public Housing Authorities (housing plans, rental application requirements, housing availability, etc.).

The following measurable activities will act as sub-measures for the overall housing benchmark.

Number of New Vouchers

Texas is very reluctant to establish specific outcomes regarding activities for which it has no control, such as housing stock/vouchers. However, while Texas' intention is to surpass the following measure, a very modest outcome measure for the MFP Demonstration is established below and , which is based on activities currently being achieved in preparation for full implementation. Texas will review this benchmark each year to revise the number upward based on our expected success.

Benchmark	FY 08	FY 09	FY 10	FY 11
Number of new units/vouchers dedicated to the MFP Demonstration	15	20	25	30

Target Out-of-Compliance PHAs

DADS will target PHAs that are out of compliance with HUD performance standards to help them understand HHS Enterprise long-term services and supports programs, and obtain support for providing housing opportunities for individuals wanting to move from institutional care settings. The number of contacts and status of discussions will be reported annually.

Targeting Out of Compliance PHAs	FY 2008	FY 2009	FY 2010	FY 2011
Number of Out-of-Compliance PHAs Visited Per year	5	5	5	5

Visit the Ten Largest PHAs in Year 1

DADS will visit the ten largest public housing authorities in Texas to provide them with education and information on the current Promoting Independence Initiative and the MFP Demonstration.

	FY 2008
Visit 10 Largest PHAs	
Number of Large PHAs Visited Per Year	10

Visit Twenty-Five PHAs Per Year

After the ten largest PHAs are visited in Year 1, DADS will go to at least twenty-five additional housing authorities per year to provide them with education and information on the current MFP Initiative and the new MFP Demonstration.

Visit 25 PHAs Each Year	FY 2008	FY 2009	FY 2010	FY 2011
Total Number of Additional PHA Visits Per Year	0	25	25	25

Review and Comment on PHA Consolidated Housing Plans

The Promoting Independence Advisory Committee will review the TDHCA draft Consolidated Housing Plans/Annual Action Plan (CHP/AAP) and provide comments on

increasing need for housing opportunities for senior citizens and individuals with disabilities. Each year, the PIAC will also review at least three other CHP/AAPs to help prepare advocates for their own review and comments at public hearings of housing authorities.

Consolidated Housing Plans	FY 2008	FY 2009	FY 2010	FY 2011
Number of PHA Consolidated Plans Reviewed/Commented Per Year	4	4	4	4

Section I, Part B – Demonstration Implementation Policies and Procedures

1. Participant Recruitment and Enrollment.

Describe the target population(s) that will be transitioned, and the recruitment strategies and processes that will be implemented under the demonstration. Specifically, please include a narrative description that addresses the issues below. In addition, the OP must include samples of all recruitment and enrollment materials that will be disseminated to enrollees.

Texas administers a hugely successful MFP policy for individuals living in nursing facilities and expedited access for individuals with intellectual developmental disabilities living in large community ICFs/MR and state supported living centers. Since 2001, over 13,337 individuals have left nursing facilities while 1315 individuals have moved from large community ICFs/MR and state supported living centers to the HCS 1915(c) waiver program. While there are many formal mechanisms that have been established during the six year period, the programs are now enculturated with Texas' consumers, advocates, providers, and government officials. This knowledge base is the result of previous outreach and education, individual experiences and word of mouth. The state will build upon its current outreach systems and general community awareness.

Target Population

Nursing Facilities. The target population is individuals who have been residing in an institutional setting for at least *ninety days, excluding any days of rehabilitative services funded through Medicare*, are enrolled in Medicaid, and are currently living in a nursing facility. The MFP Demonstration specifically will target individuals with:

- Complex functional support needs who have not been able to transition out of nursing facilities.
- Co-occurring behavioral health conditions – mental illness or substance abuse problems – that live in nursing facilities in the San Antonio area.
- Individuals with a cognitive impairment or physical disability with a medical need for specific tasks required to be performed during normal sleeping hours (*Overnight Companion Services in Region 4 and all fee for service areas in Region 11*).

The second and third target populations will receive new MFP Demonstration services (which will be discussed *Part 2, Section 5 of this Operational Protocol*).

ICFs/MR and State Supported Living Centers. The target population consists of individuals who have been residing in an institutional setting for *at least ninety days or less, excluding any days of rehabilitative services funded through Medicare*, are enrolled in Medicaid, and are living in:

- *Medium (9-13 beds) and large (fourteen beds or more) Community ICFs/MR and State Supported Living Centers.*

- *Community ICFs/MR if the owner voluntarily chooses to close the facility.*
- *Children under the age of 22 residing in community ICFs/MR who will relocate to families.*

Recruitment Strategies

Nursing Facilities. Texas currently contracts with relocation contractors who employ relocation specialists that assist in the outreach and identification of individuals interested in relocation and then prepare them for community transition. Relocation Contractor services are available throughout Texas. If an individual chooses to transition, the relocation specialist coordinates the transition with the facility and the individual's case manager or service coordinator. In addition, representatives from the following organizations also provide information and help to recruit individuals into the MFP program:

- DADS case managers or Managed Care service coordinators (if the individual resides in a location where managed care services are available).
- Local Area Agencies on Aging.
- Local Long-Term Care Ombudsmen.
- Nursing Facility Social Workers.
- Nursing Facility Family Councils
- Local Long-Term Services and Supports Providers
- Community Transition Teams

ICFs/MR and State Supported Living Centers. Recruitment occurs by ensuring that residents are informed about alternative living arrangements. This occurs through the Community Living Options (CLO) process which occurs on an annual basis, or more often if requested, through the individual's interdisciplinary team (IDT). IDT membership includes the individual, the legally authorized representative (LAR) and at the request of the individual, family members, and other persons who are actively involved in the individual's life. The CLO process goal is to identify the following:

- The individual's personal preferences for living arrangements.
- The LAR/family preferences for living arrangements.
- Identification of medical, behavioral/psychiatric issues.
- Quality of life issues.
- The Mental Retardation Authority (MRA) recommendation, if an alternative living arrangement is requested. (NOTE: Due to recent legislation, MRAs will be working with individuals residing in state supported living centers to conduct the CLO process.)

Additional recruitment also occurs from a variety of different organizations listed in the *Outreach/Marketing/Education* section of the *Operational Protocol*. One of these

organizations is Texas' federally mandated protection and advocacy agency, Advocacy, Inc. This organization has a program, Texas Community Integration Collaborative (TCIC), which assists individuals with disabilities of all ages to move from state supported living centers, ICFs/MRs and nursing facilities. The TCIC offers:

- Training and technical assistance on individual choices and living options.
- Planning for an individual's future and identification and development of resources to support living in the community.
- Training and technical assistance to family members, facility staff, community service and support providers and others.

a. Participant Selection Mechanism

Include the criteria and processes utilized to identify individuals for transitioning. Describe the process that will be implemented to identify eligible individuals for transition from an inpatient facility to a qualified residence during each fiscal year of the demonstration. Please include a discussion of: the information/data that will be utilized (i.e., use of MDS or other institutional data); how access to facilities and residents will be accomplished; and the information that will be provided to individuals to explain the transition process and their options as well as the state process for dissemination of such information.

Identifying Individuals for Transition

Identifying Individuals for Transition

Children. Texas has a strong permanency planning process for children in institutional settings. The 77th Texas Legislature (2001) passed Senate Bill 368 which mandates a proactive permanency planning process which requires a plan to be established upon institutional admission with subsequent six month reviews. The Mental Retardation Authority works with the family or the LAR to review community options and identify activities to return the child back into the community.

Nursing Facilities. As Texas has operated a MFP program for several years, most referrals of transition to a community setting are from word of mouth and from the organizations listed in the *Nursing Facility Recruitment Strategies* of this section (see above). Additionally, DADS maintains contracts with relocation contractors who in turn visit all nursing facilities in the state, help identify individuals who want to relocate, and facilitate the relocation process for return to the community.

Texas also uses information contained in the MDS dataset to the fullest extent possible in identifying eligible nursing facility residents, including those with complex supportive needs and those with behavioral health conditions. MDS Q1A information also is available on an aggregate level on the DADS Promoting Independence website for stakeholders to review. This data is the basis for identification of prospective participants, outreach to nursing facility residents and conducting a "transition" assessment. Identification of individuals with co-occurring behavioral health conditions also will be accomplished by matching DADS' nursing facility MDS data to the

Department of State Health Services (DSHS) Mental Health and Substance Abuse (MHSA) service records for the last five years. Information from the Preadmission Screening and Resident Review (PASRR) process and DSHS data system also will be used to assist in the identification of persons with behavioral health needs.

The information from these data sources is refreshed monthly and provided to relocation contractors.

ICFs/MR and State Supported Living Centers. As a result of the CLO process, an individual may be referred to the community through a designated Mental Retardation Authority (MRA). In accordance with the MRA's Performance Contract, the MRA is required to provide an *Explanation of Services and Supports* (Appendix F).

The CLO helps ensure that the individual makes an informed choice regarding movement to an alternative living arrangement or registration on the most appropriate interest (waiting) list for 1915(c) waiver services.

Individuals who reside in ICFs/MR that voluntarily close will automatically be provided residential options through the CLO process.

It should be noted that under the Texas Promoting Independence Plan, individuals who live in *medium and large* community ICFs/MR or *State Supported Living Centers* have expedited access to the HCS 1915(c) waiver program (twelve and 6 months, respectively).

Access to Facilities and Residents

Nursing Facilities. Relocation contractors spend a considerable amount of effort to build working relationships with nursing facilities throughout the state. As part of the original Texas MFP Initiative, nursing facility administrators and directors of nursing were advised of DADS' relationship with relocation contractors. Periodically, DADS sends out *Provider Letters* (Appendix B) to nursing facility administrators to remind them of the MFP Initiative and that relocation contractors are authorized to work with nursing facility residents.

Relocation specialists typically carry a copy of the most recent *Provider Letter* in case they encounter resistance in accessing a nursing facility. In the rare cases of a nursing facility refusing access to a relocation specialist, one of DADS Regional Directors will contact the nursing facility to remind them of the MFP policy and request that the relocation specialist be granted access to any resident who desires to talk to the relocation specialist. Relocation specialists are required to contact DADS toll-free complaint hotline to initiate a formal investigation of nursing facility non-compliance. (Nursing facilities are required to provide client access under the provision of DADS rule, 40 TAC § 19.413.)

ICFs/MR and State Supported Living Centers. Access to residents in community ICFs/MR has not been an issue as the residents have the right to have guests and meet privately with individuals. Access to state supported living centers is also not an issue because they are owned and operated by the State of Texas. As mentioned previously,

various advocacy organizations meet with residents in ICFs/MR and state supported living centers to discuss community living options.

As has been stated, the Promoting Independence Plan and the Texas legislature require the Community Living Option (CLO) process for all residents of large community ICFs/MR and state supported living centers. Under this policy, at least annually or more frequently if requested, the ICFs/MR or state school must discuss alternative living arrangements with the resident or the resident's Legal Authorized Representative (LAR). These discussions also are attended by all members of the Interdisciplinary Team (IDT). Each quarter, the Promoting Independence Advisory Committee receives aggregate reports on all CLO referrals. Information on the Community Living Options program will be discussed in greater detail in the next section of the *Operational Protocol*.

Information about the Transition Process and Options

Nursing Facilities. As previously mentioned, information about the transition process and various services options can come from a number of sources. The three primary sources of information are identified below.

Relocation Contractor. The relocation contractor will provide relocation assistance and intensive service coordination activities to assist NF residents to transition to community settings of their choice.

Relocation assistance will consist of but will not be limited to:

- Providing information about Medicaid 1915(c) waiver and non-waiver, non-Medicaid services and supports.
- Providing for Transition to Life in the Community (TLC), and for all program placements other than Adult Foster Care and Assisted Living, Transition Assistance Services (TAS).
- Developing person/family-directed transition plans and arrangements.
- Advocating for individuals making the transition and their family.
- Coordinating needed services/resources to transition into the community, with such entities as the local housing authority, the Mental Health Authority (MHA), the Texas Department of Assistive and Rehabilitative Services (DARS) regarding its relocation activities, and for:
 - Housing.
 - Mental health services.
 - Transportation (particularly in rural areas).
 - Medical/dental services, including prescriptions.
 - Durable medical equipment.
- Securing access to needed community services, such as:

- Utilities/telephone.
- Banking/bill payment/direct deposit.
- Household items/furniture.
- Special transit and local transportation providers.
- Follow-up assessment after transition for at least six months after the transition:
 - Once a week for the first month.
 - Twice a week for the second month.
 - At least once during the third month.
 - As frequently as the MFP participant requests.

In addition to generic policies developed for the overall MFP effort, the Behavioral Health Pilot will include the following activities:

- The local Community Mental Health Center and OSAR will be included on the transition team and will train their staff.
- The transition team and the Department State Health Services (DSHS) will periodically present information on the pilot to local mental health advocacy groups and substance abuse provider organizations.
- The DSHS Client Rights' 1-800 Hotline staff will be provided with training on the pilot so that they may refer individuals to the pilot.

DADS case managers and Managed Care Organization service coordinators will work with nursing facility residents to determine their service needs and choices. Among the topics to be discussed are:

- How to qualify for services under the MFP policy.
- What happens if the person leaves the facility before the DADS' enrollment is complete.
- Discussion of the various 1915(c) waiver programs offered by DADS and HHSC.
- Discussion of the community options available under the MFP program.
- Other services available to assist in the successful transition to a community setting:
 - Relocation services.
 - Transition to Live in the Community (TLC) services.
 - Transition Assistance Services (TAS).
 - Housing voucher programs.
- Discussion of the MFP *Informed Consent Form*.
- Relevant telephone numbers.

With advent of the roll-out of STAR+PLUS in February 2007, the state recognized the need to clarify the various roles and responsibilities of the relocation contractors and the managed care service coordinators. The Texas Department of Aging and Disability Services in conjunction with the Medicaid/CHIP Division held a statewide training meeting with its relocation contractors, the managed care organizations, and DADS local regional staff to detail each entities specific activities.

Briefly, the relocation contractor helps to provide outreach, education, and identification for potential nursing residents (NF) who want to relocate. Once identified, the NF resident is directed to the local DADS office for assistance in choosing a managed care provider. Upon that selection, a managed care service coordinator is provided who then takes the lead in relocation. However, the relocation contractor continues to have an important role in arranging housing and providing other relocation supports (and post-transition supports). It is the responsibility of the service coordinator to coordinate all relocation activities with the relocation contractor.

Function	Lead Responsible Party
Contact consumer after initial call to DADS. DADS makes referral to relocation contractor.	Star Plus Service Unit (SPSU)
SPSU posting of Form 3676-SPW, <u>STAR+PLUS Waiver Program Pre-Enrollment HMO Assessment Authorization</u> , to Tex Med. SPSU also send Form 3676-SPW to the Relocation contractor at the same time the form is sent to the HMO.	SPSU
Complete assessment including Form 3652-A, Client Assessment, Review and Evaluation (CARE); develop ISP; post ISP to TexMed.	HMO
Coordinate with Medicaid Eligibility	SPSU
Relocation contractor makes initial contact with consumer and completes TLC application and forwards to DADS Provider Services, State Office. HMO works with the relocation contractor.	Relocation Contractor with support from HMO
Develop relocation plan	HMO with support from the Relocation Contractor
Arrange transition components of relocation plan: <ul style="list-style-type: none"> a. Transition to Life in the Community (TLC) and set up of household items - <i>Relocation Contractor</i> b. Transition Assistance Services (TAS) and set up of household items - <i>HMO</i> c. Individual Service Plan (ISP) – <i>HMO</i> d. Set move out date – HMO in Coordination with SPSU and 	HMO is responsible for overall coordination of the relocation plan. Relocation Contractor will support and provide specific components of the plan.

<p>Relocation Contractor</p> <p>e. Housing – <i>Relocation Contractor</i></p> <p>f. Present at time of discharge at home site – <i>Relocation Contractor</i></p> <p>g. Coordination with Nursing Facility - <i>HMO</i></p> <p>h. Coordination with Home and Community Support Agency (HCSSA) - <i>HMO</i></p> <p>i. Coordination of Mental Health services appropriate with the MHA Medicaid – <i>HMO</i> Medicare / non-Medicaid – <i>Relocation Contractor</i></p> <p>j. Transportation – mainline, special transit and local transportation providers - <i>HMO</i></p> <p>k. Medical/dental services, including prescriptions - <i>HMO</i></p> <p>l. Durable medical equipment - <i>HMO</i></p> <p>m. Utilities/telephone – <i>HMO</i></p> <p>n. Banking/bill payment/direct deposit – <i>Relocation Contractor</i></p> <p>o. Household items/furniture – <i>TAS/TLC</i></p>	
Follow up assessment/monitor process after transition is completed	HMO and Relocation Contractor
Service Coordination	HMO

ICFs/MR and State Supported Living Centers. The Mental Retardation Authority (MRA), for individuals residing in state supported living centers, or the Interdisciplinary Team (IDT), for individuals residing in large community ICFs/MR, will meet with the individual or their Legally Authorized Representative (LAR) to provide information regarding community living options. These meetings will occur at least annually or upon the request of the resident or LAR. The IDT/MRA must use the CLO instrument. The information discussed during the CLO meeting is summarized below (see Appendix C and F for all information discussed) and the meeting is conducted based on the self-determination philosophy and using an approach that is focused on the preferences of the resident/LAR.

When an alternative living arrangement is requested, the subsequent information will be used by the local Mental Retardation Authority (MRA) to identify appropriate community resources and to develop the individual's service coordination plan.

- Individual Preference.
 - Where does the individual want to live?
 - What information has been provided on living options?

- LAR/Family Preference.
 - What information has been provided to the LAR/family member related to living options and permanency planning?
 - What is the LAR/family member's stated preference?
- Medical/Behavioral/Psychiatric Issues.
 - If present, how can these needs be met in alternative living arrangement?
 - What can the facility or MRA staff do to support/facilitate these needs in an alternative living arrangement?
 - What are the treatment needs?
- Quality of Life.
 - If a minor, has permanency planning been incorporated into the service plan and reviewed as required?
 - What efforts have been made to ensure LAR/family participation?
 - If a minor, have educational issues been addressed?
 - What are the most important factors for this person in choosing a place to live?
 - What would enable these factors to take place for the individual to live in an alternative living arrangement?
 - What can the facility or MRA staff do to support/facilitate these needs in an alternative living arrangement?
- MRA Recommendations/Input.
 - What alternative living arrangements are available to meet the individual's needs?
 - Within what timeframe could placement in an alternative living arrangement occur?
 - Was the MRA representative at the planning conference?
 - If not, what was the source of the MRA input?

If an alternative living arrangement is requested, the MRA will discuss with the individual/LAR the various living arrangements and services available. During this discussion, the following topics are discussed (also see the DADS' brochure, *Explanation of Services and Supports* located at Appendix F).

- Services and Supports Provided through DADS.
 - General Revenue funded services.
 - Determination of eligibility for mental retardation services and supports.
 - Service coordination.
 - Community supports.

- Respite.
- Employment assistance.
- Supported employment.
- Nursing.
- Behavioral support.
- Specialized therapies.
- Vocational training.
- Day habilitation.
- In-Home family support.
- Services under DADS' Medicaid 1915(c) waiver Programs.
 - Types of 1915(c) waiver programs and services available.
 - Various living arrangements allowed under the 1915(c) waiver.
 - Eligibility criteria.
 - Enrollment process.
 - Consumer preferences and choice.
 - Selection of providers.
 - Consumer directed service options.
- Useful telephone numbers.

Closure of Community ICFs/MR. As part of the MFP Demonstration, Texas plans to target providers of community operated ICFs/MR who agree to voluntarily close. The actual procedures that will be followed for these facilities will be addressed in Section 1, Part B of this *Operational Protocol*. In addition to the above information provided to individuals residing in an ICF/MR, a facility that has chosen to voluntary close will discuss the following issues with the individual/LAR:

- Types of living options for each individual.
- Description of the CLO process to be conducted prior to the closure which includes:
 - Update the current CLO documentation.
 - Identification of the proposed timelines for the closure and relocation of residents.
 - Preferred choice of living arrangements for individuals.
 - Description of the relocation assistance to be furnished by the provider.
- Actions the provider will take to ensure the facility remains in compliance with regulations during the closure process.

- Whether or not the provider intends to continue as a provider of ICF/MR services, and if provider's plan includes the conversion to Home and Community-based Services (HCS).
- Notification procedures, which will include the provider's written and verbal notice to each individual and the individual's legally authorized representative (LAR) or family at least thirty calendar days prior to the facility closure. The notice shall include a description of assistance that is available from: (1) the provider during the relocation process, (2) from the local MRA, (3) the fact that the provider will work in cooperation with the applicable MRA to assist individuals to make an informed choice, and (4) contact information.

Texas also provides additional support in the relocation of children. In these situations, DADS provides HHSC with a list of individuals who are under 22 years of age to ensure that these individuals and their families/LARs are offered assistance through the Family-based Alternatives Project.

The Family-based Alternatives project is operated by HHSC to assist children in institutions to return home to their birth families. When relocation to the family home is not possible, the project arranges for alternate families called "support families" who are carefully matched with children and their birth families to jointly care for the child on a long-term basis with the birth family. The Family-based Alternatives contractor will work with permanency planners and relocation specialists to assist in the identification and transition of children from institutional settings to their homes or to support families.

Dissemination of Information

Staff from HHSC, DADS and DSHS will market the MFP Demonstration by providing educational seminars and information about the MFP demonstration to the following organizations. (Please see the *Outreach/Marketing/Education* section of the *Operational Protocol* for a list of additional organizations that will assist in marketing the MFP Demonstration.)

- The Money Follows the Person Demonstration Advisory Committee.
- The Texas Promoting Independence Advisory Committee.
- The DADS Council.
- Legislature.
- All appropriate state business units concerning the MFP Demonstration.
- Representatives from Managed Care systems.
- Behavioral Health Providers in the pilot area.
- DADS case managers and MCO service coordinators.
- Guardianship staff.
- Meetings of various Long-Term Services and Supports provider associations.
- Statewide housing associations.

- Nursing Facilities, ICFs/MR and state supported living centers.
- The DADS, HHSC, and Texas Promoting Independence websites.

b. Qualified Institutional Settings

The qualified institutional settings that individuals will be transitioning from, including geographical considerations and targeting, the names of the facilities for the first year, and an explanation of how the facilities being targeted meet the statutory requirements of an eligible institution.

Individuals will be transitioning from Medicaid certified nursing facilities or intermediate care facilities for persons with mentally retardation as defined in Section 6071(b) (3) of the DRA. With the exception of the two pilot projects, this MFP Demonstration project will be available statewide. HHSC, DADS and DSHS will collaborate in a pilot project in the San Antonio area for transition of individuals who have behavioral health conditions (mental illness or substance abuse issues) from nursing facilities. The second pilot will include individuals who transition from a nursing facility, require *Overnight Support Services*, and reside in three counties in the Rio Grande Valley area of South Texas. With the exception of state supported living centers, all other “institutional settings” are licensed under state rules.

A list of all nursing facilities, ICFs/MR, and state supported living centers is attached at Appendix D.

c. Minimum Residency Period

The minimum residency period in an institutional setting and who is responsible for assuring that the requirement has been met.

DADS will provide relocation contractors and DADS case managers with MDS data that identifies the date individuals were admitted into a NF. MFP Demonstration participants will meet the minimum residency requirement of *at least ninety days, excluding any rehabilitative services funded through Medicare*. Relocation contractors, DADS case managers and MCO service coordinators will physically review individual records to confirm the residency requirement. MRA service coordinators and state school staff will review the individual records to confirm the residency requirement for ICFs/MR and state *Supported Living Centers*.

d. Participant Eligibility for MFP Demonstration.

The process (who and when) for assuring that the MFP participant has been eligible for Medicaid a month prior to transition from the institution to the community.

HHSC has the responsibility for determining and certifying financial eligibility for Medicaid participants. HHSC Medicaid eligibility staff will advise DADS, DSHS, Relocation Contractors, ICFs/MR and state school staff of Medicaid eligibility on a monthly basis.

e. Re-Enrollment into the Demonstration

The State's policy regarding re-enrollment into the demonstration. That is, if a participant completes 12 months of demonstration services and is readmitted to an institution including a hospital, is that participant a candidate for another 12 months of demonstration services? If so, describe the provisions that will be taken to identify and address any existing conditions that lead to re-institutionalization in order to assure a sustainable transition.

For those individuals readmitted to an institution before reaching the twelve month demonstration period, their 365-day entitlement will resume upon re-entering the community setting.

Individuals may only re-enroll into the MFP Demonstration if they meet the institutional residency requirement (6 months) as required by CMS, are Medicaid eligible, and there has been change in their condition that would improve the likelihood of success in the community. In all cases, a thorough review of the original transition will be conducted to mitigate any problems for a second transition.

When there is a significant change in an individual's condition, there is a re-assessment of the individual and the development of a new Plan of Care (POC). There is every attempt to have the new POC meet the needs of the individual and prevent re-institutionalization.

If however, the individual must be institutionalized, the individual, upon condition stabilization and a desire to return to the community, will be reassessed for community-based services and a new POC developed. The individual's re-institutionalization will be taken under consideration during the reassessment, and when appropriate and within the current array of services, the case worker or the service coordinator will address the conditions that resulted in the original medical/functional deterioration. The relocation contractor will be notified and will provide additional contacts for individuals who have to go back into the institution and return back into the community. There are going to be issues that were a one-time occurrence, without an expectation for a reoccurrence, and should not prevent the ability to return to the community.

Ultimately, the decision to return to the community remains with the individual and/or his/her legal guardian. Individuals who want to relocate and meet the eligibility criteria will be offered and encouraged to return to the community.

f. Information to Make Informed Choices

The State's procedures and processes to ensure that participants will have the requisite information to make choices about their care.

Participants have requisite information to make choices about their care. The ability of an individual to receive adequate information and make informed choices about their living arrangements and the type of services they receive is paramount in all of HHSC's and DADS' programs. Each of the Medicaid 1915(c) waivers that will be used to

transition individuals from nursing facilities, ICFs/MR, or state supported living centers back into the community requires that the state not only assure, but develop discovery mechanisms to substantiate that participants are afforded choice: 1) between 1915(c) waiver services and institutional care, and 2) among 1915(c) waiver services and long-term service and support providers.

During the process of outreach to nursing facility residents, the relocation specialist visits the resident to discuss the transition process. At this time, an assessment of the resident's relocation needs is documented and the relocation specialist contacts DADS for the assignment of a case manager. As identified in Section of B1a of this Operating Protocol, the DADS case manager (or Star+PLUS service coordinator if the resident resides in a managed care area) provides information about the transition process, long-term service and supports options available to the resident, consumer directed service options, and the types of residential settings available under the programs.

This same type of information identified in the preceding paragraph is provided to residents of ICFs/MR or state supported living centers through the Community Living Options process, which was identified previously in this *Operational Protocol*. During this process, the applicant, guardian, LAR, and, if the LAR is not a family member, at least one family member, is provided with verbal and written explanation of the services and supports for which the applicant may be eligible. The discussion is documented on a form entitled *Explanation of Services and Supports* (copy located at Appendix F).

i. Training and Dissemination of Information

How training and/or information is provided to participants (and involved family or other unpaid caregivers, as appropriate) concerning the State's protections from abuse, neglect, and exploitation (ANE), including how participants (or other informal caregivers) can notify appropriate authorities or entities when the participants may have experienced abuse, neglect or exploitation.

Information on reporting ANE is provided to the individual and LAR in writing. The service provider must ensure that the individual and their LAR are informed of how to report allegations of ANE. The service provider also provides the individual and their LAR with the toll free telephone numbers for the Texas Department of Family and Protective Services (DFPS) and the Department of Aging and Disability Services (DADS), who have the statutory responsibilities for ANE investigations.

Under the 1915(c) waivers for adults, DADS conducts a desk review of any alleged incident and DFPS investigates the allegation. In these cases, DFPS coordinates its activities with DADS.

In addition, an individual transitioning from a nursing facility or their LAR is provided with the following toll-free telephone numbers:

- DADS Consumer Rights and Services.
- Department of Family and Protective Services.
- Local Area Agency on Aging.

- Medicaid Hotline.
- State Long-Term Care Ombudsman Program.

Individuals transitioning from an ICF/MR or state school are provided with the following toll-free telephone contact for additional information or to ask additional questions:

- DADS Consumer Rights and Services.
- Advocacy, Inc. – <http://www.advocacyinc.org/index.cfm>
- EveryChild, Inc. – <http://everychildtexas.org/>
- Texas Center for Disabilities Studies – <http://uap.edb.utexas.edu/>
- Texas Council for Developmental Disabilities – <http://www.txddc.state.tx.us/>
- The Arc of Texas (and Texas Advocates) – <http://www.thearcoftexas.org/>
- Parent Association for the Retarded of Texas, Inc (PART) – <http://www.partoftx.org>
- United Cerebral Palsy of Texas – <http://www.ucptexas.org/>

ii. Identify the entity or entities that are responsible for providing training and/or information and how frequently training and education are furnished.

While a significant number of relocation activities are initiated through self identification by the individual/family member residing in a nursing facility, ICFs/MR or state school, the following organizations and/or individuals are involved as the primary entry point for all prospective MFP Demonstration participants:

- Nursing facility staff, especially the nursing facility social worker.
- ICFs/MR and state school staff.
- DADS case managers.
- MCO service coordinators.
- Mental Retardation Authorities.
- HHSC eligibility workers.
- Aging and Disability Resource Centers.
- Office of the Long-Term Care Ombudsman.
- Relocation contractors.

Representatives from these organizations provide accurate, timely information that explains how the programs work, what the benefits are, what supports are offered and how to apply. As with all programs, the information will be culturally and linguistically appropriate, and will be made available to the larger community (including family members) and other stakeholders.

As noted previously, individuals/LARs also receive information and education about reporting suspected cases of abuse, neglect or exploitation and the MFP Demonstration through routine contacts with relocation contractors, long-term care ombudsmen, nursing facility social workers, DADS case managers, home health agencies, MCO service coordinators, local MRAs and MHAs, and third-party not-for-profits. This information is available in English, Spanish and Vietnamese.

HHSC and DADS routinely hold training conferences for providers of long-term services and supports. The type and frequency of training is addressed in the Outreach/Marketing/Education section of the *Operational Protocol*.

Finally, the case worker and agency provider, or the managed care provider will provide a list of numbers the individual should call if they encounter problems; they will provide issue-specific information and set a priority of who they should call for what situation depending on the priority.

The individual will be provided, at minimum, specific information on the following: complaint procedures; rights and responsibilities; service delivery schedules; and names and telephone numbers of the person(s) delivering services.

2. Informed Consent and Guardianship

Provide a narrative describing the procedures used to obtain informed consent from participants to enroll in the demonstration. Specifically include the State's criteria for who can provide informed consent and what the requirements are to "represent" an individual in this matter. In addition, the informed consent procedures must ensure all demonstration participants are aware of all aspects of the transition process, have full knowledge of the services and supports that will be provided both during the demonstration year and after the demonstration year, and are informed of their rights and responsibilities as a participant of the demonstration. Include copies of all informed consent forms and informational materials.

a. Procedures for Providing Informed Consent

i. Criteria and requirements to provide informed consent and represent an individual.

Texas will require that all individuals participating in the MFP Demonstration or their Legally Authorized Representative (LAR) -- i.e., parent, guardian, or managing conservator of a minor individual, or a guardian of an adult -- be informed of all their rights and options for long-term services and supports and that participation is voluntary. This includes acceptance of services and the consent to participate in the evaluation component of the grant. The *Informed Consent* Form (Appendix E) will be signed only by the individual being transitioned or those who have legal authorization to act in the individual's behalf.

DADS case managers, home health agency service coordinators, MCO service coordinators, and MRA staff will secure the appropriate signatures on the *Informed Consent* form (Appendix E) which indicates that they have been informed and are voluntarily choosing to participate in the MFP Demonstration without coercion.

ii. Awareness of Transition Process/Knowledge of the services and supports

Section 1, Part B1 of the *Operational Protocol* identifies the transition process and information provided to the individual/LAR for both nursing facility and ICFs/MR and state school transitions.

As noted previously, a significant number of individuals self-identify as candidates for transition. In many cases, the initial contact for a nursing facility transition is through the relocation specialist who provides information on the transition process and conducts an assessment of the individual's transition needs. The relocation specialist then contacts the nursing facility social worker about the possible transition, followed by a contact to a DADS case manager or Managed Care service coordinator who begins the assessment process for medical eligibility (HHSC's eligibility workers collect information to determine financial eligibility) and explains the transition process, the type of long-term services and support and consumer directed options available, and begins development of the plan of care.

For the individuals in an ICF/MR or state school who have not self-identified the desire to move into a community setting, the awareness of the transition process begins with the Community Living Options process. It is during this process that the individual's desires and choices for their preferred living arrangement are determined and information is gathered to effect a successful transition. The local MRA further discusses the transition process, assists in locating the preferred living arrangement, and develops a plan of care that takes into consideration the individual's need and choice for services and supports.

iii. Information about Rights and Responsibilities

Informed consent under this MFP Demonstration will include two components: 1) the acceptance of services and; 2) the consent to participate in the evaluation component of the project.

The consent for waiver services will follow current 1915(c) waiver practices (as dictated by CMS) and will be obtained during the care planning phase of the transition but prior to the delivery of home and community-based services. Risks of receiving certain services, the range of services that are available, and any restrictions on amount, duration and scope because of cost caps will be included in the informed consent process. Additional supports necessary to carry out the service plan will be fully explained to the prospective MFP Demonstration participant or representative, particularly with regard to self-directed services and supports.

The *Informed Consent* form will include the provision that participation in the MFP Demonstration is voluntary and protects project-related information that identifies individuals. The document will state that the information is confidential and may not be disclosed directly or indirectly, except for purposes directly related with the conduct of the project. The document will also indicate that the state will obtain written consent of the individual prior to disclosure of individual level information.

Finally, the *Informed Consent* form advises the individual that they can withdraw from the project at anytime, the MFP Demonstration period is for one year, the special demonstration services are available for one year, and that their existing Medicaid 1915(c) services will continue after the MFP Demonstration period as long as they continue to meet the eligibility requirements for the program.

b. Guardian Relationships

Provide the policy and corollary documentation to demonstrate that the MFP demonstration participants' guardians have a known relationship and do interact with the participants on an ongoing basis; and have recent knowledge of the participants' welfare if the guardians are making decisions on behalf these participants. The policy should specify the level of interaction that is required by the State. In addition, the State must set the requirements for, and document the number of visits, the guardian has had with the participant within the last six months. This information must be available to CMS upon request.

Guardian Relationship and Interaction with MFP Participants.

Chapter XIII of the Texas Probate Code requires a guardianship to be determined and renewed annually by a probate judge, but does not include requirements about level of interaction. (There are 254 counties in Texas and each has their court for probate proceedings.) The annual report required by the Code, and filed with the court, requires the guardian to report the date of the last contact and the frequency of the contacts with the ward. However, the judge is given discretion to determine what is in the best interest of the ward and set minimum expectations for contacts. Many judges apply the national accreditation standard of one visit per month in this determination.

MFP Participant Welfare

For private professional guardians, the Texas Guardianship Certification Board has established a standard of one visit per month. The standards are linked to certification that is now required for these types of guardians (effective September 1, 2007).

For individuals who are wards of DADS guardianship program, DADS has adopted both the national and Texas standards, which have a minimum of one contact per month.

MFP Guardianship Requirements and Interactions

If a public guardian has been appointed for a prospective MFP Demonstration participant, the DADS case manager (or service coordinator, depending on the 1915 (c) waiver or in a managed care catchment area) will make personal contact with that guardian to explain the choices of the prospective MFP participant, key features of the MFP Demonstration program, and various long-term services and support options that are available to the individual.

However, neither HHSC nor DADS can dictate the relationship between a guardian and their ward as these issues are governed by the Texas Probate Code.

The DADS data management system does not track visits by private guardians.

3. Outreach/Marketing/Education

Submit the State's outreach, marketing, education, and staff training strategy.

NOTE: All marketing materials are draft until the Operational Protocol is approved by CMS. Please provide:

a. Information to be communicated to enrollees, providers, and State staff

Texas' Promoting Independence Initiative and Plan was created in 2001 and is well established within the long-term service and support systems throughout the state. Because of this success, participation in the MFP Demonstration for both nursing facility and ICFs/MR is expected to be consumer-driven.

Individuals in nursing facilities typically learn of the Promoting Independence Initiative and Plan by word of mouth or from relocation specialists, nursing facility social workers, Medicaid eligibility workers, or representatives of the local Office of the Long-Term Care Ombudsmen. Most participants relocate with the help of relocation specialists, DADS case managers, provider agency case managers or Managed Care service coordinators.

Individuals in ICFs/MR or state supported living centers typically learn of the Promoting Independence Initiative and Plan through the annual Community Living Option process (previously described in this *Operational Protocol*), through word of mouth, or from representatives of MRAs and local advocacy organizations.

Key players in the Promoting Independence Initiative and Plan are the relocation contractor, MRAs, and advocacy organizations which, provide outreach activities for individuals that reside in institutions and/or who have indicated an interest in relocating into community living arrangements.

The relocation contractor will provide relocation assistance and intensive service coordination activities to assist NF residents to transition to community settings of their choice.

Relocation assistance to nursing facility residents will consist of but will not be limited to:

- Providing information about Medicaid 1915(c) waiver, non-waiver, and other funded services and supports.
- Providing Transition to Life in the Community (TLC), and for all program placements other than Adult Foster Care and Assisted Living, Transition Assistance Services (TAS).
- Developing of person/family-directed transition plans and arrangements.
- Advocating for individuals making the transition and their families.
- Coordinating of needed services/resources to transition into the community, with such entities as the local housing authority, the Mental Health Authority (MHA), Department of Assistive and Rehabilitative Services (DARS) regarding relocation activities, and:

- Housing.
- Mental health services.
- Transportation (particularly in rural areas).
- Medical/dental services, including prescriptions.
- Durable medical equipment.
- Securing access to needed community services, such as:
 - Utilities/telephone.
 - Banking/bill payment/direct deposit.
 - Household items/furniture.
 - Special transit and local transportation providers.
- Following-up on post-transition activities for at least six months:
 - Once a week for the first month.
 - Twice a week for the second month.
 - At least once during the third month.
 - More frequently as the MFP participants needs warrant.

A representative from the local MRA will provide relocation assistance and intensive service coordination activities to individuals living in ICFs/MR and state supported living centers to transition to community settings of their choice. When an alternative living arrangement is requested, the following information will be used by the local Mental Retardation Authority (MRA) to identify appropriate community resources and to develop the individual's service coordination plan in coordination with the individual and/or the LAR.

- Individual Preferences:
 - Where does the individual want to live?
 - What information has been provided on living options?
- LAR/Family Preferences:
 - What information has been provided to the LAR/family member related to living options and permanency planning?
 - What is the LAR/family member's stated preference?
- Medical/Behavioral/Psychiatric Issues:
 - If present, how can these needs be met in alternative living arrangement?
 - What can the facility, MRA staff, or managed MCO service coordinator do to support/facilitate these needs in an alternative living arrangement?
 - What are the treatment needs?

- Quality of Life:
 - If a minor, has permanency planning been incorporated into the service plan and reviewed as required?
 - What efforts have been made to ensure LAR/family participation?
 - If a minor, have educational issues been addressed?
 - What are the most important factors for this person in choosing a place to live?
 - What would enable these factors to take place for the individual to live in an alternative living arrangement?
 - What can the facility or MRA staff do to support/facilitate these needs in an alternative living arrangement?
- MRA Recommendations/Input:
 - What alternative living arrangements are available to meet the individual's needs?
 - Within what timeframe could placement in an alternative living arrangement occur?
 - Was the MRA representative at the planning conference?
 - If not, what was the source of the MRA input?

In addition to generic policies developed for the overall MFP effort, the Behavioral Health Pilot will include the following activities:

- Inclusion of representatives of the Local Mental Health Authority and OSAR will be included on the transition team and will train their staff.
- Presentation of information regarding the pilot to the transition team, local mental health advocacy groups, and substance abuse provider organizations.
- Provision of training on the pilot to the DSHS Client Rights staff that operate the 1-800 hotline so that they can refer individuals to the pilot.

Additionally, DADS Regional and Local Services Division has the responsibility for supporting the regional Community Transition Teams (Team) that were originally established as part of the 2002 Real Choice grant. There is one Team in each of the DADS regions, which is comprised of representatives from DADS, consumers, local area agencies on aging, Adult Protective Services, managed care organizations, advocacy groups, housing organizations, long-term services and support providers, nursing facility directors of nursing, nursing facility social workers, Ombudsman, Mental Retardation Authorities, Mental Health Authorities, and other community-based organizations. The Team meets monthly to address specific barriers that prevent a nursing facility resident from relocating into the community, to ensure continued success and promote effective transitions from nursing facilities back to the community.

DADS Promoting Independence and MFP Demonstration staff conduct monthly teleconferences with all regional Team leads to discuss issues, receive program

updates, and learn from the experiences of one another. The MFP Demonstration will be discussed both at the DADS monthly meeting of Team leads, as well as the Team meetings.

b. Types of media to be used

A computer based training (CBT) will be developed to orient DADS staff, nursing facility and ICFs/MR and state school providers on the MFP Demonstration. The DADS website has been revised to include information on the MFP Demonstration. Clients, family members and unpaid caregivers can access the site to get information on the MFP Demonstration. Press releases will be issued announcing the MFP Demonstration upon approval of the *Operational Protocol*.

c. Specific geographical areas to be targeted

The MFP behavioral health transition from nursing facilities to community living will be limited to San Antonio. The Overnight Support Services for individuals transitioning from nursing facilities will be limited to the counties of Hidalgo, Cameron, and Willacy which are in the Rio Grande Valley area of South Texas. All other MFP Demonstration activities will be statewide.

For the Overnight Support Services, program information will be sent to provider agencies in the three county area which explains the program. For the Behavioral Health pilot, information will be shared with the Mental Health Authority, relocation contractors, and the nursing facility social workers.

d. Locations where such information will be disseminated

- Information will be provided through the DADS website, including the Promoting Independence website.
- Stakeholders will be informed through the Promoting Independence Advisory Committee and the MFP Demonstration Advisory Committee.
- Policies and procedures will be incorporated into the appropriate case management and provider manuals that are posted on the HHSC/DADS/DSHS websites. Long-term services and supports providers will be advised upon posting of information.
- Information will be provided at the trainings conducted on the MFP Demonstration.
- Information will be provided through the following organizations:
 - Advocacy, Incorporated.
 - EveryChild, Inc.
 - Texas Center for Disabilities Studies.
 - Texas Council for Developmental Disabilities.
 - The Arc of Texas (and Texas Advocates).
 - Parent Association for the Retarded of Texas, Inc.

- United Cerebral Palsy of Texas.
- ADAPT.
- Coalition of Texans with Disabilities.
- Disability Policy Consortium.
- Centers for Independent Living.
- National Alliance on Mental Illness.

e. Staff training schedules, schedules for state forums or seminars to educate the public

- Relocation Contractors receive ongoing training about the MFP Demonstration through mandatory monthly meetings.
- Presentation on MFP and Housing at the NAHRO Annual Meeting in April 2007.
- MFP staff met with the Director of the Texas Guardianship Office in May 2007.
- Waiver Optimization Meeting with Stakeholders – Case Management – May 18, 2007.
- DADS Access and Intake Division - Stakeholder Meeting – May 29, 2007.
- HCS and TxHmL Applicant Meeting – June 4, 2007.
- Statewide Independent Living Council Meeting – June 8, 2007.
- DADS Council Meeting – June 15, 2007.
- Staff Ombudsman Training - June 13-15, 2007.
- Texas Assisted Living Provider Advocacy Group – June 28, 2007.
- HCSSA Quarterly Stakeholder Meeting – July 11, 2007.
- DADS/HCSSA/Stakeholder Meeting – July 13-17, 2007.
- Texas Traumatic Brain Injury Advisory Council Meeting - July 20, 2007
- HCS and TxHmL Provider’s Meeting – July 30-31, 2007.
- Texas Promoting Independence Advisory Meeting August 24, 2007.
- Area Agencies on Aging State Meeting – August 29, 2007
- Consumer Rights Officers Training (state supported living centers, State Hospitals and Community MHMR Centers) on September 5, 2007.
- Nine-Plus ICFs/MR Voluntary Closure Training – September 5, 2007
- Presentation at the Texas Workforce Commission State Conference, July 2007.
- Presentations to representatives from Managed Care systems by October 2, 2007.
- Presentation to the Private Providers Association of Texas – October 17, 2007.

- Presentation to the Children's Policy Council.
- Specialized training on the MFP Demonstration to program managers, case managers and service coordinators from DADS, HHSC, MCOs, Mental Retardation Authorities, and Relocation Contractors by November 1, 2007.
- DADS website will include updated information on the MFP Demonstration by November 1, 2007.
- MFP will meet with all DADS business units to educate them on the MFP Demonstration by November 1, 2007.
- Attend the annual meetings of various LTSS provider associations, provide seminar and MFP materials. Frequency: as they become available.
- Attend annual meetings of statewide housing associations to provide education on Medicaid programs and MFP programs. Frequency: as they become available.

The presentation schedule will be repeated throughout the Demonstration period. Many of the presentations are for organizations that have semi-annual or annual meetings and updates regarding the Demonstration will be presented. There is great interest in MFP and the Demonstration, and staff are already booking speaking engagements into 2008.

Also the Director of the Promoting Independence Initiative will always include the Demonstration in his presentations about the Initiative.

f. Availability of bilingual materials/interpretation services and services

All of DADS 1915(c) waiver programs are compliant with the bilingual materials/interpretation services for non- English speaking clients or individuals with communication limitations. DADS currently places an emphasis on communicating in Spanish and Vietnamese and will use the current resources available to communicate information pertaining to MFP.

g. How individuals will be informed of cost sharing responsibilities

As part of the normal 1915(c) waiver enrollment process, DADS staff will inform individuals verbally and in writing of any cost sharing responsibilities.

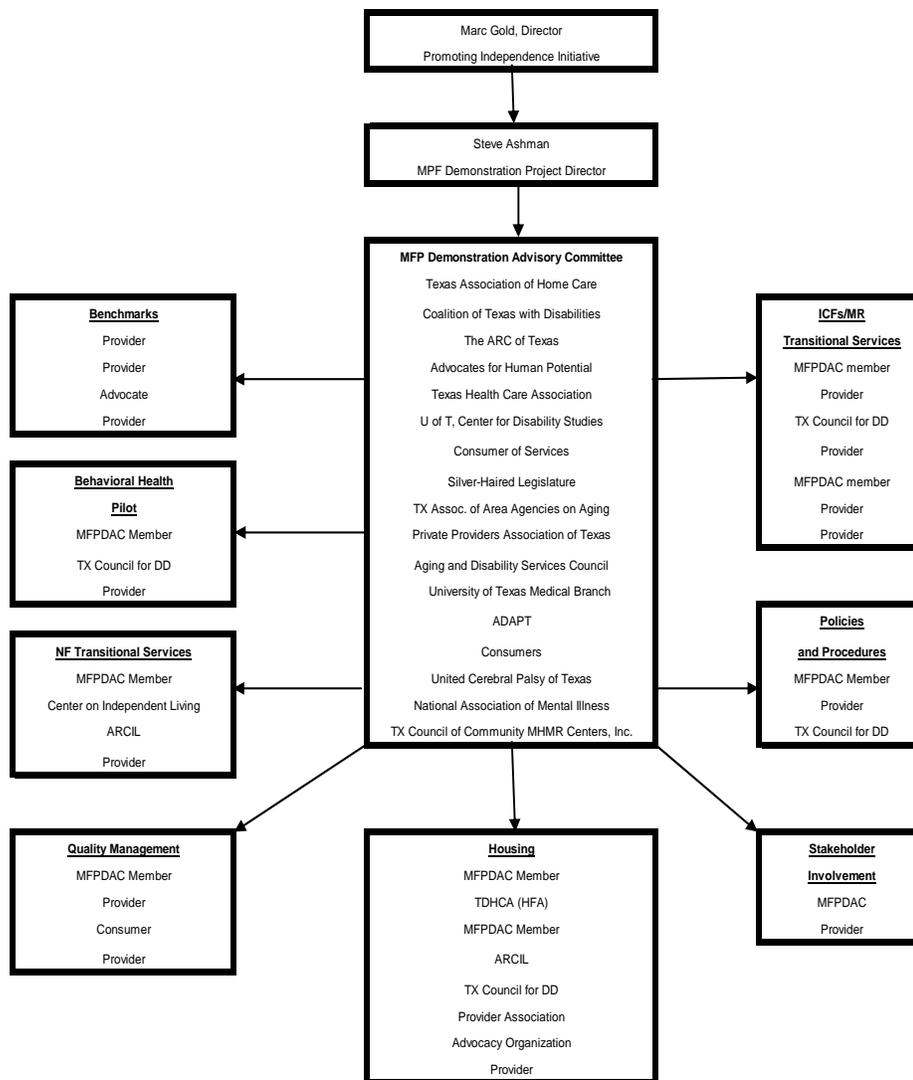
4. Stakeholder Involvement

Describe how the State will involve stakeholders in the Implementation Phase of this demonstration, and how these stakeholders will be involved throughout the life of the demonstration grant. Please include:

Chart Reflects Stakeholders Relationship and How they Influence the Project.

a. Stakeholder Organizational Chart.

As part of the MFP Demonstration, Texas organized a MFP Demonstration Advisory Committee (MFPDAC). A description of the people and organizations which are members of the committee follows the organizational chart.



b and c. Consumer and Institutional Providers Involvement

Direct consumers, advocates, and providers will continue to play a critical role in the implementation and ongoing activities associated with this MFP Demonstration, just as they have in the creation and implementation of the current MFP and Promoting Independence initiatives. These groups played a critical role in the development of the MFP application and this *Operational Protocol*.

A Money Follows the Person Demonstration Advisory Committee (MFPDAC) has been established for this MFP Demonstration and represents aging and disability (physical, intellectual/developmental disability, sensory and mental disability communities) organizations, rural and urban providers, institutional and community providers, advocates and consumer members. Staff from the HHSC, DADS, DSHS, and TDHCA are ex-officio members of the MFPDAC.

There are a number of direct consumers on the MFPDAC – two individuals with physical disabilities, and one with intellectual and developmental disabilities; these individuals participate on the full MFPDAC and on the workgroups and will be part of the ongoing monitoring. The State has extended invitations to representatives of behavioral health consumers and will continue to provide outreach in order to get permanent representation. The State will continue to increase its overall number of direct consumer representation. Because of the geographical size of the State, scan call access is provided at all of its meetings.

The MFPDAC members' primary role has been to participate in the design of the *Operational Protocol*, and in the implementation of the MFP Demonstration. In addition, the MFPDAC will provide advice in the development of operational policy. The MFPDAC has representatives from the following organizations. Additional descriptions can be found at the listed websites.

- **Texas Association of Home Care (TAHC).** <http://www.tahc.org/>
- **Coalition of Texans with Disabilities (CDT).** <http://www.cotwd.org/index.html>
- **The ARC of Texas.** <http://www.thearcoftexas.org/>
- **Advocates for Human Potential (AHP).** <http://www.ahpnet.com/>
- **Texas Health Care Association.** <http://www.txhca.org/>
- **University of Texas, Center for Disability Studies.** <http://uap.edb.utexas.edu/>
- **Consumers of Services.** Individuals who use long-term services and supports available through the Texas Health and Human Services Enterprise system.
- **Texas Silver-Haired Legislature.** <http://www.txshl.org/>
- **TX Assoc. of Area Agencies on Aging.** <http://www.nado.org/resources/t4abylaws.pdf>
- **Private Providers Association of Texas (PPAT).** <http://www.ppat100.com/>
- **DADS Council.** The Texas Aging and Disability Services Council provides management and policy recommendations to the executive commissioner of the

Texas Health and Human Services Commission and the commissioner of the Department of Aging and Disability Services regarding the management and operation of DADS. http://www.dads.state.tx.us/news_info/council/index.html

- **ADAPT.** <http://www.adapt.org/>
- **United Cerebral Palsy (UCP) of Texas.** <http://www.ucptexas.org/>
- **National Alliance on Mental Illness (NAMI).** <http://www.nami.org/>
- **Texas Council of Community MHMR Centers, Inc.** <http://www.txcouncil.com/>

In addition, anyone who wishes to attend and participate in the MFPDAC meetings is welcome to attend and add comment to the discussions. Because of the geographic size of Texas, scan call capability is made available to all who want to attend the meetings.

The MFPDAC will monitor this MFP Demonstration through successful conclusion, and will report periodically to the Promoting Independence Advisory Committee (PIAC) which meets quarterly. The MFPDAC will review the project status on a quarterly basis and provide recommendations for program improvement and successful transition outcomes. The PIAC will provide direction for the current MFP and Promoting Independence initiatives.

To obtain the widest participation possible for the MFP Demonstration, the DADS organizational unit for Stakeholder Relations helps to ensure stakeholder input, participation and involvement and serve as a central point for scheduled, ongoing communication and input. This unit assists staff throughout the agency to engage stakeholders and consider their input in policies, rules and decisions.

Institutional providers have representation on the PIAC and the MFPDAC, and have been active participants in the development of both the MFP Demonstration and this *Operational Protocol*. As stated, Texas has a well established Money Follows the Person and Promoting Independence program, and administrators of nursing facilities, ICFs/MR and state supported living centers are aware of these programs, and have been involved in all aspects of MFP policies.

In addition to strategies developed for the overall MFP effort, the DSHS system will engage stakeholders of the Behavior Health Pilot through:

- Participation of external stakeholders as integral members of the DSHS project team.
- Provision of information and engaging its state and local advisory group processes through periodic updates and seeking assistance as needed. These groups include:
 - DADS Council, which is a nine-member, governor-appointed council that makes recommendations regarding DADS rules and policies.
 - DSHS Mental Health Program Advisory Council (MH-PAC), which includes state agencies consumers, family members, advocates and others stakeholders.

- DSHS Agency Council, which is a nine-member citizen, governor-appointed advisory group which reviews and advises the DSHS Commissioner on mental health, substance abuse and public health policy and issues.
- The Consumer Advisory Council for the local mental health authority in San Antonio.
- The local BH Pilot planning and oversight team, which will include the MCO service coordinator, relocation specialist, local area agency on aging, University of Texas Health Science Center, Local Mental Health Authority the local OSAR and local DADS staff.

d. Consumers' and Institutional Providers' Roles and Responsibilities

The purpose of the MFPDAC is to participate in the design of the *Operational Protocol* and monitor implementation of the MFP Demonstration throughout the five-year period.

The committee will guide *Operational Protocol* development, provide advice, monitor MFP Demonstration implementation and progress, and review the state in its obligation to meet its benchmark evaluative standards. In addition, the MFPDAC will help the state in building consensus for the MFP Demonstration and report to the Promoting Independence Advisory Committee. It is anticipated that the MFPDAC will meet quarterly to review the activities of the MFP Demonstration.

e. Operational Activities with Consumers and Institutional Providers

Once the application for the MFP Demonstration was approved by CMS, the MFPDAC was put in place. One of the functions of the MFPDAC was to assist in the development of the *Operational Protocol*. Participation was not limited only to MFPDAC members; anyone interested in participating in the MFP Demonstration was invited to assist in the development of the *Operational Protocol*. Because Texas is such a large state, individuals were able to participate in any of the meetings through scan-calls.

The sections of the *Operational Protocol* were assigned to various workgroups. Below are listings MFPDAC meetings and workgroups meetings that were held to prepare this *Operational Protocol*; all meetings were held in calendar year 2007.

- MFPDAC (4/13, 5/4, 5/18, 5.28, 6/1, 6/8, 6/15, 6/29, 7/27, 8/10, 8/17)
- Benchmarks/Evaluation/Quality Assurance (4/5, 4/11, 4/18, 4/30, 5/25)
- Transitional Services – Nursing Facilities (5/10, 5/25)
- Transitional Services – ICF/MF (4/11, 4/24, 5/17, 5/21, 5/22, 5/24, 6/12)
- Policies and Procedures (3/21,4/2, 4/5)
- Housing (3/28, 5/16, 6/27)
- Stakeholder Involvement (4/18, 5/22)
- Behavioral Health (4/4, 4/11, 4/18, 4/25, 5/2, 5/18, 6/6, 6/13, 6/28)

5. Benefits and Services

a. Description of the Service Delivery System

Provide a description of the service delivery system(s) used for each population that the State will serve through the Money Follows the Person Rebalancing Demonstration. Include both the delivery mechanism (fee-for-service, managed care, self-directed, etc.) and the Medicaid mechanism through which qualified HCBS will be provided at the termination of the demonstration period (waiver, 1115 demonstration, Medicaid State Plan, etc.). For all HCBS demonstration services and supplemental demonstration services, there is no Medicaid mechanism understanding that the services terminate with the 365 day demonstration period; however, the State must detail the providers or network used to deliver services.

Texas uses both a fee-for-service and managed care service delivery system. The Texas MFP Demonstration will transition individuals into the existing 1915(c) home and community based waivers. A separate demonstration 1915(c) waiver will not be created for the MFP Demonstration. After the 12-month demonstration period, individuals will continue in the same 1915(c) waiver program as long as they meet the eligibility requirements of the program.

DADS operates two nursing facility 1915(c) waivers and four ICFs/MR 1915(c) waivers while HHSC operates one nursing facility waiver. Two additional 1915(c) waivers, the Consolidated Waiver Program, operate in Bexar County (San Antonio Area) and are administered as one program. All 1915(c) waivers are fee for service, with the exception of the Star+PLUS 1915 (b) and (c) waiver, which delivers managed care services and is operated by HHSC.

Texas assures CMS that all Demonstration participants will be eligible under the waiver cost limits approved by the State when transitioning from the Demonstration to the population at-large as long as they meet all the other eligibility criteria. Additionally, case management is reimbursed as an administrative service, not as targeted case management.

Provider manuals for all home and community based 1915(c) waivers can be accessed at the following website:

http://www.dads.state.tx.us/news_info/publications/handbooks/index.html#handbooks

All aspects of the home and community based 1915(c) waiver programs are under continuous quality review. Accordingly, the websites have the most up to date program information.

b. Available Service Package

List the service package that will be available to each population served by the Demonstration program. Include only services that are provided through the demonstration (home and community-based long-term care services and

supplemental services). Do not include acute care service or institutional services that will be paid for through the regular Medicaid program. **Divide the service list(s) into Qualified Home and Community-Based Program Services, HCBS demonstration services, and supplemental demonstration services reflecting the categories of services that are listed in the solicitation. If any qualified Home and Community-based Services are not currently available to Medicaid recipients in the State (and are, therefore, not included in the State's maintenance of effort calculations), provide a detailed account of when and how they will be added to the Medicaid program. For HCBS demonstration services and supplemental demonstration services, indicate the billable unit of service and the rate proposed by the State. For supplemental demonstration services, provide any medical necessity criteria that will be applied as well as the provider qualifications.**

Qualified Home and Community Based Program Services

Brief descriptions of the 1915(c) waiver programs that will be used in the MFP Demonstration program are identified below.

Medically Dependent Children Program (MDCP)

Eligibility: Younger than 21 years of age, Medicaid financial determined by the Health and Human Services Commission (HHSC), individuals must meet the medical necessity requirements for nursing facility care.

Services: The MDCP is a fee for service 1915(c) waiver program that provides services and supports for families caring for children who are medically dependent as an alternative to residing in a nursing facility. Specific services include:

- Case management
- Adaptive aids
- Adjunct support services
- Minor home modifications
- Respite
- Transition assistance services.

Case Management: Case management is provided by DADS staff and is separate from direct services.

Star+PLUS Managed Care

Eligibility: Age 21 or older, Medicaid financial eligibility determined by HHSC, individuals must have a need for skilled nursing care and meet at least two of the nursing facility risk criteria.

Services: The Star+PLUS program is a (1915 (b) and (c)) waiver that provides both acute and long-term services and supports to individuals who have a physical disability

or are elderly as an alternative to residing in a nursing facility. Long-term services include:

- Case management
- Adaptive aids
- Medical supplies
- Adult foster care
- Assisted living/residential care
- Emergency response
- Nursing Services
- Minor home modifications
- Occupational therapy
- Personal assistance (including consumer-directed personal assistance services)
- Home delivered meals
- Physical therapy
- Respite care
- Transition assistance services
- Speech language pathology

As the Star+PLUS program is a Managed Care Service, the following additional benefits and services are available to eligible participants:

- Prescription medication (no limits)
- Service Coordination (Acute and Long-Term Care)
- Adult well checks
- Disease Management
- Medical Home (Primary Care Physician)
- Acute care medical and behavioral health services, such as:
 - MH counseling by master's level therapists
 - psychiatry
 - psychological services
 - inpatient detoxification
- Value-added services (varies by MCO), such as:
 - partial hospitalization / extended day treatment
 - intensive outpatient treatment / day treatment

- residential services
- off-site services
- health psychology interventions

Community Based Alternatives Program (CBA)

Eligibility: Age 21 or older, Medicaid financial eligibility determined by HHSC, individuals must have a need for skilled nursing care and meet at least two of the nursing facility risk criteria.

Services: The CBA program is a fee for service 1915(c) waiver program that provides services and supports to individuals who have a physical disability or are elderly as an alternative to residing in a nursing facility. Services include:

- Case management
- Adaptive aids
- Medical supplies
- Adult foster care
- Assisted living/residential care
- Emergency response
- Nursing services
- Minor home modifications
- Occupational therapy
- Personal assistance (including consumer-directed personal assistance services)
- Home delivered meals
- Physical therapy
- Respite care
- Transition assistance services
- Speech language pathology

Case Management: Case management is provided by DADS staff and is separate from direct services.

Consolidated Waiver (CWP)

Eligibility: No age limit, Medicaid financial eligibility determined by HHSC, individuals must have a need for skilled nursing care and meet at least two of the nursing facility risk criteria OR have either mental retardation or a related condition. Participants must reside in Bexar County.

Services: CWP is two 1915(c) waivers that are administered as a single program and operates in Bexar County for individuals on the interest lists for the CBA, CLASS,

DBMD, HCS and MDCP Programs. The program provides an alternative to residing in a nursing facility or an ICF/MR. Services include:

- Case management
- Adaptive aids and medical supplies
- Adult foster care
- Assisted living/residential care
- Audiology
- Behavior communication
- Child support services
- Dental
- Dietary services
- Emergency response services
- Family surrogate services
- Habilitation
- Home-delivered meals
- Independent advocacy
- Intervener services (to facilitate communication and interaction)
- Minor home modifications
- Nursing services
- Orientation and mobility services
- Personal assistance services
- Transportation
- Psychological services
- Respite
- Social work
- Physical and occupational therapy
- Speech and language pathology

Case Management: Case management is provided by DADS staff and is separate from direct services.

Home and Community-based Services (HCS)

Eligibility: No age limit for enrollment, Medicaid financial eligibility determined by HHSC, individuals must have either mental retardation or a related condition that results in deficits in adaptive behavior and full scale IQ of 75 or below.

Services: The HCS Program is a 1915(c) waiver that provides services and supports to individuals with mental retardation and certain persons with a related condition, as an alternative to residing in an ICFs/MR. Individuals enrolled in HCS may live in any one of four residential assistance types. Individuals receiving supported home living services live in their own home or their family's home. Individuals receiving foster/companion care live in the home of a foster care provider or in their own residence with a companion care provider. Individuals receiving supervised living services reside in a three or four bed home that is owned or leased by the program provider and have overnight staff available if the individual needs assistance during the night. Individuals receiving residential support also live in a three or four bed home that is owned or leased by the program provider but require an awake staff while the individual is present in the residence. Other services in the HCS 1915(c) waiver program include:

- Case management
- Supported employment
- Day habilitation
- Respite
- Dental treatment
- Adaptive aids
- Minor home modifications
- Specialized therapies such:
 - Social work
 - Psychology
 - Occupational therapy
 - Physical therapy
 - Audiology
 - Speech and language pathology
- Dietary services
- Licensed nursing services

Case Management: Both case management and direct services are provided by the same provider agency.

Community Living Assistance & Support Services (CLASS)

Eligibility: No age limit, Medicaid financial eligibility determined by HHSC, individuals must have a related condition, reside in a CLASS catchment area, and require habilitation, as determined by the individual's service planning team.

Services: The CLASS program is a 1915(c) waiver that provides services and supports to individuals who have a related condition as a primary diagnosis, as an alternative to residing in an ICFs/MR. Individuals may live in their own or family home or in a residence with no more than three individuals with developmental disabilities who are receiving similar services. Services include:

- Adaptive aids and medical supplies
- Case management
- Habilitation
- Minor home modifications
- Nursing services
- Occupational and physical therapy
- Psychological services
- Respite
- Specialized therapies
- Speech and language pathology
- Transition assistance services
- Support family services (provided in foster family settings for individuals under 18 years of age.)

Case Management: Case management and direct services are provided by separate provider agencies.

Deaf/Blind with Multiple Disabilities waiver (DBMD)

Eligibility: Age 18 or older, Medicaid financial eligibility determined by HHSC, individuals must be deaf-blind and have another disability, such as mental retardation or a related condition, that impairs independent functioning.

Services: The DBMD is a 1915(c) waiver that provides services and supports to individuals who are deaf-blind with one or more other disabilities as an alternative to residing in an ICFs/MR. Individuals may reside in their own or family home or in small group homes. Services include:

- Adaptive aids and medical supplies
- Assisted living
- Behavior communication services

- Case management
- Chore provider
- Environmental accessibility
- Habilitation
- Intervener services (to facilitate communication and interaction)
- Nursing services
- Occupational therapy
- Physical therapy
- Orientation and mobility
- Respite
- Dietary services
- Minor home modifications
- Transition assistance services
- Speech language pathology

Case Management: Case management and direct services are provided by the same provider agency.

Integrated Care Management

Integrated Care Management (ICM) is a new model of service delivery that will be administered in the Dallas and Tarrant service delivery areas. ICM is a non-capitated managed care system that will provide community-based services to all SSI individuals.

Eligibility: Age 21 or older, Medicaid financial eligibility determined by HHSC, individuals must have a need for skilled nursing care and meet at least two of the nursing facility risk criteria.

Services: The ICM is a fee for service 1915 (b) and (c) waiver program, which will operate in the Dallas and Tarrant service areas. The program provides services and supports to individuals who have a physical disability or are elderly as an alternative to residing in a nursing facility. Services include:

- Case management
- Adaptive aids
- Medical supplies
- Adult foster care
- Assisted living/residential care
- Emergency response

- Nursing Services
- Minor home modifications
- Occupational therapy
- Personal assistance (including consumer-directed personal assistance services)
- Home delivered meals
- Physical therapy
- Respite care
- Transition assistance services
- Speech language pathology

Case Management: Case management provided by contracted provider and is separate from direct services.

HCBS Demonstration Services

Behavioral Health Pilot

The MFP BH pilot is designed to assist adults with behavioral health conditions who wish to relocate to the community from nursing facilities. Individuals with behavioral health conditions face additional barriers to community integration, including:

- Insufficient understanding and lack of long term care provider competency in dealing with psychiatric disorders, making providers reluctant to serve these individuals.
- Need for a process for identifying and connecting individuals with psychiatric or substance abuse disorders with appropriate long-term services and support options.
- Lack of long-term services and support options appropriate for individuals with co-occurring psychiatric disorders.
- Lack of availability of substance abuse services for adults under Medicaid.
- Lack of safe and affordable housing.

The BH pilot began upon approval of this *Operational Protocol* in Bexar County (San Antonio). *The third amendment to the Operational Protocol expanded the BH pilot to the seven counties that make up the Bexar County Star+Plus service area and the Travis County Star+Plus service area.* Up to fifty individuals will be served each year in the pilot. The pilot will also include training for long term service and support providers and relocation specialists in understanding and serving individuals with behavioral health disorders, and training for behavioral health providers in working with the relocation specialists, transition teams and long term care providers.

The MFP BH pilot is designed to assist adults with behavioral health conditions who wish to relocate to the community from nursing facilities. Individuals with behavioral health conditions face additional barriers to community integration, including:

- Insufficient understanding and lack of long term care provider competency in dealing with psychiatric disorders, making providers reluctant to serve these individuals.
- Need for a process for identifying and connecting individuals with psychiatric or substance abuse disorders with appropriate long-term services and support options.
- Lack of long-term services and support options appropriate for individuals with co-occurring psychiatric disorders.
- Lack of availability of substance abuse services for adults under Medicaid.
- Lack of safe and affordable housing.

The BH pilot will begin upon approval of this *Operational Protocol* in Bexar County (San Antonio). Up to fifty individuals will be served each year in the pilot. The pilot will also include training for long term service and support providers and relocation specialists in understanding and serving individuals with behavioral health disorders, and training for behavioral health providers in working with the relocation specialists, transition teams and long term care providers.

The local Community Transition Team will work with the DSHS system to address difficult cases and systemic problems, and develop locally-focused solutions. The team in San Antonio includes the local *mental health authority*, relocation specialist, *Star+PLUS MCO administrative and care coordination staff*, advocacy organizations, and local DADS staff.

The local relocation specialist will work with the local DSHS system to identify and facilitate relocation for individuals from nursing facilities, help coordinate paperwork, secure housing, establish households, and be present for the actual move.

Individuals in the pilot will receive transitional assistance and ongoing acute and long term care services through the Star+PLUS program operated by the single state Medicaid Agency (Health and Human Services Commission – HHSC). Individuals will also have access to Medicaid state plan behavioral health benefits, such as psychosocial rehabilitative services administered by the local DSHS system, and two new MFP Demonstration services, *provided through a contract with the local Mental Health Authority*:

- Cognitive Adaptation Training.
- Adult Substance Abuse Treatment Services.

Cognitive Adaptation Training is a specialized, evidence-based service that provides community-based and in-home assistance to help individuals with psychiatric disorders establish daily routines, organize their environment and function independently. A key approach will be the use of motivational interviewing, as part of the overall Cognitive

Adaptation Training, to engage the consumer in performing self-care, using environmental modifications to facilitate independence. For example, a system of reminders unique to the needs of the consumer may be implemented to assist with adherence to critical medication management.

Community-based substance abuse treatment for adults is not currently a Medicaid benefit in Texas and services may be difficult for long-term service and supports clients to access.

Demonstration services will be initiated prior to relocation from the nursing facility when clinically indicated to help prepare the individual for community living and to establish the therapeutic relationship that will be continued in the community. This pre-relocation relationship is vital for the eventual success of the relocation and to establish the groundwork for efficient use of the behavioral health services post-relocation.

At least a Master's Level qualified CAT therapist is required to perform CAT assessments, develop service plans, train *and supervise* CAT providers, educate Star+PLUS providers and monitor CAT service delivery to ensure quality. A qualified CAT therapist is an individual who is licensed to provide mental health therapy in Texas, has a master's level or higher who has been trained in CAT by the University of Texas Health Science Center in San Antonio (UTHSCSA).

A Bachelor's Level CAT provider is required to provide CAT interventions specified in the CAT plan. A qualified CAT provider is an individual who has a Bachelor's Degree in psychology or related field, a minimum of 2 years experience providing direct services to individuals with mental health or related issues and who has been trained by UTHSCSA to provide CAT services.

Substance abuse treatment providers will meet Texas (DSHS) licensure or certification standards for delivery of services.

Pilot Objectives

- Improve coordination and education across DADS, HHSC and DSHS systems to more effectively identify, relocate, serve and measure the experience of adults with behavioral health conditions who move from nursing facilities.
- Determine the efficacy of the MFP Demonstration behavioral health services in supporting independence/decreasing inappropriate institutionalization. If successful, Texas will consider these services for inclusion in DADS Community-based Alternatives 1915(c) and HHSC Star+PLUS 1915(c) waivers.
- Eliminate barriers that restrict individuals with BH disorders from getting HCBS services (e.g. personal care and other services appropriate to their needs).

Eligibility Criteria

Pilot participants must meet the following criteria.

- *Adult – the primary target group is ages 21 through 64. Individuals over 65 may also be included, on a case-by-case basis.*
- *Individual has resided in an institutional setting for at least ninety days, excluding any days of rehabilitative services funded through Medicare, is Medicaid-certified, and living in licensed nursing facility at time of discharge (individuals may receive pre-transition services before the ninety day criteria is met if the anticipated discharge date meets the ninety day criteria and there is a reasonable expectation that the individual will secure community housing).*
- *Individual will reside in the community within Bexar County.*
- *Individual has signed the MFP Demonstration consent form and has met all MFPD and STAR+PLUS waiver criteria*
- *Individual is part of DSHS' mandated adult population criteria:*
 - *Global Assessment of Functioning (GAF) score =<50 **and***
 - *Diagnostic and Statistical Manual of Mental Disorders (DSM) IV – R behavioral health (mental health or substance abuse) disorder, **or***
 - *Diagnosis of severe mental illness.*

Pilot Timeline

- *Protocol Development – September – June 2007*
- *Protocol Submission to CMS – September 2007*
- *CMS Approval – January 2008*
- *Project, Phase 1: January – December 2008*
 - *Contract with local Mental Health Authority for CAT and substance abuse services (DSHS)*
 - *training for DADS relocation team, providers, DSHS team*
 - *identification and assessment of potential participants*
- *Project, Phase 2: April 2008 – September 2011*
 - *Service delivery*
 - *Interim evaluation*
- *Project, Phase 3: September 2011 – September 2012*
 - *Cease intake*
 - *Phase-out activities*
 - *Final evaluation*

The following services will be available through the DSHS system to pilot participants as specified in their individual plans of care:

Substance Abuse Services (Demonstration)	Description	Rate/Unit
<i>Adult Outpatient</i>	<i>An outpatient setting providing an average of 10 hours of structured services per week, often called intensive outpatient.</i>	\$64/hr* <i>individual</i>
	<i>* to be billed in 15 minute increments.</i>	<i>\$17/hr group*</i>
<i>Pharmacotherapy</i>	<i>A medically supervised outpatient setting designed for persons who are opioid/narcotic addicted. Services include methadone and/or LAAM (levo-alpha-acetyl-methadol) administration.</i>	<i>\$11 per day</i>

Mental Health Services	Description	Rate
<i>Cognitive Adaptation Training (CAT) - Demonstration</i>	<i>A service that addresses the cognitive deficits of the individual, assists the person to arrange their environment and provide tools to support skill acquisition, including improvement in medication adherence, personal care and activities of daily living, social skills, and integration into the community.</i>	<i>Psychosocial rehabilitative rates</i>

Relocation Assistance

DADS has entered into a contractual relationship with nine organizations throughout the state to provide relocation assistance to individuals residing in a nursing facility. The organizations include Centers for Independent Living and an Area Agency on Aging. Below is a description of the services they provide.

Outreach: Relocation specialists provide outreach, identification, information, and facilitation services for nursing facility residents. Relocation specialists work with nursing facility residents who will be relocating to either a fee-for-service or managed care community system. For purposes of the MFP Demonstration, individuals must have been in an institutional setting for at least *ninety days excluding any days of rehabilitative services funded through Medicare* and residing in a nursing facility at the time of relocation. Relocation contractors are required to utilize the Minimum Data Set

(MDS), Section Q data provided by DADS to contact interested nursing facility residents.

Identification and Assessment Process: After a relocation request is made, the relocation specialist, an employee of the relocation contractor, must make initial contact with the individual within fourteen calendar days. The relocation specialist will administer an assessment that will be used to help determine the functional supports required for a successful relocation.

Relocation Assistance: Relocation specialists provide transition assistance and intensive service coordination to assist nursing facilities residents to transition to community settings of their choice. Relocation assistance includes:

- Providing information about Medicaid 1915(c) waiver and non-waiver services and supports (information is available at <http://www.dads.state.tx.us/services/index.html> and in DADS' rules contained in 40 TAC Part 1).
- Providing Transition to Life in the Community (TLC), and for all program placements other than Adult Foster Care and Assisted Living, Transition Assistance Services (TAS).
- Development of individual-directed transition plans and arrangements.
- Advocacy for individuals making the transition and their families.
- Coordination of needed services and resources to transition into the community, with such entities as the local housing authority, the Mental Health Authority (MHA), Texas Department of Assistive and Rehabilitative Services' (DARS) in order to provide the following information or services:
 - Housing.
 - Mental health services.
 - Transportation.
 - Medical/dental services, including prescriptions.
 - Durable medical equipment.
 - Utilities/telephone.
 - Banking/bill payment/direct deposit.
 - Household items/furniture.
 - Mainline, special transit and local transportation providers.
 - Follow-up assessment after transition.
 - Vocational Rehabilitation.

Establishing Community Households: Individuals transitioning to a community setting may need assistance establishing a community household. DADS will provide one-time start-up funds to help an individual establish a community residence. These start-up funds will be available through Transition Assistance Services (TAS) and/or

Transition to Life in the Community (TLC) programs. TLC are general revenue funds and TAS is a Medicaid service which is part of the 1915(c) waiver array.

TLC may be used for expenses that are not covered by Medicaid or other long-term services programs. Start-up funds available through TAS are not allowed for individuals relocated to Adult Foster Care or Assisted Living facilities. The start-up funds can be used for expenses directly related to moving, including but not limited to paying others to move household belongings; rental security deposits; utility deposits; cooking utensils; other moving-related expenses and household start-up costs. For transition into community-based 1915(c) waiver programs, TAS funds must be accessed before TLC funds can be used, as TLC funds are to complement, not supplant, TAS funds.

Post-Transition Services. Relocation specialists are required to maintain contact with individuals relocated from nursing facilities for a minimum of seven post-transitional contacts, in compliance with the following schedule: one every week for the first month, every two weeks for the second month, once a month for the third month and thereafter as needed. The purpose of these contacts is to ensure that individuals are receiving appropriate services and to assist with adjustments in service needs. The type of contact (e.g., face-to-face, telephone, collateral) will be determined on an individual basis.

Reimbursement Rate/Unit for Transitional Services. Relocation services meet the September 2007 CMS guidance for *Reimbursement of Transition Service Costs* and will be matched at the enhanced rate of up *\$2625 for pre-transition services and \$875 for post-transition services*. This maximum reimbursement amount of *\$3500* is based upon the historical cost of nursing facility transitions.

Overnight Companion Services

Administration of Texas' MFP policy since 2001 has identified the need for overnight support as one of the barriers to a successful transition. Many of the home health providers have expressed their concerns about accepting clients with complex needs because of their overnight needs. For example, an individual may need assistance with ambulating to the bathroom, assistance with toileting, ventilation assistance, etc.

In April 2006, DADS convened a special workgroup to address the relocation issues of individuals with complex needs, which resulted in a several recommendations for change (most of which have been incorporated into DADS' business practices). One of the recommendations made by advocates and providers was the need for overnight support.

Therefore, Texas proposes to offer a demonstration service for individuals who have specific functional needs and lack the informal supports to assist them during normal sleeping hours. The individual will remain eligible for this service for up to one year or until the individual, with the assistance of the case manager, is able to secure the informal supports necessary to meet their need, but not longer than one year.

During the MFP Demonstration project, Texas will evaluate this pilot service and, if considered successful, will consider amending its current adult nursing facility 1915(c) waivers (including CBA) to include this service.

Eligibility Criteria

A person is eligible for this service if the individual:

- Has a cognitive impairment or physical disability.
- Is eligible for and choose to participate in the MFP Demonstration.
- Has a medical need for specific tasks to be performed during normal sleeping hours.
- Does not have someone currently available to meet these needs.
- Is willing to seek informal supports to meet these needs.
- Understands and agrees that this service is limited to a 365 day demonstration period.

Texas Operational Protocol Amendment Number 3 still allows someone who is not capable of providing information supports to reside in the household with the MFPD participant. To help increase enrollment in the OCS pilot, the attendant will also be allowed to reside in the same household as the MFPD participant, subject to the Qualifications of the OCS attendant noted in the next paragraph.

Qualifications of the Overnight Companion Services Attendant

This demonstration service will require an attendant to meet the same qualifications as Texas' 1915(c) waiver Personal Attendant Services program (PAS). The individual receiving OCS may select to receive these services from an agency or may select the consumer directed services option. PAS provides non-medical in-home attendant services to individuals. The basic qualifications are:

- Be an employee of the provider agency (unless the MFPD participant uses the consumer directed services option.
- Be 18 years of age or older.
- Pass all registry checks.
- Not be a legal or foster parent of a minor who receives the service..
- Not be the spouse of a client who receives the service.

Qualifications of the Provider

To ensure service plan coordination, the actual providers of this service will be 1915(c) waiver providers and will meet all of the licensure and operational requirements for PAS.

Location of the Demonstration Service

This Demonstration service will be limited to all fee-for-service counties in Region 11 (Brooks, Cameron, Duval, Hidalgo, Jim Hogg, Kenedy, Live Oak, McMullen, Starr, Webb, Willacy, and Zapata) and all counties in Region 4 (Anderson, Bowie, Camp, Cass, Cherokee, Delta, Franklin, Gregg, Harrison, Henderson, Hopkins, Lamar, Marion, Morris, Panola, Rains, Red River, Rusk, Smith, Titus, Upshur, Van Zandt, and Wood).

Unit/Cost of Service

A unit of service is defined as eight to 12 hours, during normal sleeping hours, within 24 hour period. The reimbursement rate for this service is \$44.17 per unit.

HCBS Demonstration Services

Transition to Life in the Community (TLC)

Individuals who reside nursing facilities and wish to receive their long-term services and support in a community setting may need assistance setting up residence in the community. DADS will provide one-time start-up funds to help an individual establish a community residence.

TLC funds may be used for expenses that are not funded by Medicaid or other long-term services programs. Start-up funds can be used for expenses directly related to moving, including but not limited to:

- *Expenses directly related to moving, such as the cost of paying others to move household belongings, the cost of moving cartons, and the cost of transporting the individual to the community setting.*
- *Rent deposits, limited to the first and last month's rent plus reasonable damage and security deposits.*
- *Utility deposits, including deposits required by electricity, gas, water, wastewater, telephone, and sanitation companies.*
- *Cooking utensils, dishes, cleaning supplies, furniture, appliances, towels, sheets, blankets, and other items needed to set up a household.*
- *Other moving-related expenses and household start-up costs approved by the case manager and DADS.*

A MFP Demonstration participant must utilize Transition Assistance Services (TAS) funds, a 1915(c) waiver service, before TLC can be utilized. TLC will not be used unless an individual has exceeded the amount allowable under TAS or the item to be purchased is not allowable under TAS.

Availability of funds and approval of benefits must be confirmed by DADS before commitment is made to disburse funds. Additionally, the TLC program will not provide benefits that the individual is eligible for and able to receive through any other program.

Eligibility Criteria

To be eligible to receive benefits from the TLC program, the individual must:

- *not have received prior benefits through the TLC program.*
- *be a Texas Medicaid recipient who resides in a licensed nursing facility.*
- *be expected to be able to move to a community setting within 60 days after transition funds are made available to the individual.*
- *participate in developing a budget that indicates the financial ability to maintain ongoing household expenses after the temporary TLC assistance, including any temporary rental assistance, has been exhausted.*
- *need assistance with relocation expenses that cannot be met by other resources owned by, or available to, the individual.*

- *be accepted for services in one of the following service programs:*
 - *Community Based Alternatives (CBA);*
 - *Community Living Assistance and Support Services (CLASS);*
 - *Medically Dependent Children Program (MDCP);*
 - *Deaf-Blind with Multiple Disabilities (DB-MD);*
 - *other DHS community care service programs; or*
 - *other Medicaid-funded community-based service program offering ongoing services.*

Qualifications of the TLC Provider

A TLC provider must be contracted with DADS as a Relocation Contractor.

Cost of Service

The maximum amount for TLC is \$2,500 per individual or actual costs, whichever is less.

6. Consumer Supports

Describe the process and activities that the state will implement to ensure that the participants have access to the assistance and support that is available under the demonstration including back-up systems and supports, and supplemental support services that are in addition to the usual HCBS package of services. Please provide:

Education Materials

A copy of the educational materials used to convey procedures the State will implement in order for demonstration participants to have needed assistance and supports and how they can get the assistance and support that is available;

DADS has two documents that are currently used to provide information on the process and services available for an individual desiring to transition from an institutional setting. The *Explanation of Services and Supports* (Appendix F) is provided to individuals residing in an ICF/MR or state school. The *Money Follows the Person to Community Living* brochure (Appendix F) is provided to individuals wanting to transition from a nursing facility. Each of these brochures explains how to obtain additional information and provides contact telephone numbers.

DADS and DSHS will design an informational brochure that describes each of the demonstration services.

24-Hour Back Up Systems

A description of any 24 hour back up systems accessible by demonstration participants including services and supports that are available and how the demonstration participants can access the information (such as a toll free telephone number and/or website).

Texas takes its responsibility for protecting health and welfare as one of its most important functions. Unless otherwise noted, the information presented in this *Consumer Supports* section pertains to both fee-for-service and Managed Care Waiver programs.

Each of the waiver programs require that an agency be responsive to a telephone call after business hours and procedures to respond to an individual's urgent call. Agency staff will triage the situation and make an appropriate decision for a successful outcome. The case manager will take immediate action to call 911 when there is an immediate threat to health or welfare as precious time could be lost in responding to such an emergency. In other cases, the issue may be able to be resolved during the next business day or the situation may require an amendment to the plan of care, etc.

Fee-for-Service Waivers. Texas has standardized public policies and expected outcomes for back-up plans. These policies place the responsibility at the local provider agency level. Texas is too large of a state to have all consumers contact an office in Austin. The answer to this question and subsequent questions concerning consumer supports will help clarify Texas' policies concerning 24 hour back-up systems.

Under licensing rules, an agency must adopt and enforce a written policy to ensure that backup services are available when an agency employee or contractor is not available to deliver services. Additionally, an agency must adopt and enforce a written policy to ensure that clients are educated in how to access care from the agency or another health care provider after regular business hours.

At the time the Plan of Care (POC) is initiated, the individual is provided with the names and telephone numbers for all agencies which will provide services under that POC. They are also provided with information on complaint procedures, their rights and responsibilities, their service delivery schedule, and the names and telephone numbers of the people delivering services. If an individual is scheduled to receive services and the worker fails to show up, the individual has been instructed to call the agency which is required to provide a back up worker.

Managed Care Waivers. The HHSC Uniform Managed Care Contract requires that all covered services as specified in the service array must be available to members on a timely basis in accordance with medically appropriate guidelines and consistent with generally accepted practice parameters, The HMO must provide coverage for emergency services to members 24 hours a day and 7 days a week, without regard to prior authorization or the emergency service provider's contractual relationship with the HMO. The HMO's policy and procedures, covered services, claims adjudication methodology, and reimbursement performance for emergency services must comply with all applicable state and federal laws and regulations, whether the provider is in-network or out-of-network. A HMO is not responsible for payment for unauthorized non-emergency services provided to a Member by Out-of-Network providers.

The HMO must also have an emergency and crisis Behavioral Health Services Hotline available twenty-four hours/seven days a week, toll-free throughout the service area. For Medicaid Members, a HMO must provide coverage for emergency services in compliance with 42 Code of Federal Regulations. §438.114. The HMO may arrange emergency services and crisis Behavioral Health Services through mobile crisis teams.

For the STAR, STAR+PLUS, and CHIP Programs, and for CHIP Perinatal Newborns, HMO must require, and make best efforts to ensure, that PCPs are accessible to members twenty-four hours/seven days a week and that its Network Primary Care Providers (PCPs) have after-hours telephone availability. CHIP Perinatal HMOs are not required to establish PCP Networks for CHIP Perinatals.

The HMO must provide that if medically necessary covered services are not available through Network physicians or other Providers, the HMO must, upon the request of a

Network physician or other provider, within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation, allow a referral to a non-network physician or provider.

The HMO must fully reimburse the non-network provider in accordance with the out-of-network methodology for Medicaid as defined by HHSC, and for CHIP, at the usual and customary rate defined by Texas Department of Insurance in 28 Texas Administrative Code Section 11.506.

Include information for back-up systems including but not limited to:

Transportation

Texas' Medicaid entitlement programs authorize a medical transportation program (MTP) to provide eligible individuals with the most cost-effective means of transportation for allowable medical and dental care services within reasonable proximity of their residence. The case manager, service coordinator, or relocation specialist will provide all MFP participants with telephone numbers and contact names on how they can access transportation in their community.

Direct service workers

Under existing program rules, a home health agency must ensure that any authorized or scheduled personal assistance services are delivered in accordance with the plan of care and special attendants may be used to prevent a break in service and provide on-going service coverage for the individual. The case manager, service coordinator, or relocation specialist will provide all MFP participants with the telephone numbers and contact names of state and provider staff in case they experience an interruption in community-based services so that appropriate action can be taken.

As stated previously, all agencies must adopt and enforce a written policy to ensure that backup services are available when an agency employee or contractor is not available to deliver the services. The backup services may be provided by an agency employee, a contractor, or the individual's designee who is willing and able to provide the necessary services. (If the individual's designee has agreed to provide backup services, the designee is required to sign a written agreement to be the backup service provider.) Further, the Texas Administrative Code requires that an agency must ensure that clients are educated in how to access care from the agency or another health care provider after regular business hours.

Licensed home health agencies must have a telephone number where an individual receiving 1915(c) services can reach a person during the agency's operating hours. After normal business hours, the home health agencies must have call back or on-call systems in place to respond to messages left on a machine or answering services. If there were an essential equipment failure after hours that could be a threat to their health or safety, the individual should call 911 for immediate assistance. If the

individual were to call the licensed home health agency under such circumstances, the agency representative would triage the situation and take the appropriate action, including calling 911 for emergency assistance. If services were scheduled to be provided after normal business hours, a replacement would be dispatched.

Repair and replacement DME/Equipment

The case manager, service coordinator, or relocation specialist will provide all MFP participants with the telephone numbers and contact names of who they should contact when they experience a problem with durable medical equipment or other equipment.

Access to medical care

An individual is assisted with initial appointments, how to make appointments and deal with problems and issues with appointments and how to get care issues resolved.

Any of the following provide the above assistance to individuals in need of medical care: the DADS case manager, MCO service coordinator, relocation specialist, MRA service coordinator, and home health agency case manager.

Complaint Resolution Process

A copy of the complaint and resolution process when the back-up systems and supports do not work and how remediation to address such issues will occur.

An individual receiving any 1915(c) waiver service can file a complaint with HHSC, DADS, or any of the MCOs. The contacts can be through toll-free telephone access or to HHSC's or DADS websites.

DADS has an established Consumer Rights division which has a twenty-four hour complaint hotline. This line is answered by in-office employees from 8 a.m. to 5 p.m. Monday through Friday; voice mail is available twenty-four hours a day, seven days a week. Voice mail is monitored by in-office employees from 8 a.m. to 5 p.m. on Saturday, Sunday, and holidays.

Both DADS and the MCOs have developed, implemented, and maintain systems for tracking all complaints and appeals from long-term services and support (LTSS) providers and individuals/LAR's enrolled in any Medicaid 1915(c) waiver. Depending upon the nature of the complaint, LTSS providers must respond fully and completely to each complaint and appeal. All complaints are tracked to document the status and final disposition of each complaint and appeal.

Complaints are logged with a priority assigned. Priority is assigned based on the circumstances and the threat to an individual's health and welfare. The priority may be assigned upon intake or by the investigating staff. The priority level of a complaint determines the timeframes for completing the investigation.

The complaint is referred to the appropriate staff for investigation based on the allegation. Complaints may also be referred to multiple departments or divisions, which coordinate investigations when applicable.

Complaint investigations are unannounced. The LTSS provider's complaint history is reviewed prior to the on-site visit. During the on-site investigation, a sample of participant records is reviewed. The sample may or may not be random, based on the nature of the allegation. The investigation may include interviewing participants, LTSS provider staff and others as necessary.

Upon completion of the investigation, the investigator determines if the allegation can be substantiated. The investigator then determines which, if any, areas of non-compliance with rules and regulations will be cited and recommends appropriate action. There are state rules and policies which go into effect if the violations are not cleared within the promulgated timeframe.

The provider must document, investigate, and resolve all complaints that are reported to them within five workdays from receipt of the complaint report unless a different time frame is found in the service-specific program requirement. Finally, the provider must maintain a log of consumer complaints and must ensure that:

- All written complaints are stamped with the date of receipt;
- All verbal complaints are documented with the date of receipt and a narrative of the allegation(s); and
- The complaint log is accessible to DADS staff.

Additionally, all documentation of complaint investigations must contain the following information:

- Who conducted the investigation;
- Who was contacted during the investigation;
- The findings of the investigation; and
- Any actions taken as a result of the investigation.

Finally, when a consumer-initiated complaint is resolved, the provider agency must obtain the individual's (or LAR's) initials or a witness's signature if the individual (or LAR) refuses to sign. (Texas Administrative Code)

These complaint logs are reviewed by DADS during the on-site provider review. If it is determined that the provider has not properly followed these investigation procedures, a corrective action plan will be required and monitored by DADS. Information gathered by DADS concerning complaint information will be reviewed as part of its evidence-based continuous quality improvement process.

7. Self-Direction (See Appendix G)

Appendix A (renamed and placed at Appendix G of this MFP Protocol) is considered part of the Operational Protocol and is required for States using self-direction for MFP demonstration participants. An electronic copy of the form is available at http://www.cms.hhs.gov/DeficitReductionAct/20_MFP.asp or can be e-mailed directly by your CMS project officer. CMS requires that adequate and effective self-directed supports are in place. Provide a description of the self-direction opportunities under the demonstration before the Institutional Review Board (IRB) approval. In addition to completing Appendix A, please respond to the following:

Self-Direction Opportunities

All of the 1915(c) waivers and Medicaid State Plan services either currently have or will soon have self-direction options for individuals. The consumer directed services (CDS) option for the Home and Community-based Services 1915(c) waiver is scheduled for implementation in February 2008. DADS is currently conducting statewide training to prospective providers on this option. (Currently, self-directed services include attendant and respite services. Texas is working towards including other services such as therapies and nursing.)

Individuals who live in their own residences or the home of a family member may choose to self-direct some or all of their services. Individuals who choose to self-direct will assume and retain responsibility to:

- Recruit their service providers.
- Conduct criminal history checks.
- Determine the competency of service providers.
- Hire, train, manage and fire their service providers.

The individual/legal authorized representative (LAR) may appoint a designated representative (DR) to assist with or perform employer responsibilities to the extent approved by the individual. In addition, the individual has budget authority over the services being directed. The individual's LAR or DR, however, cannot be paid to deliver the services.

Another option currently available is the Service Responsibility Option (SRO). Under this option the individual/LAR selects, trains, and supervises the attendant.

The traditional home health agency option, where the agency is responsible for all employer functions, is available to provide authorized services to individuals who decide not to self-direct services.

Each individual who chooses to direct their own services will receive support from a Financial Management Service (FMS) provider also referred to as a CDSA, chosen by the individual. The individual develops a budget, with assistance from the CDSA, for each service to be self-directed based on the plan of care (called the Individual Plan of Care or Plan of Care, depending on type of 1915(c) waiver).

The individual's case manager (or service coordinator, depending upon the type of program) informs the individual about the option to self-direct 1915(c) waiver or Medicaid State Plan services at the time of enrollment and at least annually thereafter. At anytime, the individual may elect to self-direct services or to terminate self-direction of services, or to change the CDSA. If the participant chooses to terminate self-direction, the case manager revises the POC to have the services provided through a home health agency.

The individual, LAR and/or the DR are responsible for developing the backup plan with assistance and input from others. A backup plan may include the use of non-1915(c) waiver services, non-state services, other service providers, family members and friends, use of other professionals, and informal supports in the absence of the regular service provider.

Voluntary Termination of Self-Direction

Describe how the State accommodates a participant who voluntarily terminates self-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 self-direction to the alternative service delivery method.

An individual or LAR may voluntarily terminate participation in the CDS option at anytime. The individual's case manager (or service coordinator) assists the individual in revising the individual's service plan for the transition of services previously delivered through the CDS option to be delivered by the 1915(c) waiver or Medicaid State Plan program provider chosen by the individual, LAR and/or DR.

The CDSA 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. The continuity of service is assured by authorizing services to be provided under the new plan to begin right after the CDS services are terminated. An individual may always reconsider the CDS option in the future.

Involuntarily Termination of Self-Direction

Specify the circumstances under which the State will involuntarily terminate the use of self-direction and thus require the participant to receive provider-managed services instead. Please include information describing how continuity of services and participant health and welfare will be assured during the transition.

Involuntary termination of the CDS option may occur when:

- The individual's service planning team, in conjunction with the CDSA, case manager (or service coordinator) or DADS staff, determines that continued participation in the CDS option would not permit the individual's health and welfare needs to be met.
- The individual's service planning team, in conjunction with the CDSA, or case manager (service coordinator) or DADS staff determines that the individual or the individual's LAR and/or DR, when provided with additional support from the CDSA or

through support consultation, has not carried out employer responsibilities in accordance with requirements of the option.

The individual's case manager (service coordinator) and service planning team will assist the individual to ensure continuity of all 1915(c) waiver/ Medicaid State Plan services through a home health agency service delivery option and maintenance of the individual's health and welfare during the transition from the CDS option.

The CDSA 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. Similar to the voluntary termination of CDS services, the continuity of service is assured by authorizing services to be provided under the new plan to begin right after the CDS services are terminated. Again, the individual may always reconsider the CDS option in the future.

Self-Direction Demonstration Goals

Specify the State's goal for the unduplicated number of demonstration participants who are expected to avail themselves of the demonstration's self-direction opportunities.

The decision to self-direct services can only be made by the individual/LAR. Texas will educate, explain, and offer the option of self-directing services to every MFP participant. As noted in Appendix G, Texas estimates that 578 individuals will participate in one of the self-direction options.

8. Quality

Provide a description of the State's quality management system (QMS) for demonstration participants during the demonstration year and a description of what system they will be transitioned to after the 12-month demonstration period. Regardless of the financing and/or service delivery structure proposed under the demonstration, states must demonstrate how services during the 12-month transition period will:

- ***Be utilized to inform the CMS evaluation of the state's MFP demonstration; and***
- ***Meet or exceed the guidance for a QMS set forth under Appendix H of the 1915(c) HCBS waiver program.***

Description of Texas' Quality Management System

Texas will provide a MFP-specific Quality Management Strategy for Medicaid 1915(c) waivers that do not currently utilize the new Appendix H, version 3.4 requirements. The quality management strategies have been developed to meet the MFP Operational Review Criteria, Quality Section I.B.8 Addendum, furnished by CMS.

Texas currently utilizes Appendix H, version 3.4, for the following Texas 1915(c) Medicaid waivers:

- Community Based Alternatives (CBA), waiver number TX-2066
- Integrated Care Management (ICM), waiver number TX-19
- Medically Dependent Children's Program (MDCP), waiver number TX-0181
- Texas Home Living (TxHmL), waiver number TX-0403
- Deaf-Blind with Multiple Disabilities (DBMD), waiver number TX-0281, has been submitted to CMS.

A MFP specific Quality Management Strategy is attached at Appendices J, K, L, and M for the following Texas 1915(c) Medicaid waivers:

- Community Living and Assistance Support Services (CLASS), waiver number TX-0221.
- Consolidated Waiver Program (CWP), waiver number TX-0373.
- STAR+Plus, waiver number TX-0325.90
- Home and Community-Based Services (HCS), waiver number TX-0110.

As required by the *Operational Protocol* and Appendix H of the 1915(c) Home and Community Based Services (HCBS) waiver application, the required assurances will focus on the following issues:

- Level of care determinations
- Services plan description
- Identification of qualified HCBS providers for those participants being transitioned
- Health and Welfare
- Administrative authority
- Financial accountability

Quality Management staff from HHSC, DADS and DSHS will also coordinate oversight of incidents and service delivery issues/risks to determine how to improve services to participants. Consistent with HHSC and DADS practice, DSHS will conduct desk reviews of individual participant records maintained by a behavioral health provider as warranted by findings from an administrative data review. The Local Mental Health Authority will also provide ongoing oversight through its quality management program.

The quality management strategy specifically identifies:

- Each discovery process
- All responsible entities
- The frequency of various processes
- Data and type of information used
- Generated reports

In addition, the quality management strategy will measure the following:

- Participant access
- Participant-centered service planning and delivery
- Provider capacity and capability
- Participant safeguards
- Rights and responsibilities
- System performance
- Participant outcomes

MCOs (MCOs) maintain a quality improvement program that includes the following elements:

- Measure long-term service and support (LTSS) provider performance.
- Identify opportunities for improving performance
- Develop and implement action steps to improve performance

- Measure whether the targeted improvements have been achieved.
- Inform long-term service and support providers about the quality assurance program and related activities.
- Conduct utilization review activities on a sample of individuals receiving long-term services and supports.

HHSC contracts with an External Quality Review Organization (EQRO) to assist in improving the services delivered by MCOs through the following activities:

- Measuring and monitoring quality of care for Medicaid.
- Measuring and monitoring consumer and provider satisfaction.
- Monitoring the accessibility of care for eligible recipients.
- Monitoring Medicaid Star+PLUS participating managed care organizations' (MCOs) quality assurance and performance improvement plans and projects.
- Measuring financial performance and cost-effectiveness of the Medicaid MCOs.
- Conducting focused studies and special ad hoc analyses.
- Maintaining a data analysis platform and system to enable all functions.
- Performing MCO data validation, certification, and support activities for HHSC rate setting purposes.

An individual's initial POC is developed after a complete assessment has been conducted to assess the individual's health needs. The type and amount of each service component is supported by:

- Documentation that other sources for the service component are unavailable and the service component does not replace existing supports;
- Assessments of the individual that identify specific service components necessary for the individual to live in the community, to ensure the individual's health and welfare in the community, and to prevent the need for institutional services; and
- Documentation of the deliberations and conclusions of the service planning team that the services components are necessary for the individual to live in the community, to ensure the individual's health and welfare in the community, and are appropriate to ensure the individual's health and welfare in the community, and to prevent the need for institutional services. (40 Texas Administrative Code 97.157)

All providers are required to develop and maintain a Quality Assessment and Performance Improvement Program (QAPI) that is implemented by a QAPI committee. Some of the elements of a QAPI Program must include an analysis of a representative sample of services furnished to clients contained in both active and closed records;

review of negative client outcomes, effectiveness and safety of all services provided, the promptness of service delivery, and the appropriateness of the agency's responses to client complaints and incidents; a determination that services have been performed as outlined in the POC, etc. (40 TAC 97.287).

Complaint and Incident Reporting Management

Please see Appendix N for complaint and incident management procedures.

Current Data Systems

Texas has mechanisms in place to monitor service utilization, enrollment data, billed services, planned services, and promptness of service initiation. These mechanisms include the Client Assessment, Review, and Evaluation (CARE) Form System (CFS), the Service Authorization System (SAS), the Quality Assurance and Improvement (QAI) Data Mart, and the EQRO's data system.

Client Assessment, Review, and Evaluation Form System

The Client Assessment, Review, and Evaluation (CARE) Form System (CFS) is used by the Home and Community Support Services Agency (HCSSA) to submit CARE forms to the Texas Medicaid and Healthcare Partnership (TMHP, the state's MMIS contractor) for the determination of medical necessity (MN) and the Texas Index for Level of Effort (TILE – provider reimbursement calculation) scores. DADS staff may generate reports on MN and TILE scores in CFS.

SAS

SAS is used by DADS staff to authorize services and collect, process, and report participant authorization data. SAS maintains participant information, provider information, billing and payment information, and participant satisfaction interviews. Codes defining specific programs, services, and TILE scores drive the functionality of the system. A wide variety of reports can be generated from the data.

Medicaid Eligibility Service Authorization Verification Reports

HHSC's MCOs and their long-term services and supports providers have access to the Medicaid Eligibility Service Authorization Verification (MESAV) report to request information about participants they are authorized to serve. This information can include Medicaid eligibility, medical necessity, co-payment, level of service, and service authorization.

Quality Assurance and Improvement Data Mart

The QAI unit of the Center for Policy and Innovation (CPI) of DADS will also use the QAI Data Mart designed as a result of funds received from the 2003 Quality Assurance/Quality Improvement (QA/QI) Real Choice Systems Change grant. The QAI Data Mart produces standardized reports and has the capacity to generate ad hoc reporting of provider performance and consumer outcome data. The QAI Data Mart

provides an automated system to trend and analyze individual assessment data (e.g., Mental Retardation/Related Conditions [MRRC] and Minimum Data Set [MDS]) measures, performance indicators, and plan of care data in order to monitor trends.

EQRO Data System

HHSC employs the services of an EQRO to conduct some of its quality improvement activities. The EQRO has its own data system to identify and analyze the following types of events: Medicaid fee-for-service claims, all current and historical Medicaid encounter data submitted from the MCOs, Medicaid enrollment data, and Medicaid Behavioral Health Data from the Department of State Health Services (DSHS).

Plans for Future Enhancement of Mechanisms for Meeting Assurances

Texas is committed to continuous quality enhancement for 1915(c) waiver programs. As each 1915(c) waiver is renewed, a quality management strategy will be identified through the Appendix H portion of the Application for a 1915(c) HCBS waiver template.

Quality Review through Annual Surveys

Texas is using quality inventory tools for all community-based 1915(c) waiver and ICF/MR services. DADS joined the National Core Indicators Project and has contracted with an external entity to conduct both face-to-face and mail experience surveys of program participants on an annual basis. The project uses the National Core Indicators tool developed by the Human Services Research Institute (HSRI), as well as the Participant Experience Survey (PES) tool developed by MEDSTAT for the Centers for Medicare and Medicaid Services (CMS). Texas is one of the few states in the country that undertakes a survey of this size and scope.

The purpose of the project is to obtain information from the participant's perspective about his or her experiences receiving DADS services. The first phase was conducted in 2005 and provided an initial baseline of data that DADS will build upon. Future surveys will provide additional data that will enable DADS staff to complete trend analysis to identify areas for improvement, and to measure if improvement strategies are effective. The results provide an important discovery method for areas of improvement as identified by the participants receiving services.

The DADS QAI unit anticipates conducting pre-transition surveys of MFP participants and incorporating the MFP Demonstration participants in future annual experience surveys. Individuals receiving services under the Star+PLUS 1915(c) waiver will be included in the survey activities.

Please follow the guidelines set forth below for completion of this section of the OP:

- a. If the State plans to integrate the MFP demonstration into a new or existing 1915(c) waiver or HCBS SPA, the State must provide written assurance that the MFP demonstration program will incorporate, at a minimum, the same level of quality assurance and improvement activities articulated in Appendix***

H of the existing 1915(c) HCBS waiver application during the transition and during the 12 month demonstration period in the community.

The state need not provide documentation of the quality management system already in place that will be utilized for the demonstration. But, rather provide assurances in the OP that:

- i. This system will be employed under the demonstration; and***
- ii. The items in section (C) below are addressed.***

In addition, the state should provide a brief narrative regarding how the existing waiver QMS already or will be modified to ensure adequate oversight/monitoring of those demonstration participants that are recently transitioned.

MFP Assurances

- a. Texas can assure that the MFP Demonstration will meet the existing level of quality assurance and improvement activities of the current 1915(c) waivers. Texas' MFP Demonstration will utilize existing 1915(c) waiver services as currently approved by CMS.
- ai. Texas can assure that the same level of quality assurance and improvement activities as articulated in Appendix H will occur for the existing 1915(c) waivers during the transition and during the 12 month demonstration period.
- aii. With respect to items in section (c), below, Texas is not offering any supplemental demonstration services. Texas can assure that the quality assurance process of its current 1915(c) CMS approved waivers have adequate remediation and improvement processes.

The *Quality Section* of this *Operational Protocol* (Section 8) describes how Texas' existing waiver quality management strategies will ensure adequate oversight and monitoring of demonstration participants.

If the State plans to utilize existing 1915(b), State Plan Amendment (SPA) or an 1115 waiver to serve individuals during and after the MFP transition year, the State must provide a written assurance that the MFP demonstration program will incorporate the same level of quality assurance and improvement activities required under the 1915(c) waiver program during the individual's transition and for the first year the individual is in the community. The state must provide a written narrative in this section of the OP regarding how the proposed service delivery structure (1915(b), SPA, or 1115) will address the items in section (c) below.

1915(b), State Plan Amendments, or 1115 Waivers.

Texas will not use a Medicaid 1115 waiver for purposes of this MFP Demonstration. The only 1915(b) waiver to be used is for managed care (Star+PLUS) in order to waive freedom of choice and limit the number of MCOs.

There is sufficient capacity in Texas' Medicaid 1915(c) waivers for MFP participants. The Texas Legislature (2005) codified the MFP policies and created a separate line item for NF residents who want to relocate. This appropriation does not take away from other community slots appropriated by the Legislature.

For individuals with intellectual and developmental disabilities, there are specifically funded Home and Community-based Services (HCS) slots for individuals wanting to leave large (14+ bed) ICFs/MR and state supported living centers, and well as a priority set from slots abandoned by current users of HCS slots (referred to as "attrition slots") due to death, leaving state, etc.

b. The Quality Management System under the MFP demonstration must address the waiver assurances articulated in Appendix H of the 1915(c) HCBS waiver application and include:

- i. Level of care determinations;***
- ii. Service plan description;***
- iii. Identification of qualified HCBS providers for those participants being transitioned;***
- iv. Health and welfare;***
- v. Administrative authority; and***
- vi. Financial accountability.***

Texas' 1915(c) waivers meet all of CMS assurances. This information was provided in the description earlier in this section of the *Operational Protocol*.

c. If the State provides supplemental demonstration services (SDS), the State must provide:

- 1. A description of the quality assurance process for monitoring and evaluating the adequacy of SDS service(s) to manage the barrier it was selected to address; and,***
- 2. A description of the remediation and improvement process.***

Texas is not proposing to offer supplemental demonstration services during the MFP Demonstration. However, Texas will be providing Demonstration Services.

9. Housing

a. ***Describe the State's process for documenting the type of residence in which each participant is living (See chart for examples in Appendix B). The process should categorize each setting in which an MFP participant resides by its type of "qualified residence" and by how the State defines the supported housing setting, such as:***

- i. ***Owned or rented by individual,***
- ii. ***Group home,***
- iii. ***Adult foster care home,***
- iv. ***Assisted living facility, etc.***

If appropriate, identify how each setting is regulated.

Documentation of Qualified Residence

Information on the type of qualified residence that an individual chooses is verified at the time the participant is enrolled in a 1915(c) waiver. This information can be accessed by one of the data base systems (SAS or CARE) currently utilized by DADS.

Texas will only enroll an individual in the MFP Demonstration to a setting that meets the definition of a "qualified residence" as defined in Section 6071(b) (6) of the Deficit Reduction Act. For the individuals transitioning from a nursing facility, Texas licenses the following types of residential living arrangements that meet this definition.

- Assisted living apartment.
 - An assisted living apartment is a living unit that is a private space with living and sleeping areas, a kitchen, a bathroom and adequate storage space. The bedroom must be single occupancy unless the participant requests double occupancy. The living unit must have a private kitchen and bath.
- Residential care apartment.
 - A residential care apartment is a living unit that is a private space with connected sleeping, kitchen, and bathroom areas and adequate storage space. The bedroom must be double occupancy. The living unit must have private kitchen and bathroom facilities.
- Adult foster care.
 - Adult foster care is a setting that provides a twenty-four hour living arrangement in a DADS enrolled foster home for persons who, because of physical or mental limitations, are unable to continue independent functioning in their own homes. Services may include meal preparation, housekeeping, personal care and nursing tasks, help with activities of daily living, supervision and the provision of or arrangement of transportation.
- Texas does not license or regulate a home owned or leased by the individual or the individual's family member.

For individuals transitioning out of an ICF/MR or state school, the following identify the types of residences that meet the definition of a qualified residence according to Texas rules.

- An individual's own home or family home.
 - Foster Companion Care home.
 - A care provider who lives in the residence in which no more than three individuals or other persons receiving similar services are living at one time and in a residence in which the provider does not hold a property interest.
 - Three person group home.
 - A residence in which no more than three individuals receiving supervised living or other persons receiving similar services are living at any one time; provides services as needed by individuals and is present in the residence at any one time; the program provider holds a property interest.
 - Four person group home.
 - A residence in which no more than four individuals and other persons receiving similar services are living at any one time; the provider is present in the residence and is awake whenever an individual is present in the residence; the program provider holds a property interest.
- b. ***Describe how the State will assure a sufficient supply of qualified residences to guarantee that each eligible individual or the individual's authorized representative can choose a qualified residence in which the individual will reside.***

Assurance of Sufficient Supply of Qualified Residences

Historically, approximately eighty percent of individuals transitioning from ICFs/MR and state supported living centers have successfully transitioned into the residential model of HCS (definitions provided in the previous section); the other twenty percent return to family living arrangements. Accordingly, at this time, Texas can state that there are adequate housing opportunities for individuals in these transition situations. Additionally, the state has a sufficient provider base to serve all individuals who relocate back into the community.

With respect to nursing facility transitions, Texas is dependent on adequate additional funding from the Department of Housing and Urban Development (HUD) to meet all current and future demand for safe, affordable, and accessible housing for individuals who desire to participate in the MFP Demonstration. Without this support, Texas cannot make such an assurance. It must be noted that Texas has successfully transitioned more than 13,000 individuals into community residences.

However, as noted in the *Benchmarks* section of this *Operational Protocol* and restated below, Texas intends to carry out activities to expand housing opportunities and awareness of housing needs throughout the state. It is a goal of this MFP Demonstration to be able to make the global assurance.

- i. ***Describe existing or planned inventories and/or needs assessments of accessible and affordable community housing for persons with disabilities/chronic conditions; and***

Planned Inventories of Accessible and Affordable Housing

DADS will work with the TDHCA, the Texas Council on Developmental Disabilities, United Cerebral Palsy of Texas, and the Texas Low-Income Housing and Information Services to develop a housing inventory that will be linked on each agency's website. Individuals interested in looking for affordable housing will be able to search these websites. These activities will begin in 2007 and will be an ongoing effort to provide the following information from state and local PHAs and public and private owners of rental stock.

In addition, DADS and the above organizations will organize a housing summit in early 2008 with a goal to generate recommendations to increase affordable housing opportunities for Texas. The first planning meeting held on September 5, 2007.

- ii. ***Explain how the State will address any identified housing shortages for persons transitioning under the MFP demonstration grant, including:***
- iii. ***Address how the State Medicaid Agency and other MFP stakeholders will work with Housing Finance Agencies, Public Housing Authorities and the various housing programs they fund to meet these needs; and***

Working with Housing Finance Agencies and Public Housing Authorities

The recent activities of the PIAC and TDHCA have brought attention to the continued need for health and human service agencies and advocates to work closely with the state and local PHAs. The efforts necessary to increase the stock of affordable and accessible housing and rental assistance must come through mutual cooperation, identification of housing need and education by all parties involved.

The MFP Demonstration Coordinator will act as the housing liaison for the Health and Human Services Enterprise's housing related issues. Furthermore, Texas will build upon its recent preliminary successes to establish more comprehensive working relationships with its state housing finance agency and its PHAs. Texas will begin this process with the subsequent activities.

- Targeting of out-of-compliance PHA's.
- Visits to the ten largest PHAs in year one of the MFP Demonstration.
- After the first year, DADS will visit twenty-five additional PHAs per year.
- Review and comment on PHA Consolidated Housing Plans.

DADS is currently working with the Fort Worth Public Housing Authority to establish a model working collaborative to be replicated elsewhere in Texas.

- iv. ***Identify the strategies the State is pursuing to promote availability, affordability or accessibility of housing for MFP participants.***

Strategies to Promote Availability, Affordability or Accessibility of Housing

There is recognition of the importance of educating all stakeholders about housing and about Medicaid services. Therefore, DADS, in conjunction with its partners, will:

- Collect and distribute basic information on housing and housing plans. Information collected and shared will include: the most recent Consolidated Housing Plan and Annual Action Plan to identify priorities for HOME, Low Income Housing Tax Credit, Community Development Block Grant and other programs used to develop affordable housing.
- Develop a Computer Based Training (CBT) curriculum for PHAs regarding the HHS Enterprise home and community-based services. This project will begin in state fiscal year 2008.
- Create a Housing Advocacy E-mail Distribution list to distribute housing related information. As an example, federal Notice of Funds Availability (NOFA) and draft housing/action plans can be distributed in a more expedient manner.
- Provide linkages to the DADS Promoting Independence website for individuals who want more information about Texas' Public Housing Authorities (housing plans, rental application requirements, housing availability, etc.).

10. Continuity of Care Post the Demonstration.

To the extent necessary to enable a State initiative to meet the demonstration requirements and accomplish the purposes of the demonstration, provide a detailed description of how the following waiver provisions or amendments to the State plan will be utilized to promote effective outcomes from the demonstration and to ensure continuity of care:

Continuity for Demonstration MFP Participants

Texas has methodically worked with stakeholders to develop its long-term services and supports system to include community-based programs and services to meet the needs of individuals who want to remain in their communities. 1915(c) waiver service arrays were carefully selected in order to promote community living and help to ensure a successful relocation.

MFP Demonstration participants will be accessing established 1915(c) waivers. They will continue to be served through these waivers in the post-demonstration period as long as they continue to meet the eligibility criteria. Therefore, there will not be a lapse in services for MFP Demonstration participants and a transition plan is not required.

After the MFP Demonstration period, if an individual does not meet the institutional level of care requirement or medical necessity, that individual would not be eligible to participate in any of the Medicaid 1915(c) waiver programs. However, if the individual met Medicaid financial eligibility, and the functional eligibility criteria for Texas' state plan programs, then the state will assist that individual in the enrollment of one of those programs (attendant supports or adult day care). If Medicaid financial eligibility is not met, the individual will be assessed to determine eligibility for services available under the Older American Act programs, Title XX block grant services, and/or Texas' general revenue funded services.

Managed Care/Freedom of Choice (Section 1915(b)) – for participants eligible for managed care/freedom of choice services, provides evidence that:

- i. ***Services are ensured for the eligible participants; or***
- ii. ***A new waiver will be created.***

Managed Care/Freedom of Choice

As stated in the Part B, Section 8 of this *Operational Protocol* concerning quality issues related to the MFP Demonstration, HHSC currently operates Star+PLUS 1915(b) and (c) managed care waivers. These managed care services cover a significant percentage of the aged and physically disabled population in Texas. Individuals who live in managed care catchment areas will receive managed care 1915(c) waiver services.

Home and Community-Based (Section 1915(c)) – for participants eligible for “qualified home and community-based program” services, provide evidence that:

- i. ***Slots are available under the cap;***
- ii. ***A new waiver will be created; or***
- iii. ***There is a mechanism to reserve a specified number of slots via an amendment to the current 1915(c) waiver.***

Home and Community-Based

All necessary waiver slots are currently available as Texas’ Promoting Independence Initiative has its own legislatively approved budget strategy for individuals transitioning from institutional settings to the community.

No new waiver will be created, as MFP participants will transition from a qualified institution back to the community with long-term services and supports provided through one of the existing 1915(c) Medicaid waivers. Services will continue for MFP participants as long as they desire to remain on the 1915(c) waiver and meet the eligibility criteria.

No new 1915(c) waivers will be created.

a. Research and Demonstration (Section 1115) – for participants eligible for the research and demonstration waiver services, provide evidence that:

- i. ***Slots are available under the cap;***
- ii. ***A new waiver will be created; or***
- iii. ***There is a mechanism to reserve a specified number of slots via an amendment to the current Section 1115 waiver.***

Research and Demonstration

Section 1115 waivers will not be utilized for the MFP Demonstration.

b. State Plan and Plan Amendments - for participants eligible for the State plan option services, provide evidence that there is a mechanism where there would be no disruption of care when transitioning eligible participants to and from the demonstration program

State Plan and Plan Amendments

As noted above, MFP participants will remain on the appropriate Medicaid 1915(c) waiver as long as they meet the appropriate program requirements. No state plan or 1915(c) waiver amendments are anticipated during the MFP Demonstration.

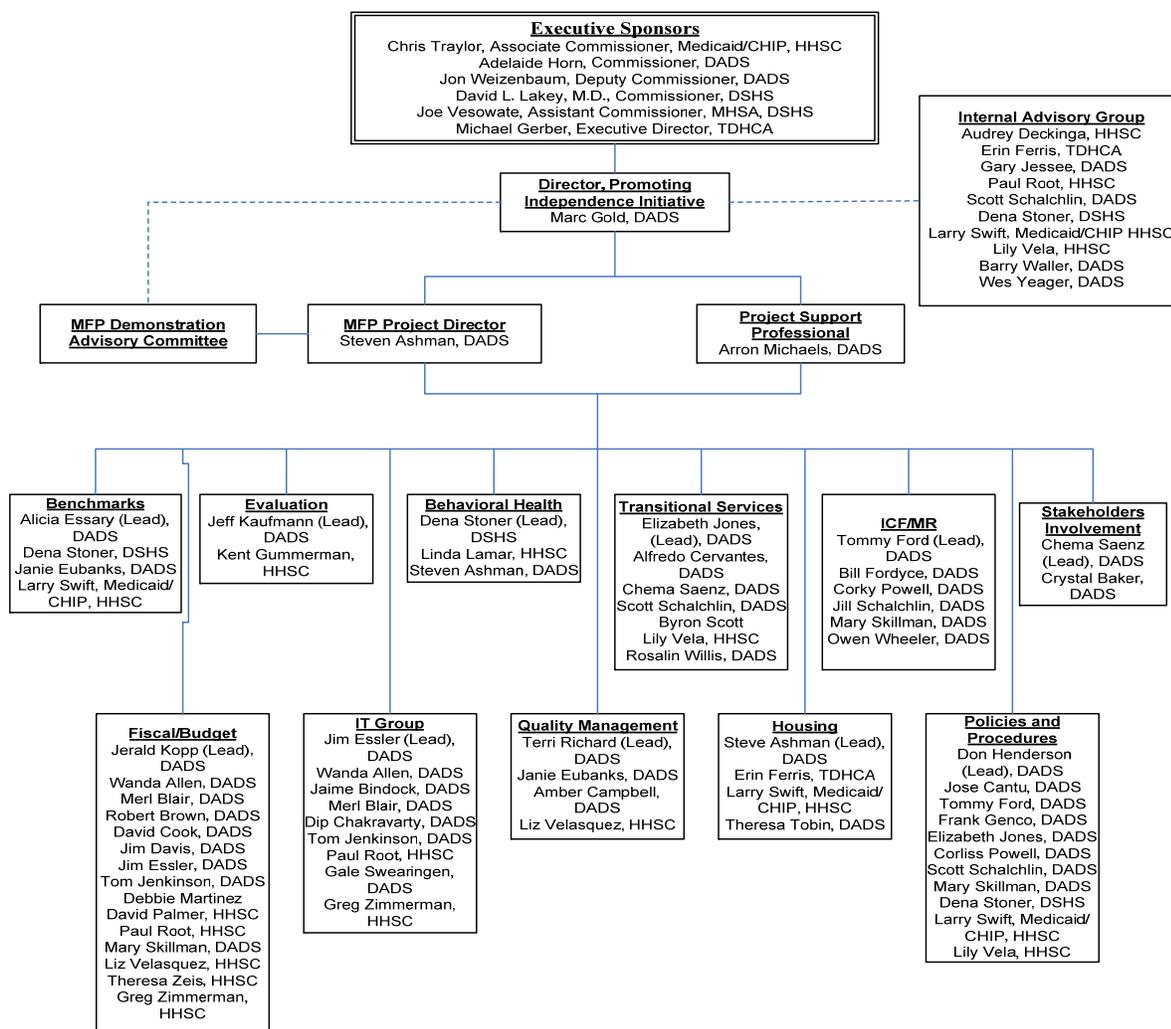
As discussed elsewhere in this *Operational Protocol*, DADS will introduce Overnight Support Services and DSHS will provide Cognitive Adaptive Training and an array of substance abuse services as demonstration services for the MFP Demonstration. If these pilot projects prove effective, Texas will consider these services for an amendment to the Community-based Alternatives (CBA) and Star+PLUS 1915(c) waiver programs.

Part C - Organization and Administration

Provide a description of the organizational and structural administration that will be in place to implement, monitor, and operate the demonstration. Please include the following:

Organizational Structure

Provide an organizational chart that describes the entity that is responsible for the management of this grant and how that entity relates to all other departments, agencies and service systems that will provide care and services and have interface with the eligible beneficiaries under this grant. Show specifically the relationship of the organizational structure to the Medicaid Director and Medicaid agency.



CHIP Children's Health Insurance Program
 DADS Texas Department of Aging and Disability Services
 DSHS Texas Department of State Health Services
 HHSC Texas Health and Human Services Commission
 MHSA Mental Health and Substance Abuse Services
 TDHCA Texas Department of Housing and Community Affairs

Staffing Plan

Provide a staffing plan that includes:

- a. A written assurance that the Project Director for the demonstration will be a full-time position and provide the Project Director's resume.***

Texas assures that the Project Director for the MFP Demonstration is a full time position. A copy Mr. Ashman's resume is located at Attachment _.

- b. The number and title of dedicated positions paid for by the grant. Please indicate the key staff assigned to the grant.***

Mr. Ashman's position title is MFP Project Director and the only position paid for by this grant.

- c. Percentage of time each individual/position is dedicated to the grant.***

Please see below narrative.

- d. Brief description of role/responsibilities of each position.***

Please see below narrative.

- e. Identify any positions providing in-kind support to the grant.***

There are no positions providing in-kind support for the MFP Demonstration.

- f. Number of contracted individuals supporting the grant.***

The only contracted individuals supporting the grant are providers of MFP Demonstration 1915(c) services.

The relocation contract is held in DADS Provider Services Division. However, the Director of the Promoting Independence Initiative (PII) is also part of the Executive Staff which provides significant interaction. PII provides leadership in the area of the relocation contractor activity and conducts monthly scan calls with the contractors to ensure that contract benchmarks are being met and to provide a forum to discuss common issues. PII will participate during any re-procurement of the relocation contract.

Relocation contractors are paid on a cost reimbursement basis so any additional caseload increase will be compensated and they are being trained on Demonstration requirements.

- g. Provide a detailed staffing timeline.***

All staff have been hired for the MFP Demonstration.

- h. Provide in a timeline format a brief description of staff that have been hired and staff that still need to be hired.***

Please see below for the responsibilities of the staff member that has been hired for this position. No additional staff are anticipated.

i. Specify the entity that is responsible for the assessment of performance of the staff involved in the demonstration.

Texas has reconfigured its health and human services system to an organizational umbrella with an oversight agency, the Health and Human Services Commission (HHSC) that also functions as State Medicaid Agency. HHSC has direct authority over four HHSC operating agencies; DADS is one of these agencies. HHSC has delegated the operational activities of the MFP Demonstration to DADS.

Marc Gold, Director of the Promoting Independence (PI) Initiative for Texas, has overall responsibility for the PI Initiative and the MFP Demonstration and will assess the performance of staff involved in the MFP Demonstration.

Responses to questions c and d.

All necessary staff for successful operation of the MFP Demonstration have been hired. Marc Gold, Director of the Promoting Independence Initiative for Texas, will dedicate 50 percent of his time to managing the project director, providing overall leadership for the MFP Demonstration, and assessment of the performance of the staff involved in the MFP Demonstration.

Steve Ashman has been hired as the MFP project director and will dedicate 100 percent of his time to the MFP Demonstration. Mr. Ashman's duties and responsibilities include: daily management of the MFP Demonstration activities; preparation of the *Operational Protocol*; liaison with the Centers for Medicare and Medicaid Services in all grant-related activities; preparation and submittal of all CMS and state required reports; convening and monitoring the internal and external workgroups; staff support to the MFP Demonstration Advisory Committee; support for all Promoting Independence Initiative activities; analysis of state/federal legislation and public policy; preparation of internal communications; present information to internal/external stakeholders. The position will also be the liaison with the Texas Department of Housing and Community Affairs and function as the health and human services housing coordinator. A copy of Mr. Ashman's resume is located at Appendix H.

The chief liaison with the State Medicaid Director's Office will be Larry Swift, HHSC Policy Analyst, who will dedicate five percent of his time to ensure coordination and State Medicaid Office oversight. Dena Stoner, Senior Policy Advisory to the Assistant Commissioner for the Department of State Health Services, Mental Health and Substance Abuse Services, will dedicate five percent of her time to ensure the coordination of behavioral health supports. Tommy Ford, Section Director for Institutional Services, DADS Provider Services Division, will dedicate five percent of his time for working with facility closures and resident community transfers. Jeff Kaufmann, Manager of Policy Analysis and Support, and Terri Richard, Manager of Quality Assurance and Improvement, within the Center for Policy and Innovation, will each dedicate five percent of their or their staff's time for this project. Mr. Kaufmann will be involved in MFP evaluation while Ms. Richard will be responsible for the MFP quality assurance and improvement activities. Many other DADS and HHSC staff that oversee

current operation of 1915(c) waivers and programs will continue their current roles and contribute support for the MFP Demonstration on an as needed basis. DADS will continue its current contracts with relocation specialists to assist individuals with transitioning from nursing facilities to the community.

Billing and Reimbursement Procedures

Describe procedures for insuring against duplication of payment for the demonstration and Medicaid programs; and fraud control provisions and monitoring.

The state uses the MMIS claims processing system to verify that the participant was Medicaid-eligible on the date of service delivery specified in the 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 validity of the information and compliance with business rules for the service/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 plan of care has sufficient units in the plan of care to cover amounts claimed or that an authorized level of care is registered in the claims management system, the claim will be rejected.

Texas uses a fiscal review process to ensure that providers for the various Medicaid 1915(c) waivers 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; comparison of provider billings to service delivery and other supporting documentation.

Current procedures provide for on-site fiscal reviews to examine the provider agency's service delivery and financial records and verify that all payments made to the provider agency were supported with documentation. Typically, a one-month sample of the provider's records is reviewed unless an increase in the review is 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, all improper payments are recovered. The state also recovers payments when it verifies the provider was overpaid because of improper billing. The state may take adverse action against the provider's contract or require a corrective action plan for any fiscal review finding.

Part D - Evaluation

Although not required as a component of the MFP demonstration, States may propose to evaluate unique design elements from their proposed MFP program. If these activities are undertaken by the State, the following information must be provided to CMS:

This section is not applicable. Texas does not plan to contract for an evaluation of the MFP Demonstration nor propose any evaluation activities. At this time, Texas will rely on the activities of the national evaluator, Mathematica. After reviewing Mathematica's final evaluation plan, Texas will meet with the Money Follows the Person Demonstration Advisory Committee and the Texas Promoting Independence Advisory Committee to determine if there are any other unmet evaluation needs unique to Texas. If there are any other evaluation requirements, Texas will then propose an amendment to this *Operational Protocol*.

Part E - Final Budget

1. **MFP Budget Form**: Utilizing the MFP Budget Form provided in Appendix C (relocated to Appendix I in the Operational Protocol), include an annual budget divided into the categories described below. The MFP Budget Form is set up to have the states fill in necessary information and then CMS can use the information to automatically calculate several indicators. The only cells that should be filled in by the States are those highlighted in yellow. Most of these cells represent total cost measures. This means that the number filled in should be the total costs of the service or administrative expense (not just the enhanced portion and not just the state or federal share).

MFP Demonstration Enrollment	Target Group	FY08	FY09	FY10	FY11	Total
Number of individuals relocating from medium and large community ICFs/MR and SSLCs, including children under the age of 22	MRDD	200	325	375	375	1275
Number of individuals relocating from ICFs/MR because of closure	MRDD	42	94	94	237	467
Number of individuals relocating from nursing facilities	Elderly	157	157	157	388	859
	Physical Disability	118	118	118	292	646
	Sub-Total	275	275	275	680	1505
Number of individuals relocating from nursing facilities with behavioral health needs	Elderly	29	29	29	29	116
	Physical Disability	21	21	21	21	84
	Sub-Total	50	50	50	50	200
Number of individuals relocating from a nursing facility and receive Overnight Companion Services	Elderly	11	11	11	11	44
	Physical Disability	9	9	9	9	36
	Sub-Total	20	20	20	20	80
Total MFP Demonstration Enrollment		587	764	814	1362	3527

Please see Appendix I for the MFP Demonstration budget related information.

- a. **Enrollees: An unduplicated count of individuals the State proposes to transition under the demonstration. Please count the person in the year that he or she will physically transition.**

Amendment No. 3 revisions for this benchmark have increased the number of relocations for each target group, include all community ICFs/MR that close regardless of size, and add children under the age of 22, a Texas Promoting Independence Priority Population, as an eligible person for the Money Follows the Person Demonstration. The changes to enrollment estimates in years 2008-2010 are to correct mathematical errors (i.e. in year 2008 the total was reported as 572 individuals but should have been 587).

Texas has been very successful with the ICF/MR voluntary closure target group but at the time of Amendment #3 of the OP, there are no new applicants. Accordingly, the revised estimate is based on 237 individuals relocated through the voluntary closure target group in 2011 and another 100 in 2012. After 2012, Texas will revise these estimates annually during the supplemental funding request.

- b. **Services: In each service costs section, provide cost estimates for the maximum number of participants in the demonstration project and their projected annual service costs.**
 - i. **“Qualified home and community-based program” services (eligible for enhanced FMAP);**
 - ii. **Home and community-based demonstration services (eligible for enhanced FMAP); and**
 - iii. **Supplemental** demonstration services (those eligible for the regular FMAP).

This information on the MFP Budget form located in Appendix I.

- c. **Administrative Budget: Please include projections for annual costs regarding the routine administration and monitoring activities directly related to the provision of services and benefits under the demonstration. Indicate any additional actions that are required to secure State funding (e.g., appropriation by the legislature, etc.), as well as costs associated with participation with the National Evaluation and Quality initiatives implemented by CMS.**

This information on the MFP Budget form located in Appendix I.

- d. **Evaluation Budget:**

Texas will work with the national evaluation organization selected by CMS and will not expend funds for program evaluation contracts.

2. Budget Presentation and Narrative: Please provide a budget presentation and narrative that provides justification for items E.1.c. and E.1.d. above. Please address the following items:

a. Personnel

One (1) full time employee as MFP Project Director

b. Fringe benefits

Retirement, OASI, Group Insurance

c. Contractual costs, including consultant contracts

No contractual costs.

d. Indirect Charges, by federal regulation

None

e. Travel

Out of state travel to attend required MFP Demonstration related meetings and in-state travel to attend meetings to discuss, promote, and educate people and organizations about the MFP Demonstration, including representatives from public housing authorities.

f. Supplies

Paper, pencils, etc.

g. Equipment

Office furniture, telephone hook-up, annual lease payment for computer, non-pool per capita expenses.

h. Other costs

IT consulting services (500 hrs/year @\$100/hour), and central cost pools.

3. The operational protocol should be submitted with a final budget. Below are links to the required forms to include with the protocol:

- <http://www.whitehouse.gov/omb/grants/sf424.pdf> (Application for Federal Assistance SF-424)
- <http://www.whitehouse.gov/omb/grants/sf424a.pdf> (Budget Information Sheets)
- <http://www.whitehouse.gov/omb/grants/sf424b.pdf> (Assurances-Non Construction SF-424B)
- <http://www.cms.hhs.gov/states/letters/certns.pdf> (Additional Assurances)
- <http://www.whitehouse.gov/omb/grants/sflll.pdf> (Disclosures for Lobbying Activities)

DADS Project Director, Steve Ashman, contacted the CMS Project Officer, Kate King, on September 5, 2007, to discuss submission of the above documents. A copy of the

SF424a is attached at Appendix I and identifies projected MFP Demonstration expenditures throughout the remainder of this grant period.

The SF424, Application for Federal Assistance, is on file with CMS and will be updated when requested by Ms. King. The other two documents are also on file with CMS and will be updated or resubmitted at the request of CMS.

Appendix A – Glossary of Terms

Activities of Daily Living: Activities essential to daily self-care, such as bathing, dressing, grooming, toileting, housekeeping, shopping, and meal preparation.

Abuse: Any act or failure to act, done knowingly, recklessly or intentionally, including incitement to act, which causes or may cause major or minor physical and/or emotional injury to an individual. This includes exploitation and sexual activity.

Active Treatment: A continuous treatment program that each ICF/MR client must receive, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services, that is directed toward the acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible while preventing or decelerating regression or loss of current optimal functional status.

Adaptive Behavior: In general, the effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected of his or her age and cultural group.

Administrative Hearing: A proceeding in which the legal rights, duties, or privileges of a party are to be determined by a state agency after an opportunity for an adjudicative hearing.

Adult Day Care: An array of services provided in a congregate, non-residential setting to dependent adults who need supervision but do not require institutionalization. These services may include any combination of social or recreational activities, health maintenance, transportation, meals and other supportive services.

Adult Foster Care (AFC): Residential services and care in a family's home or in a small group home.

Advocate: A person who represents his or her own interest publicly or a person who represents the interests of another individual.

Aged: Persons 65 years of age and older.

Amount, Duration, and Scope: How a Medicaid benefit is defined and limited in a state's Medicaid plan. Each state defines these parameters, thus state Medicaid plans vary in what they cover.

Applicant: A persons that has applied for benefits.

Applied Income: That portion of a client's income that must be applied towards the cost of institutional care. Also used in Texas Works to indicate a household member's income that is counted in determining eligibility and benefits.

Assisted Living Facility: Assisted living facilities provide food and shelter to four or more persons unrelated to the owner. Facility types range from adult foster care homes, or facilities serving residents capable of self-evacuation, to facilities serving residents who may require nighttime attendance and assistance with evacuation.

Autism: A pervasive developmental disorder characterized by (1) qualitative impairment in reciprocal social interactions; (2) qualitative impairment in verbal and non-verbal communications and in imaginative thinking; (3) markedly restricted repertoire of activities and interests; and (4) onset during infancy or childhood.

Behavioral Health Care: Assessment and treatment of mental or emotional disorders and chemical dependency disorders.

Beneficiary: One who benefits from a publicly funded program. Most commonly used to refer to persons enrolled in the Medicare program.

Benefit Level: The limit or degree of services a person is entitled to receive if the services are medically necessary.

Capitation: A prospective payment method that pays the provider of service a uniform amount for each person covered, usually on a monthly basis. Capitation is used in managed care alternatives such as HMOs.

Care Coordination: An ongoing process including assessing the needs of a client and effectively planning, arranging, coordinating and following-up on services which most appropriately meet the identified needs as mutually defined by the client, the access and assistance staff, and where appropriate, a family member or other caregiver.

Caregiver Education and Training: This includes developing a resource library, developing information resources, developing and/or facilitating support groups, seminars and focus groups, facilitating individual or group counseling, and providing education services to groups or individuals.

Case Management: A process whereby covered persons with specific health care needs are identified and a plan that efficiently utilizes health care and other resources is formulated and implemented to achieve the optimum outcome in the most cost-effective manner.

Centers for Medicare and Medicaid Services (CMS): The federal agency responsible for administering Medicare and overseeing state administration of Medicaid, formerly known as the Health Care Financing Administration (HCFA).

Certified Medicaid Eligible: A person who has gone through the Medicaid application process and has been determined by the state to be eligible for the Medicaid program.

Children with Special Health Care Needs (CSHCN): Defined by the Center for Medicare and Medicaid Services as Medicaid beneficiaries under 19 years of age who receive SSI, are eligible under 1902(e) (3), are in foster care and receiving foster care or adoption assistance, or are receiving Title V-funded care coordination services. CSHCN is also the name of a non-Medicaid program administered by the Texas Department of State Health Services.

Chore Maintenance: Performing household chores such as heavy cleaning (e.g., scrubbing floors, washing walls, and washing outside windows), moving heavy furniture, yard and walk maintenance which an older person is unable to handle on their own and which do not require the services of a trained homemaker.

Client: A person who has applied for a service or benefit and has been determined eligible.

Client Assignment and Registration System (CARE): An on-line data entry system that provides demographic and other data about individuals with mental retardation issues that are served by DADS.

Client Managed Personal Attendant Services (CMPAS): Personal care program in which the attendant is supervised by the individual receiving the service.

Community Attendant Services (CAS): An optional state plan benefit that allows states to provide home and community-based services to functionally disabled individuals. In Texas, this optional benefit provides personal care services to people who have income in excess of SSI limitations but who would be financially qualified for services provided in an institutional setting.

Community-Based Alternative Waiver (CBA): A waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act that allows Texas to provide community-based services to adults as an alternative to nursing facility care.

Community-Based Services: Services based within the community.

Community Care for the Aged and Disabled (CCAD): A group of services that are provided in the community to aged or disabled persons who have functional limitations.

Community Living Assistance and Support Services Waiver Program (CLASS): A Medicaid waiver granted under Section 1915(c) of the Social Security Act that allows Texas to provide community-based services to persons with developmental disabilities other than mental retardation as an alternative to ICF/MR institutional care.

Community Living Plan: A written agreement developed by an individual's interdisciplinary team with active participation by the individual and legally authorized representative which details the responsibilities of all parties signing the plan during and after the individual's move from a facility into a community living arrangement.

Community Mental Health and Mental Retardation Centers: Public entities, locally governed components of the mental health and mental retardation service delivery system located in various communities throughout the state, providing community-based mental health and/or mental retardation services.

Compliance, Assessment, Regulation, Enforcement System (CARES): DADS Regulatory Services database system.

Congregate Meal: Meals that comply with the Dietary Guidelines for Americans and provide a minimum of one-third (1/3) of the daily recommended dietary allowances (RDA) as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Science and are served in a congregate setting. These include standard meals and therapeutic meals/liquid supplements.

Consolidated Waiver Program (CWP): A Medicaid waiver granted under Section 1915(c) of the Social Security Act that allows Texas to provide community-based services to people who meet intermediate care facility or nursing facility criteria.

Consumer Directed Services: A service delivery model in which the consumer or representative has the ability to hire, fire, train and supervise personal attendants, as well as the opportunity to directly purchase needed services.

Continuity of Services: Activities undertaken to ensure coordination of services to individuals within and between components of the service delivery system.

Co-pay: A cost-sharing arrangement in which a covered person pays a specified amount for a specified service. Payment is usually required at the time the service is rendered.

Continuity of Care: The degree to which the care of a patient is not interrupted.

Contractor: Persons or organization with which the State has negotiated an agreement for the provision of required tasks.

Co-payment: An amount a recipient must pay as a share of the cost of a service.

Data Warehouse: A system that stores data in formats useful for structured query and analysis.

Day Activity and Health Services (DAHS): A long-term service provided during the day, Monday through Friday, for persons living in the community. Services are provided at locations that are sometimes called adult day-care centers and include nursing and personal care, meals, transportation, and social and recreational activities.

Deaf-blind with Multiple Disabilities Waiver (DBMD): A Medicaid waiver granted under Section 1915(c) of the Social Security Act that allows Texas to provide community-based services to people who are deaf and blind and have a third disability, as an alternative to ICF/MR institutional care.

Developmental Disability: A severe, chronic disability manifested during the developmental period before age 22, which results in impaired intellectual functioning or deficiencies in essential skills.

Direct Care Staff: Any person who works directly with clients and assists clients with daily needs.

Durable Medical Equipment (DME): Equipment that can stand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person unless the person is ill or injured, and is appropriate for using at home.

Dual Diagnosis: A term used to describe a person's condition involving diagnosis of more than one type of mental disability, such as mental illness occurring with mental retardation, or mental illness occurring with chemical dependency.

Dual Eligible: A person who qualifies for both Medicare benefits and Medicaid assistance.

Emergency Response Services (ERS): Services provided to the homebound, frail, older person using an automatic monitoring system to link them to emergency medical services when their life or safety are in jeopardy. ERS services include the installation of the individual monitoring unit, training associated with the use of the system, periodic checking to ensure that the unit is functioning properly, equipment maintenance calls, response to an emergency call by a medical professional, paraprofessional or volunteer and follow-up with the client.

Enhanced Match Rate: Federal matching rate that is higher than the regular federal medical assistance percentage.

Exploitation: The illegal or improper act or process of an employee using the resources of a person served by DADS for monetary or personal benefits, profit or gain.

Fair Hearing: A meeting conducted by a regional hearing officer with a client or his/her representative who disagrees with and wishes to appeal some action taken on the client's case.

Family Care (FC): A community care service provided to aged and disabled adults who are functionally limited in performing activities of daily living. Services include assistance with personal care, housekeeping tasks, meal preparation and escort services.

Federal Fiscal Year (FFY): The Federal fiscal year is a 12-month period that begins on October 1 and ends September 30.

Federal Medicaid Assistance Percentage (FMAP): The percentage of federal dollars available to a state to provide Medicaid services. This percentage is recalculated annually based on a formula designed to provide a higher federal matching rate to states with a lower per capita income.

Federal Poverty Levels (FPL): Income amounts published annually by the federal government that are guidelines for determining eligibility for services.

Fee-for-Service Reimbursement: The traditional health care payment system under which physicians and other providers receive a payment for each unit of service they provide.

Frail-elderly (FE): A Medicaid Community entitlement service that is now referred to as Community Attendant Services.

Freedom of Choice: In general, a state must ensure that Medicaid beneficiaries are free to obtain services from any qualified provider. Exceptions are possible through waiver of Medicaid and special contract options.

Guardian: A person lawfully invested with the power, and charged with the duty, of taking care of the person and managing the property and rights of another person who, for deficit of age, understanding, or self-control, is considered incapable of administering his/her own affairs.

Habilitation: A broad term referring to procedures and intervention designed to help an individual with a developmental disability achieve greater mental, physical, and social development. The habilitation process enhances the well being of the individual, teaches skills and increases the possibility that he/she will make progressively independent and responsible decisions about social behavior, quality of life, job satisfaction and personal relationships.

Health and Human Services Commission (HHSC): The oversight agency for health and human services in Texas, and is the single state Medicaid agency for Texas.

Health Maintenance: Services that include one or more of the following activities: medical treatment by a health professional; health education and counseling services for individuals or groups about lifestyles and daily activities; home health services including but not limited to nursing, physical therapy, speech or occupational therapy; and provision of medications, nutritional supplements, glasses, dentures, hearing aids, or other assistive devices.

Health Screening/Monitoring: Investigation or analysis by a medical or health professional to determine the need for a health service, including routine testing for blood pressure, hearing, vision diabetes and anemia, or the periodic checking/monitoring of a known condition such as monthly blood pressure checks for hypertension or tests for anemia.

Home and Community-Based Services Waiver (HCS): A Medicaid waiver granted under Section 1915(c) of the Social Security Act which allows Texas to provide community-based services to people with mental retardation as an alternative to ICF/MR institutional care.

Home and Community Support Services Agencies (HCSSA): HCSSAs provide one or more home health services to individuals in a residence or independent living environment.

Home Health Services: One or more health services required by an individual in a residence or independent living environment. Health services include nursing, physical, occupational, speech, respiratory therapy, medical social services, or intravenous therapies; dialysis; services by unlicensed personnel; medical equipment and supplies (excluding drugs); or nutritional counseling.

Home-delivered Meal: A meal that is delivered to an eligible person in his/her place of residence and that complies with the Dietary Guidelines for Americans, providing a minimum of one-third (1/3) of the daily recommended dietary allowances (RDA) as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Science.

Homemaker: A service provided by trained and supervised individuals involving the performance of housekeeping/home management, meal preparation and/or escort tasks and shopping assistance, provided to individuals who require assistance with these activities in their place of residence. The objective is to help the recipient sustain independent living in a safe and healthful home environment.

Hospice: An array of special services provided to individuals who are terminally ill, and to their family. This includes physical care and counseling. Hospice is for all age groups, including children, adults and the elderly during their final stages of life. The goal of hospice is to care for the patient and the family, not to cure the terminal illness. A team of doctors, nurses, home health aides, social workers, counselors and trained volunteers help the patient and family cope with the illness. Hospice services may be provided in the home or other residential settings.

Information, Referral and Assistance: Assessing customers' needs; finding organizations capable of meeting the needs; evaluating all appropriate resources; providing enough information about each resource to help customers make informed choices; helping customers find alternative resources; actively linking people to needed services; and performing follow-up to ensure the services were provided.

Individual Service Plan (ISP): The information used to determine an individual's eligibility for home and community services and for the utilization review related to provider's claims payments.

In-Home and Family Support Services (IHFS): A program that disburses funds as assistance to persons with a disability or their family for the purpose of purchasing services or items that are above and beyond the scope of usual needs, that are necessitated by the person's disability, and that directly support the person in living in his/her own home rather than living in a more restrictive setting at a higher cost.

Instruction and Training: These services provide the experience and/or knowledge for clients or professionals working with clients to acquire skills in a formal, informal, individual, or group setting.

Interdisciplinary Team: A group of persons that is drawn from or represents those professions, disciplines, service areas, or agencies that are relevant to identifying an individual's needs and designing a program to meet those needs.

Interest List: A list of individuals who have added their name as interested in receiving a DADS service. Interest lists are maintained for a variety of programs. Eligibility has not been determined for persons on these lists.

Intermediate Care Facility for Persons with Mental Retardation (ICF/MR or ICF-MR/RC): An optional Medicaid service that provides an active treatment program in a residential setting for individuals with mental retardation or other related condition(s).

Legal Awareness: The dissemination of accurate, timely and relevant information, eligibility criteria, requirements and procedures to older persons about public entitlements, health/long-term care, individual rights, planning/protection options, housing, and consumer issues in a group setting.

Level of Care (LOC): An assessment of the type of care necessary to meet the client's individual needs. The assessment takes into consideration the client's needs in all aspects of development, level of functioning, and potential to benefit from a particular program.

Local Mental Health Authority: The local component of the mental health system designated to carry out the planning, policy development, coordination, and resource development for mental health services in the community.

Long-Term Supports and Services (LTSS): Assistance and care for persons who are elderly or have some other chronic disabling condition. The goal of long-term supports and services is to help these individuals remain as independent as possible.

Managed Care: A system in which the overall care of a patient is overseen by a single provider or organization. Many state Medicaid programs include managed care components as a method of improving quality and controlling costs.

Medicaid: A federal medical assistance program for certain persons with low income. Medicaid is financed by both federal and state funds. Each state designs and administers its own program under the general oversight of the U.S. Department of Health and Human Services. The program was enacted in 1965 under Title XIX of the Social Security Act.

Medical Assistance Only (MAO): MAO clients receive no income assistance but are eligible for Medicaid. Except for their income and resources, these clients would be eligible for money payments. This means they are in one of the categories of aged, blind, disabled, or families with dependent children.

Medicaid Eligible (ME): In Texas, this term is used when referring to persons who have been determined eligible to receive Medicaid services after having gone through a certification process.

Medical Necessity (MN): Health services that are reasonably necessary to prevent illness or medical conditions or to provide interventions and/or treatments for conditions that cause suffering or pain.

Medically Dependent Children Program (MDCP): A 1915(c) Medicaid waiver program that provides respite, minor home modifications, adaptive aids and Medicaid benefits to children as an alternative to nursing facility care.

Medicare: The nation's largest health insurance program financed by the federal government. The program provides insurance to people who are age 65 and older, who are disabled, or who have permanent kidney failure.

Mental Illness: A single severe mental disorder, excluding mental retardation, or a combination of several mental disorders as defined in the latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual on Mental Disorders.

Mental Retardation (MR): Significantly sub-average intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

Mental Retardation Authority (MRA): The local authority designated by the department to carry out the legislative mandate to provide certain community-based mental retardation services and coordinate continuity of services to consumers who are members of the Department's defined priority population. The department designates one MRA for each local service area and the MRA is usually a community MHMR center.

Neglect: A negligent act or omission by any person responsible for providing services that caused or may have caused physical or emotional injury to a person served by the Department, or which placed a person served at risk of physical or emotional injury or death.

Nursing Facility (NF): A facility licensed by the state in which individuals receive nursing care and appropriate rehabilitative and restorative services.

Nutrition Consultation: Provision of information related to nutrition by a licensed dietician or other qualified person. Services are to be provided by AAAs or nutrition providers.

Nutrition Counseling: Provision of individualized advice and guidance to individuals who are at nutritional risk because of their health or nutritional history, dietary intake, medication(s) use or chronic illness, about options and methods for improving their nutritional status, and performed by a health professional in accordance with state law and policy.

Nutrition Education: Provision of information to participants to promote nutritional well being.

Ombudsman: Services that identify, investigate, and resolve complaints made by or on behalf of residents of nursing facilities and assisted living facilities, and which relate to action, inaction, or decisions that may adversely affect the health, safety, welfare, or rights of the residents, providers, or representatives of providers of long-term services, public agencies, or health and social services agencies.

Omnibus Budget Reconciliation Act(s) (OBRA): Federal laws that provide direction regarding how federal monies are to be expended. Amendments to Medicaid eligibility and benefit rules are frequently made in these Acts.

Part A: Medicare hospital insurance that helps pay for medically necessary inpatient hospital care, and, after a hospital stay, for inpatient care in a skilled nursing facility, for home care by a home health agency or hospice care by a licensed and certified hospice agency.

Part B: Medicare medical insurance that helps pay for medically necessary physician services, outpatient hospital services, outpatient, physical therapy and speech pathology service, and a number of other medical services and supplies that are not covered by the hospital insurance.

Part C: Previously called Medicare+Choice, this part of the Medicare program was renamed to Medicare Advantage and modified by the Medicare Prescription Drug, Improvement and Modernization Act of 2003. It provides for certain managed care coverage options in Medicare, under which managed care organizations receive a capitated monthly payment per covered beneficiary.

Part D: A new, voluntary Medicare prescription drug benefit created by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 that began January 1, 2006. Beneficiaries who remain in traditional Medicare may choose a private drug-only plan; those who choose to enroll in a managed care organization may choose a plan that offers a drug benefit.

Permanency Planning: A philosophy and planning process that focuses on the outcome of family support for a minor by facilitating a permanent living arrangement in which the primary feature is an enduring and nurturing parental relationship.

Person-directed Planning (PDP): A process that empowers the individual to direct the development of a plan of supports and services that meet the individual's goals.

Personal Assistance: Routine ongoing care or services required by an individual in a residence or independent living environment that enable the individual to engage in the activities of daily living. Personal Care An optional Medicaid benefit that allows a state to provide attendant services to assist functionally impaired individuals in performing the activities of daily living such as bathing, dressing, grooming, feeding, etc. Personal care is also provided as a non-Medicaid service to assist aged and disabled persons who are functionally limited in performing activities of daily living.

Preadmission Screening and Resident Review (PASRR): An evaluation process used to determine whether a person with mental illness, mental retardation and/or related condition is most appropriately placed in a nursing facility and needs training and/or treatment for the conditions.

Preventive Care: Comprehensive care that emphasizes prevention and early detection and treatment of conditions, generally including physical examination, immunization and well-person care.

Primary Home Care (PHC): A Medicaid-funded community care program that provides personal care services to aged and disabled individuals. This program is administered by DADS.

Priority Population: Groups of persons with mental retardation identified by DADS as being most in need of mental retardation services.

Program of All-inclusive Care for the Elderly (PACE): A Medicaid waiver granted under Section 1115(c) of the Social Security Act. This waiver allows Texas to provide comprehensive community and medical services under a capitated, risk-based system to frail elderly people (55 and Older) as a cost effective alternative to institutional care. This waiver is part of a national demonstration project.

Promoting Independence (PI): This is a state initiative in response to the U. S. Supreme Court ruling in *Olmstead v. L.C.* mandating that states provide community-based services to persons with disabilities who would otherwise be entitled to institutional services when certain conditions are met.

Provider: A person, group, or agency other than an agency staff person who performs a service for a client for a fee paid by DADS; sometimes called vendor.

Qualified Disabled Working Individuals (QWDI): These are Medicare beneficiaries with an income limit of 200 percent of the federal poverty level who do not qualify for full Medicaid benefits. Medicaid pays Medicare Part A premiums for disabled working individuals.

Qualified Individuals (QI): These are Medicare beneficiaries with an income limit of 175 percent of the federal poverty level who do not qualify for full Medicaid benefits. Medicaid pays a portion of their Medicare Part B premium.

Qualified Medicare Beneficiary (QMB): These are Medicare beneficiaries with an income limit of 100 percent of the federal poverty level who do not qualify for full Medicaid benefits. Medicaid pays all of their Medicare Part A and B premiums, deductibles, and coinsurance.

Quality Improvement (QI): A continuous process that identifies problems in service delivery, test solutions to those problems and constantly monitors the solutions for improvements.

Quality Monitor: A function that provides external review of the access to and the quality of care provided to Medicaid clients enrolled in Medicaid managed care.

Recipient: A person who receives services.

Rehabilitative Services for Mental Illness: Specialized services provided to people age 18 and over with severe and persistent mental illness and people under 18 with severe emotional disturbance. Includes plan of care oversight, community support services, and day program services for both children and adults.

Related Condition (RC): A disability other than mental retardation that manifests itself during an individual's developmental period (before age 22) and results in substantial functional limitations in three of six major life activities (self-care, expressive/receptive language, learning, mobility, self-direction and capacity for independent living).

Residential Care: A community care program that provides services to eligible adults who require access to services on a 24-hour basis, but who do not need daily nursing intervention.

Residential Repair: Repairs or modifications of client-occupied dwellings that are essential for the health and safety of the occupants.

Respite Care: A component of a waiver that provides short term services for individuals who require care and/or supervision, while allowing their caregiver temporary relief.

Service Coordination (SC): A system in which a single accountable staff person performs activities in the service of an individual, ensuring to the maximum extent possible that the individual has access to and receives all resources and services necessary to reach and maintain an optimal level of functioning.

Service Delivery Area (SDA): Regions of the State established by the Health and Human Services Commission for the purpose of planning and providing services.

Service Responsibility Option (SRO): A service delivery model in which the consumer has the ability to train personal attendants.

Skilled Nursing Facility (SNF): An institution that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above room and board) that can be made available to them only through institutional facilities and is not primarily for the care and treatment of mental disorders.

Social Security Administration (SSA): The Federal agency responsible for determining eligibility for Supplemental Security Income (SSI) benefits in Texas and most other states.

Special Services for Persons with Disabilities: A community program that contracts with public or private agencies for services to help persons with disabilities achieve habilitative or rehabilitative goals that encourage maximum independence.

Specified Low-income Medicare Beneficiaries (SLMB): Medicare beneficiaries with an income limit of 120 percent of the federal poverty level who do not qualify for full Medicaid benefits. Medicaid pays Medicare Part B premium.

State Fiscal Year (SFY): The Texas state fiscal year begins on September 1 and runs through August 31 of each year.

State Mental Retardation Facility: Any one of the thirteen facilities providing campus-based residential services for persons with mental retardation.

Supplemental Security Income (SSI): A federal cash assistance program for low-income elderly people and people of all ages with disabilities, administered by the Social Security Administration.

Texas Home Living Waiver (TxHmL): A Medicaid waiver granted under Section 1915(c) of the Social Security Act that allows Texas to provide community-based services to current Medicaid recipients with mental retardation or related conditions as an alternative to ICF/MR institutional care.

Texas Integrated Eligibility and Redesign System (TIERS): A project created to improve the delivery of state-funded services. The project will replace several outdated automated systems with a state of the art integrated eligibility system and will change business processes to improve service delivery.

Titles of the 1965 Social Security Act:

- II Old age, Survivors and Disability Insurance Benefits.
- IV-A Temporary Assistance for Needy Families; WIN Social Services
- IV-B Child Welfare
- IV-D Child Support
- IV-E Foster Care and Adoption
- IV-F Job Opportunities and Basic Skills Training
- V Maternal and Child Health Services
- XVI Supplemental Security Income
- X VIII Medicare
- XI X Medicaid
- XX Social Services
- XXI Children's Health Insurance Program

Transportation: Taking an older person or a person with disabilities from one location to another.

Utilization Review (UR): A formal assessment of the medical necessity, efficiency or appropriateness of services and treatment plans on a prospective, concurrent or retrospective basis.

Vendor Hold: Temporary suspension of payment from the department to a service provider.

Waiting List: A list of individuals who meet the eligibility criteria for service(s).

Waiver: An exception to the usual requirements of Medicaid grant to a state by the Centers of Medicare and Medicaid Services.

Appendix B – Provider Letter to Nursing Facilities

[Provider Letter #04-18 – Relocation Services Contract Staff Access to Nursing Facility Residents and Clinical Records](#)

[Information Letter # 07-67 Relocation Contractor Staff Access to Nursing Facility Residents and Clinical Records](#)

Appendix C – Community Living Options Instrument

Purpose

The Community ICF/MR Living Options instrument was designed to standardize criteria and objectify the process of making living option recommendations upon admission into the ICF/MR program, at the annual planning conference, or any time interest is indicated in an alternative living arrangement by an individual or legally authorized representative (LAR).

Instructions

4. The Living Options Instrument must be utilized by the Interdisciplinary Team as a guide to planning conferences with the individual/LAR when living options are discussed.
5. Prior to using the Living Options Instrument, the ICF/MR provider will ensure that facility staff participating in planning conferences with the individual/LAR have received adequate training on the use of the instrument.
6. Items on the Living Options Instrument will be incorporated as an essential element of interdisciplinary team policy and procedure at each facility, and will serve as the basis for all planning conferences with the individual/LAR at which living options are discussed.
7. Staff at each facility will coordinate monitoring of planning conferences to assure the process is being utilized as designed.
8. Staff at each facility will coordinate monitoring of record documentation (on a random basis) to evaluate the written product for a specified period of time.

Questions

Staff is encouraged to obtain this information using an approach that is focused on the preferences of the individual/LAR. Each of the factors below should be addressed by the IDT. Documentation in the IDT staffing summary will include: a) source of the information; b) relevant deliberation; and c) outcome of the discussion. Final recommendations will address individual/LAR preferences regarding living options.

Information obtained from this instrument should be used to update the individual's program plan for the ICF/MR program. Additionally, when an alternative living arrangement is requested, the information will be used by the MRA to identify appropriate community resources and to develop the individual's service coordination plan.

Community ICF/MR Living Options Instrument

Factors	Essential Elements
Person's Preference	<ul style="list-style-type: none"> • Does the latest planning conference with the individual indicate a clear preference of where the individual wishes to live? If so, where? • What information has been provided to the individual related to living options? • What is the source of this information? Where is this documented? • What was the individual's preference in his/her last planning conference? • Is there a noted change in his/her preference compared to the previous planning conference? If so, why?

Factors	Essential Elements
LAR/Family Preference	<ul style="list-style-type: none"> • Does the individual have a legally authorized representative (LAR)? • If there is no LAR, does the individual have family involvement and/or other natural supports? What information has been provided to the LAR and family/natural supports related to living options and permanency planning? • What is the LAR and family/natural support's stated preference? • What is the source of this information? Where is this documented?
Medical Issues	<ul style="list-style-type: none"> • Does this individual have medical/nursing needs? If so, what are they? • What would enable these needs to be met in an alternative living arrangement? • What can facility/MRA staff do to support/facilitate these needs being met in an alternative living arrangement (e.g., in-service training, extended trial visits, professional consults, provision of adaptive equipment, respite, etc.)?
Behavioral/Psychiatric Issues	<ul style="list-style-type: none"> • Does the individual have behavioral/psychiatric treatment needs? • If so, what are the treatment needs (e.g., behavior management plan, psychoactive medication, etc.)? • What would enable these needs to be met in an alternative setting? • What can facility/MRA staff do to support/facilitate these needs being met in an alternative living arrangement (e.g., in-service training, extended trial visits, psychiatric/ psychological consultation, respite, etc.)?
Quality of Life	<ul style="list-style-type: none"> • If the individual is a minor, has permanency planning been incorporated in the minor's service plan and reviewed as required? • If the individual is a minor, what efforts have been made to ensure LAR/family participation in service planning activities (including permanency planning issues)? • If a minor, have educational issues been addressed, including contact with the local school district? • What factors are most important to this person in choosing a place to live (e.g., family, friends, employment, special communication needs, leisure, living arrangements, daily routine, privacy, eating, community integration, etc.)? • What would enable these factors to take place for the individual in an alternative living arrangement? • What can facility/MRA staff do to support/facilitate these factors being met in an alternative living arrangement?

Factors	Essential Elements
MRA Recommendations/Input (required when an individual/LAR Requests an alternative living arrangement)	<ul style="list-style-type: none"> • What alternative living arrangements are available to meet the individual's needs? • Within what timeframe could placement in an alternative living arrangement occur? • Was an MRA representative present at the planning conference? • If not, what was the source of the MRA input?
Other Issues	<ul style="list-style-type: none"> • Were other factors (issues) discussed at the planning conference? If so, explain.

Appendix D - List of Nursing Facilities, ICFs/MR, and State Schools

The files for the list of nursing facilities and ICFs/MR are too large to transmit by email. The lists can be viewed from the below website.

<http://fives.dads.state.tx.us/facilitycapacity/facilityreport.asp>

To find a list of state schools, visit the website below:

<http://www.dads.state.tx.us/employment/stateschools/locations.cfm>

Appendix E – MFP Informed Consent Form

[Click here for DADS Form 1580 Texas Money Follows the Person \(MFP\) Demonstration Project Informed Consent for Participation in English](#)

[Click here for DADS Form 1580 Texas Money Follows the Person \(MFP\) Demonstration Project Informed Consent for Participation in Spanish](#)

Appendix F – Informational Brochures

English

[Money Follows the Person to Community Living \(brochure\)](#)

[You may not have to live in a nursing facility \(poster\)](#)

Spanish

[Money Follows the Person to Community Living \(brochure\)](#)

[You may not have to live in a nursing facility \(poster\)](#)

Appendix G – Self-Direction Appendix

Participant Centered Service Plan Development

Part I

a. Responsibility for Service Plan Development.

Specify who is responsible for the development of the service plan and the qualifications of these individuals (*check each that applies*):

0	Registered nurse, licensed to practice in the State
0	Licensed practical or vocational nurse, acting within the scope of practice under State
0	Licensed physician (M.D. or D.O)
X	<p>Case Manager. <i>Specify qualifications:</i></p> <p>For nursing facility waivers: The DADS case manager must have:</p> <ul style="list-style-type: none"> • Knowledge of special problems of long term care service clients; • Knowledge of interviewing techniques to obtain personal information, make inquiries, and resolve conflicting statements; • Ability to listen to clients, exploring and reflecting feelings, and present relevant alternatives describing the feasibility and consequences of choices; • Ability to appraise living conditions including physical and emotional environments; • Professional experience working in social services; • Computer experience; and • Education which demonstrates possession of knowledge, skills, and abilities related to working with the elderly and individuals of all ages with physical disabilities. <p>For ICF/MR waivers: Case Managers/Service coordinators have the following requirements:</p> <ul style="list-style-type: none"> • Licensed social worker; or • A Bachelor's degree in a health and human services related field plus two year of experience in the delivery of human services to persons with disabilities; or • An Associates degree in a health and human services related field plus four years of experience in the delivery of human services to persons with disabilities; or • (only for DBMD) A High School degree with eight years of experience in the delivery of services to persons who are deaf blind with disabilities, and fluency in all communication systems used by their clients; and • (only for DBMD) Be fluent in the communication system used by their clients. <p>For HCS and Texas Home Living:</p> <ul style="list-style-type: none"> • Have a bachelor's degree with major specialization in social, behavioral or human services or related fields; or • Have a high school diploma or Certificate of High School Equivalency (GED credentials) with related volunteer experience comparable to two years full-time work in social, behavioral, or human services or related fields; or • Have a high school diploma or Certificate of High School Equivalency (GED credentials) with a minimum of two years full-time work experience in social, behavioral, human services or related work; or • Be licensed in the State of Texas as a Registered Nurse or Licensed Vocational Nurse with one year of experience in human services. <p>For CLASS: Case Managers must be licensed by the Texas State Board of Social Work Examiners at the time of employment or no later than nine months after employment as a Licensed Master Social Worker or a Licensed Baccalaureate Social Worker; or the case manager must have the formal educational equivalent of a bachelor's</p>

	degree in a health and human services to persons with disabilities.
0	Social Worker. <i>Specify qualifications:</i>
0	Other (<i>specify the individuals and their qualifications</i>):

b. Service Plan Development Safeguards.

Select one:

x	Entities and/or individuals that have responsibility for service plan development may not provide other services to the participant.
0	Entities and/or individuals that have responsibility for service plan development may provide other direct 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. <i>Specify:</i>

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.

<p>The IDT supports the applicant or participant in setting goals that address the needs identified during assessment and educates the applicant or participant about all service options available. The applicant or participant and the IDT then work together to develop a Plan of Care that addresses the applicant or participant's goals and identifies providers, caregivers, and other third party resources that will contribute to goal achievement.</p> <p>The applicant or participant participates in the IDT, and may choose to include other appropriate individuals. The applicant or participant and other IDT members, including any designated representative, sign the Plan of Care before implementation.</p>
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d. Service Plan Development Process

In three 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; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how the MFP demonstration and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) assurance that the individual or representative receives a copy of the plan. 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):

<p>For Nursing Facility Waivers:</p> <p>(a) The applicant/participant, the case manager/service coordinator, and individuals chosen by the applicant/participant, develop the Individual Plan of Care (IPC). A re-evaluation is conducted annually and an IPC is developed for services for the next year. The participant, DR, LAR, or provider on behalf of the participant can request changes in the IPC. The case manger/service coordinator discusses the requested IPC changes with the participant/participant representative and approves or denies the changes.</p> <p>(b) The medical assessment form is utilized in developing the IPC.</p> <p>The case manager/service coordinator works with the applicant and representative to set goals to address caregiver relief, health care, social, and other support needs identified for and by the applicant during the initial assessment. They develop a plan to achieve each goal, including those goals requiring non-waiver/non/Medicaid State Plan services that are otherwise important to the applicant/participant's health and well being. The IPC must reflect the</p>

most integrated setting possible and desired by the applicant.

(c) The case manager/service coordinator must educate the applicant/participant and representative about all waiver and Medicaid State Plan services as part of the IPC development.

(d) The IPC or service plan must reflect the goals desired by the applicant/participant. The applicant/participant or representative must sign the plan to indicate understanding of the IPC. If the applicant/participant does not agree with the IPC, the applicant/participant or representative may file an appeal.

(f) The IPC shall include services (e.g., units, frequency, etc), and the roles of the applicant/participant, case manager, providers, family, and informal caregivers in achieving the goals and meeting the applicant/ participant's needs, including health care needs. The case manager is responsible for monitoring and overseeing the implementation of the IPC. Monitoring and implementing the IPC requires that the case manager maintain contact with the participant and their representative to ensure appropriate service delivery.

(g) The IPC can be updated at the request of the participant, the representative or the provider when the participant's condition changes.

For ICF-MR Waivers and Medicaid State Plan Services, generally the process is similar. The service coordinator initiates, coordinates and facilitates the planning process to assure that an individual's service plan addresses the desires and need as identified by an individual and the DR or LAR. The initial service plan must be developed with 45 days of the date the applicant, DR or LAR chooses the waiver/Medicaid State Plan service and self-direction. The service plan must be reevaluated at least annually and can be changed before that. The participant may include others, such as family, friends or service providers for his or her service planning team.

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/service coordinator, with support from appropriate professionals, uses assessment information along with the applicant's/participant's/representative's input to determine any risks that might exist to health and safety as a result of living in the community. The development of back-up plans is an integral part of the service planning process. Key backup planning activities include use of informal supports, third party resources, and other community resources identified by the participant. The case manager incorporates back-up plans into the IPC or service plan.

The DADS website provides service coordinators/case managers and other service planning team members, access to a "Person-directed Plan Discovery Tool," which assists in considering a variety of risks such as risks related to health factors; abuse, neglect, or exploitation; and safety risks.

f. Informed Choice of Providers.

Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the services in the service plan.

For the nursing facility waivers, the case manger/service coordinator provides a list of service providers at the initial home visit and during the IPC/service planning process. The list includes the providers available in the area and is maintained by local DADS staff. Participants indicate that they were given choice on the Service planning form.

For the ICF/MR waivers the service coordinator provides a current list of service providers once the individual has indicated a choice of waiver services over ICF/MR services. The list includes the name of providers contracted to serve the local service area, name of a local contact person for the provider and numbers of people served by the

provider sorted by county.

DADS has also posted on its website an “interview tool” that individuals and the families may tailor for their own use during the process of provider selection.

Participants indicate that they were given a choice of providers on the “Documentation of Provider Choice” form.

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 or other agency operating the MFP demonstration project:

HHSC Medicaid LTSS staff has discretion to participate with DADS in on-site visits to provider agencies and will participate in at least one review per waiver per year. HHSC staff reviews multiple plans of care and verify compliance of the MOU between HHSC and DADS which is the operating agency.

During the waiver development and waiver renewal processes, HHSC reviews and approves/disapproves standards and practices related to the development of plans of care. HHSC approves/disapproves:

- the method for determining individual cost ceilings which provide a limit on the amount of services available in the plan (Form 3652 TILE determination);
- the method for assessing the need for specific services based on consumer need and level of functioning (Form 2060 Assessment);
- requirements for consumer and other participation in the development of the plan of care; and
- requirements related to the annual and as needed re-evaluations of the plan of care.

Additionally, through automation, 100 percent of plans of care are assessed for cost-effectiveness through electronic edits in the Service Authorization System. Authority to approve assessment-based plans of care is delegated to the operating agency case managers.

Additionally, while on-site, HHSC staff review 100 percent of the samples that DADS pulls and monitors the process used by the operating agency to collect and aggregate annual waiver performance information reported to HHSC annually as provided for in 2.2.2 Individual Service Plan, Assurance 1, Indicator 1 of the Evidentiary Information as it relates to plan of care requirements.

DADS’ staff reviews each plan of care to verify that medical necessity determination has been met and that the cost of the plan of care is within range for the individual’s cost ceiling.

h. Maintenance of Service Plan Forms.

Written copies or electronic facsimiles of service plans are maintained for the duration of time that the state is operating the Money Follows the Person project plus one year. For example, if the state enrolls individuals into the MFP program for three years the state must retain all service plans for four years time (the three years of the demo plus one additional year.) Service plans are maintained by the following (check each that applies):

<input type="checkbox"/>	Medicaid agency
<input checked="" type="checkbox"/>	Operating agency
<input type="checkbox"/>	Case manager
<input checked="" type="checkbox"/>	Other (specify): Providers

Part II

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.

(a) The case manager/service coordinator is responsible for assessing how well services are meeting a participant's needs and enabling the participant to achieve the goals described in the Individual Plan of Care (IPC)/service plan.
(b) The IPC/service plan reassessment process must mirror the initial assessment and care planning process. It must include the case manager, the participant/representative, and others participating in the participant's care in evaluating goals and outcomes and revising the IPC/service as needed. The case manager/service coordinator monitors the implementation of the IPC/service plan at regular intervals by contacting the participant and caregiver. The case manager/service coordinator must reevaluate the appropriateness of the IPC whenever the participant's condition changes significantly or upon request of the participant.
(c) The case manager/service coordinator reviews the IPC/service plan with the participant and caregiver in-person at least every 12 months and monitors service delivery and IPC/service plan implementation.

b. Monitoring Safeguards.

Select one:

X	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.
0	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:

Overview of Self-Direction

Part III

a. Description of Self-Direction.

In no more than two pages, provide an overview of the opportunities for participant direction in the demonstration, 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 demonstration's approach to participant direction.

(a) Opportunities for Participant Direction Waiver/ Medicaid State Plan participants who live in their own private residences or the home of a family member may choose to self-direct some or all of their waiver services: a breakdown by waiver is shown later in this document. By choosing to self-direct these services, participants will assume and retain responsibility to: <ol style="list-style-type: none">1. Recruit their attendants;2. Conduct criminal history checks;3. Determine the competency of attendant; and4. Hire, train, manage, and fire their attendants. The participant/employer may appoint a designated representative (DR) to assist with or perform employer responsibilities to the extent approved by the participant/employer. In addition, the participant/employer has budget authority over the services he or she is directing. The traditional agency option (provider-managed service delivery
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method) and independent providers are available to provide authorized services to participants who decide not to self-direct services.

Each participant electing to direct his or her own services will receive support from

(a) Financial Management Service (FMS) provider referred to as a Consumer Directed Service Agency (CDSA), chosen by the participant. The participant/employer develops a budget with the assistance from the CDSA, for each service to be self-directed based on the individual plan of care (IPC)/service plan.

(b) How Participants May Take Advantage of These Opportunities

The case manager/service coordinator informs the participant of the option to self-direct select waiver/ Medicaid State Plan services at the time of enrollment and at least annually thereafter. At anytime, a participant may elect to self-direct services or to terminate self-direction of services, or to change the Consumer Directed Service Agency (CDSA). If the participant/employer decides to terminate self-direction, the case manager will ensure that those program services delivered through the self-direction option are transitioned over to the participant's waiver/ Medicaid State Plan provider.

(c) Entities Supporting Participants who choose to self-direct

The CDSA provides Financial Management Services (FMS) including:

1. Assisting the participant/employer with verifying each applicant's (potential service provider) criminal conviction history and citizenship status;
2. Processing payroll to include withholding applicable to federal, state and local employment-related taxes, making deposits of withholding, and filing reports with applicable governmental agencies as the employer-agent;
3. Collecting and processing time sheets and other documentation for payment of services; and
4. Generating status reports to the participant/employer related to transactions and budget status.

The CDSA also provides initial orientation and ongoing support and training to the participant/employer on how to be an employer including recruiting, hiring, training, managing, evaluating, and dismissing employees. The CDSA must also respond promptly to employer related questions from the participant/employer and notify him or her of changes in any regulations related to employment issues.

(d) Other Relevant Information related to the Waiver Medicaid State Plan's Approach to Self-Direction

To participate in self-direction, the participant/employer:

1. Selects a CDSA;
2. Participates in orientation and ongoing training conducted by the CDSA;
3. Performs all employer tasks that are required for self-direction or designates a designated representative (DR) capable of performing these tasks on the participant's behalf; and
4. Maintains a backup plan for each self-directed service determined by the participant/employer to be critical to the participant's health and welfare.

The participant/employer and/or the DR or LAR are responsible for developing the backup plan with assistance and input from others. A backup plan may include the use of non-waiver/non-State Plan/non-program resources, other service providers, family members and friends, use of other professionals, and informal supports in the absence of the regular service provider.

b. Participant Direction Opportunities

Specify the participant direction opportunities that are available in the demonstration. Select one:

0	Participant – Employer Authority. As specified in Appendix E-2, Item a, the participant (or the participant's
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	representative) has decision-making authority over workers who provide demonstration 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.
0	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 demonstration services. Supports and protections are available for participants who have authority over a budget.
x	Both Authorities. The demonstration provides for both participant direction opportunities as specified in Appendix E-2. Supports and protections are available for participants who exercise these authorities.

a. Availability of Participant Direction by Type of Living Arrangement.

Check each that applies:

x	Participant direction opportunities are available to pa
0	Participant direction opportunities are available to individuals who reside in other community-based living arrangements where services (regardless of funding source) are furnished to four or fewer persons unrelated to the proprietor.
0	The participant direction opportunities are available to persons residing in a leased apartment, with lockable access and egress, and which includes living, sleeping, bathing and cooking areas over which the individual or individual's family has domain and control.

b. Election of Participant Direction

Election of participant direction is subject to the following policy (select one):

X	The demonstration is designed to afford every participant (or the participant's representative) the opportunity to elect to direct demonstration services. Alternate service delivery methods are available for participants who decide not to direct their services.
0	The demonstration 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:

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.

<p>At the time of an individual's enrollment in a DADS program that offers the CDS option, and at least annually thereafter, a case manager, service coordinator, or other person designated by the individual's program must:</p> <p>(1) provide written materials on the CDS option to the individual or LAR;</p> <p>(2) meet with and provide the individual or LAR with an oral explanation of the CDS option specific to the individual's program; and</p> <p>(3) complete Form 1581, Consumer Directed Services Option Overview.</p> <p>An individual or LAR may request that a case manager, service coordinator, or other person designated by the individual's program provide additional oral and written information to the individual or LAR regarding the CDS option or assist with enrollment in the CDS option at any time. The case manager, service coordinator, or designee must comply within five working days after receipt of the request.</p> <p>An individual or LAR declining participation in the CDS option may at any time elect to participate in the CDS option while receiving services through a DADS program that offers the CDS option.</p>

c. Participant Direction by a Representative

Specify the State’s policy concerning the direction of demonstration services by a representative (select one):

0	The State does not provide for the direction of demonstration services by a representative.
x	The State provides for the direction of demonstration services by a representative. Specify the representatives who may direct demonstration services: <i>(check each that applies)</i> :
x	Demonstration services may be directed by a legal representative of the participant.
x	Demonstration services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of demonstration services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:
	The individual or the LAR may appoint a non-legal representative adult as a DR to assist in performance of employer responsibilities to the extent desired by the individual or LAR. Neither the DR nor the spouse of the DR may be employed or receive compensation or be the provider of waiver/ Medicaid State Plan services for the individual. The DR must be 18 years of age or older and must pass a criminal background check.

d. Participant-Directed Services

Specify the participant direction opportunity (or opportunities) available for each demonstration service. (Check the opportunity or opportunities available for each service):

Participant-Directed Demonstration Service	Employer Authority	Budget Authority
Personal Assistance Services	x	x
Nursing		x
Respite	x	x
Occupational therapy		x
Day Habilitation		x
Physical therapy		x
Speech, hearing and language therapy		x
The CDS services available for the waivers are listed below: MDCP: adjunct support services (personal assistance services) and respite care <ul style="list-style-type: none"> • CBA: Personal assistance services, nursing services, physical therapy, occupational therapy, respite services and speech, hearing and language therapy • CLASS: respite care and habilitation • Primary Home Care: personal assistance services 		

e. Financial Management Services

Generally, 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 demonstration participant. Select one:

x	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:
	0 Governmental entities
	x Private entities
0	No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. Do not complete Item E-1-i.

f. Provision of Financial Management Services

Financial management services (FMS) may be furnished as a demonstration service or as an administrative activity. Select one:

x	FMS are covered as a Demonstration service. Fill out i. through iv. below:																														
0	FMS are provided as an administrative activity. Fill out i. through iv. below:																														
	<table border="1"> <tr> <td>i.</td> <td>Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services: Private entities. Services are procured through an annual open enrollment.</td> </tr> <tr> <td>ii.</td> <td>Payment for FMS. Specify how FMS entities are compensated for the activities that they perform: FMS agencies are paid a flat monthly rate for the services they provide.</td> </tr> <tr> <td>iii.</td> <td>Scope of FMS. 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g. 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):

0	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 demonstration:
x	Demonstration Service Coverage. Information and assistance in support of participant direction are provided through the demonstration service coverage (s) entitled: Financial Management Services (FMS) provided by a CDSA, a required service for participation in the CDS option, and Support Consultation in some waivers/ Medicaid State Plan services provided by a Support Advisor as an optional service to support participant direction.
0	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 demonstration; (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:

h. Independent Advocacy

(select one).

0	Yes. Independent advocacy is available to participants who direct their services. <i>Describe the nature of this independent advocacy and how participants may access this advocacy:</i>
x	No. Arrangements have not been made for independent advocacy.

i. 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:

A participant or the participant's designated representative can change from the self-direction delivery to traditional agency service delivery method at any time. The individual's case manager must make arrangements for a HCSSA of the person's choosing to provide the services that were self-directed. The case manager must also negotiate a transfer date not to exceed 14 days to begin services through the HCSSA. The HCSSA will additionally be sent an updated plan of care.

If the individual requires assistance before the transfer can take place, the individual may be able to contract for services through the HCSSA using CDS funds. It is the responsibility of the case manager to arrange for services as quickly as possible and assist individual in exploring other resources, as necessary. If delegated skilled nursing tasks are involved, the HCSSA may need to deliver emergency services. The individual should be acquainted with other resources outlined in the training provided by the CDSA and should have back-up arrangements available at all times.

The suspension of self-directed services must last at least 90 days. The DADS case manager assists the participant in revising his or her plan of care to transition those services previously delivered through self-direction to the provider of the participant's choosing. 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.

j. 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 provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

<p>Involuntary termination of the CDS option may occur when:</p> <ul style="list-style-type: none"> • The individual’s service planning team, in conjunction with the CDSA, case manager/service coordinator or DADS staff, determines that continued participation in the CDS option would not permit the individual’s health and welfare needs to be met; or • The individual’s service planning team, in conjunction with the CDSA, or case manager/service coordinator or DADS staff determines that the individual or the individual’s representative, when provided with additional support from the CDSA or through Support Consultation, has not carried out employer responsibilities in accordance with requirements of the option. <p>The individual’s service coordinator and service planning team assist the individual to ensure continuity of all waiver/Medicaid State Plan services through the traditional agency service delivery option (provider-managed service delivery) and maintenance of the individual’s health and welfare during the transition from the CDS option. The CDSA 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.</p>
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k. Goals for Participant Direction

In the following table, provide the State’s goals for each year that the demonstration is in effect for the unduplicated number of demonstration 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 demonstration services.

Demonstration Year	Employer Authority Only Number of Participants	Budget Authority Only or Budget Authority in Combination with Employer Authority Number of Participants
Year 1		0
Year 2		107
Year 3		132
Year 4		157
Year 5		182

Participant Employer

Participant – Employer Authority

(Complete when the demonstration offers the employer authority opportunity as indicated in Item E-1-b)

Participant Employer Status.

Specify the participant’s employer status under the demonstration. Check each that applies:

x	<p>Participant/Co-Employer. The participant (or the participant’s representative) functions as the co-employer (managing employer) of workers who provide demonstration 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. <i>Specify the types of agencies (a.k.a., “agencies with choice”) that serve as co-employers of participant-selected staff:</i></p>
x	<p>Participant/Common Law Employer. The participant (or the participant’s representative) is the common law employer of workers who provide demonstration services. An IRS-approved Fiscal/Employer Agent functions as</p>

	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.
--	--

Participant Decision Making Authority

The participant (or the participant's representative) has decision making authority over workers who provide demonstration services. Check the decision making authorities that participants exercise:

x	Recruit staff
x	Refer staff to agency for hiring (co-employer)
x	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: The costs for such investigations may be budgeted and paid through the CDS budget for the service to be provided by the applicant or employee. The Participant may refer a potential provider for enrollment; however, the State has the authority to ensure the provider meets required credentials and qualifications before providing service.
x	Specify additional staff qualifications based on participant needs and preferences
x	Determine staff duties consistent with the service specifications
x	Determine staff wages and benefits subject to applicable 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)
x	Discharge staff from providing services (co-employer)
0	Other (specify):

Participant – Budget Authority

(Complete when the demonstration offers the budget authority opportunity as indicated in Item E-1-b)

Participant Decision Making Authority

When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. Check all that apply:

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
x	Specify how services are provided
x	Identify service providers and refer for provider enrollment
x	Authorize payment for demonstration goods and services
x	Review and approve provider invoices for services rendered
0	Other (specify):

Participant-Directed Budget

Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for demonstration 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.

All participants/employers, in conjunction with the CDSA, must develop a budget.

The CDSA uses the Plan of Care to determine the budget for those services that will be self-directed. The CDSA, the participant/employer and the DR (if applicable) develop a budget for each service on an annual basis. The CDSA and the participant/employer based the budget on the number of hours or units authorized and the established rate for that particular service per year. The participant-directed budget is composed of those authorized services and estimated costs that the participant/employer will direct and itemized in the Plan of Care authorized by DADS.=

The CDSA must approve the budget for each service component and any revisions, prior to implementation. The CDSA must ensure that projected expenditures are within State set spending limits and are allowable and reasonable. The CDSA projects the expenditures over the effective period of the plan to ensure that sufficient funds will be available to the end date of the Plan of Care. With the approval of the CDSA, the participant/employer may make revisions to a specific service budget that does not change the amount of funds available for the service in the approved Plan of Care. Revisions to the Plan of Care amount available for a particular service, or a request to shift funds from one self-directed waiver service component to another, must be justified by the participant's/employer's interdisciplinary team and authorized by DADS. With assistance of the CDSA, the participant/employer revises the CDS budget to reflect a revision in the Plan of Care.

The budget methodology is part of DADS' CDS rules, described in 40 TAC, Part 1, Chapter 41, Subchapter E.

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 Consumer Directed Services Agency (CDSA) and the DADS case manager inform the participant/employer of the amount authorized for the particular service before the budget is developed. The participant/employer may request an adjustment to the budget at any time, subject to cost ceilings. When DADS denies a participant/employer request for an adjustment to the budget is entitled to a fair hearing.

An individual whose request for an adjustment to his/her participant-directed budget is denied is entitled to a fair hearing in accordance 1 TAC Part 15, Chapter 357, Subchapter A. DADS must send written notification to the participant, DR or legally authorized representative (LAR), indicating the reason for the denial, the participant's right to a fair hearing and the process the participant must follow to request a fair hearing.

Participant Exercise of Budget Flexibility.

Select one:

<input type="radio"/>	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:
<input checked="" type="radio"/>	Modifications to the participant-directed budget must be preceded by a change in the service plan.

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 CDS budget is calculated and monitored based on projected utilization and frequency of the service as determined by the DADS case manager or the service coordinator/case manager. The CDSA 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 DADS case manager. When an over- or under-utilization is not corrected by the individual or DR/LAR, the CDSA 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 care plan.

Appendix H – MFP Project Director Steve Ashman's Resume

SKILLS SUMMARY

Senior management positions with extensive experience in the development of senior citizen and other special needs housing, Medicaid programs and Older American Act funded services. Skilled in use of federal, state and local funding strategies for supportive services and the development of senior and special needs housing. Excellent background in facility design, construction, operations and budgeting for senior/special needs housing, adult day care and senior centers. Experienced in developing and implementing health care, supportive and recreational services for senior and special needs programs. Certified Housing Development Finance Professional through the National Development Council.

Employment

Director, Division of Senior and Disabilities Services, State of Alaska, September 2001 to July 2005, Juneau, Alaska

- Responsible and accountable for the planning, budgeting, staffing and operations of the Division of Senior and Disabilities Services.
- Annual operating budget of approximately \$285 million and a staff of 85.
- Managed the following programs: four Medicaid waiver programs, Nursing Home admissions, Personal Care Attendant programs, Adult Protective Services, Assisted Living Licensing, Alaska Medicare Information Help Line, Medicaid Quality Assurance Program, US Administration on Aging programs and Rural Long-Term Care Development activities.
- Managed funding sources, program compliance and technical assistance for all US Administration on Aging/Older American's Act programs operated in the state of Alaska.
- Development and implementation of new state law, regulation and policy and procedure for health, supportive and recreational services for senior citizens and other special needs populations.
- Liaison to the Office of the Governor, the Alaska Legislature and the public regarding program and policy issues.
- Improved processing time of medical eligibility determinations by 65%.
- Achieved a 15% reduction of state general funds through regulatory changes to Waiver programs, implementation of operational efficiencies and refinancing strategies.
- Directed recruitment, retention and professional development of supervisors and staff.
- Negotiated and consummated all professional contracts.

Housing Relations Officer, Alaska Housing Finance Corporation. October 1990 to September 2001, Anchorage, Alaska

Primary responsibilities were two fold: administration of the Senior Housing Office and management of the corporation's HOME CHOICE program (home buyer education, counseling and outreach activities).

- Administration, development and management of the Senior Housing Office, including administration of the Senior Housing Revolving Fund.
- Conducted market demand and financial feasibility analysis for senior housing development for locations throughout the State of Alaska.
- Authored and published the Senior Housing Market Demand and Financial Feasibility Analysis for the State of Alaska - 1995 through 2010.
- Underwrote commercial real estate loans for the development of senior and special needs housing.

- Expertise in funding programs and strategies utilizing bond financing, Low Income Housing Tax Credits, and grant funds, including HUD and USDA Rural Development Housing programs (Section 8 Certificates/Vouchers, HUD 202, 221, 232, 811, HOME, CDBG programs, USDA RD 515, etc.).
- Provided expert opinion to corporate management, Alaska's administrative and legislative bodies, senior citizen organizations, developers and the banking industry on trends and issues affecting senior citizens.
- Responsible for coordination with other private, local, state and federal agencies to promote a comprehensive response to the unique needs housing of Alaskan senior citizens and people with disabilities.
- Liaison to HUD, USDA Rural Development, Alaska Department of Health and Social Services and Regional Housing Authorities concerning the development of senior and special needs housing.
- Expanded the senior housing market – doubling the number of independent senior housing units and tripling the number of assisted living units within the State of Alaska.
- In the educational area, responsible for development of educational materials and curriculum, supervision of class instructors and clerical support and outreach to the real estate, banking and construction industry. Professional experience in teaching adults exceeds four years and almost 2,000 hours in a classroom setting.
- (Note: in 1992, the Alaska Legislature merged all housing related activities to the Alaska Housing Finance Corporation. While operating the Senior Housing Office for the State Department of Community and Regional Affairs, I was designated as the Rural Development Officer and provided guidance and over site to field offices on rural economic development activities.)

Loan Examiner III, Alaska Department of Natural Resources and Department of Commerce and Economic Development, July 1987 to October 1990 and August 1985 to July 1987, Anchorage, Alaska

- Detailed financial analysis of loan applications based upon repayment capacity, character, credit worthiness and collateral offered by the applicant or required by the lender.
- Financing ranged from funding of working capital, property acquisition to long term economic development projects.
- Conducted appraisals of collateral and property inspections.
- Represented the Department(s) at meetings and conferences of local community organizations, trade groups and trade associations.

EDUCATION

- Bachelors of Science, Business Management
- California Polytechnic State University, San Luis Obispo, CA

BOARD AND COMMISSION MEMBERSHIPS

- Commissioner, Alaska Commission on Aging
- State Director, Alaska State Unit on Aging, US Older American Act Programs
- Board Member, Alaska State Independent Living Council
- Board Member, Alaska Traumatic Brain Injury Advisory Council
- Commissioner's Designee, Governors Council on Disabilities and Special Education
- Advisory Board, Alaska Geriatric Education Center, University of Alaska, Anchorage
- Member, Health Steering Committee, Alaska Denali Commission
- Member, Governor's Task Force on Prescription Drugs

Appendix I – MFP Budget Information

Instructions: Please fill in only the cells highlighted in YELLOW. All other cells will autopopulate. Please DO NOT alter any formulas.

MFP Grant Basics
State/Grantee:
TEXAS
Grant #:
1LICMS300151
Demonstration Program Title:
Money Follows the Person

FMAP

Please express FMAP as a decimal. (example: 68.32%=.6832)

	State FMAP	Enhanced FMAP
FFY 2007	0.6078	0.8039
FFY 2008	0.6056	0.8028
FFY 2009	0.5944	0.7972
FFY 2010	0.5944	0.7972
FFY 2011	0.5944	0.7972

Populations to be Transitioned (unduplicated count)

Unduplicated Count - Each individual is only counted once in the year that they physically transition.

All population counts and budget estimates are based on the Calendar Year (CY).

	Elderly	MR/DD	Physically Disabled	Mental Illness	Dual Diagnosis
CY 2007					
CY 2008	171	242	129	50	
CY 2009	171	419	129	50	
CY 2010	171	469	129	50	
CY 2011	171	469	129	50	
Total Count	684	1599	516	200	0
				Total of Populations	2999

Demonstration Budget

- Qualified HCBS Services, Demonstration HCBS Services and Supplemental Services are defined in the RFP.
- Administration - Normal - costs that adhere to CFR Title 42, Section 433(b)(7); Administrative - 75% - costs that adhere to CFR Title 42, Sections 433(b)(4) and 433(b)(10); Administrative - 90% - costs that adhere to CFR Title 42 Section 433(b)(3)
- Federal Evaluation Supports - costs related to administering the Quality of Life Survey (reimbursed @ \$100 per survey).
- Rebalancing Fund is a calculation devised by CMS to estimate the amount of State savings attributed to the Enhanced FMAP Rate that could be reinvested into rebalancing benchmarks.
- Other - Other costs reimbursed at a flat rate (to be determined by CMS)

Total Expenditures (2007 - 2011)	Rate	Total Costs	Federal	State
Qualified HCBS		0	0	0
Demonstration HCBS		107225258	85527267.29	21697990.71
Supplemental		0	0	0
Administrative - Normal		5170253	2585126.5	2585126.5

Administrative - 75%		0	0	0
Administrative - 90%		0	0	0
Federal Evaluation Supports		0	0	0
Other		0	0	0
State Evaluation		0	0	0
Total		112395511	88112393.79	24283117.21

- Per Capita Service Costs: 35753.671
- Per Capita Admin Costs: 1723.9923
- Rebalancing Fund:107225258

NOTE: Budget will be amended once Texas and CMS discuss and agree upon survey methodology.

CY 2007	Rate	Total Costs	Federal	State
Qualified HCBS	0.8039		0	0
Demonstration HCBS	0.8039		0	0
Supplemental	0.6078		0	0
Administrative - Normal	0.5	143401	71700.5	71700.5
Administrative - 75%	0.75		0	0
Administrative - 90%	0.9		0	0
Federal Evaluation Supports	1		0	0
Other	1		0	0
State Evaluation (if approved)	0.5		0	0
Total		143401	71700.5	71700.5

Actual Grant Award for CY	143401
Total Fed Costs	71700.5
Balance	71700.5
Award Request for next year	7407946.3
Total (Balance + Request)	7479646.8

CY 2008	Rate	Total Costs	Federal	State
Qualified HCBS	0.8028		0	0
Demonstration HCBS	0.8028	8444930	6779589.804	1665340.196
Supplemental	0.6056		0	0
Administrative - Normal	0.5	1256713	628356.5	628356.5
Administrative - 75%	0.75		0	0
Administrative - 90%	0.9		0	0
Federal Evaluation Supports	1		0	0
Other	1		0	0
State Evaluation (if approved)	0.5		0	0
Total		9701643	7407946.304	2293696.696

Actual Grant Award for CY	7407946.3
Total Fed Costs	7407946.3
Balance	0
Award Request for next year	
Total (Balance + Request)	0

CY 2009	Rate	Total Costs	Federal	State
Qualified HCBS	0.7972		0	0
Demonstration HCBS	0.7972	30580872	24379071.16	6201800.842
Supplemental	0.5944		0	0
Administrative - Normal	0.5	1256713	628356.5	628356.5
Administrative - 75%	0.75		0	0
Administrative - 90%	0.9		0	0
Federal Evaluation Supports	1		0	0
Other	1		0	0
State Evaluation (if approved)	0.5		0	0
Total		31837585	25007427.66	6830157.342

Actual Grant Award for CY	25007427.7
Total Fed Costs	25007427.7
Balance	0
Award Request for next year	
Total (Balance + Request)	0

CY 2010	Rate	Total Costs	Federal	State
Qualified HCBS	0.7972		0	0
Demonstration HCBS	0.7972	34099728	27184303.16	6915424.838
Supplemental	0.5944		0	0
Administrative - Normal	0.5	1256713	628356.5	628356.5
Administrative - 75%	0.75		0	0

Administrative - 90%	0.9		0	0
Federal Evaluation Supports	1		0	0
Other	1		0	0
State Evaluation (if approved)	0.5		0	0
Total		35356441	27812659.66	7543781.338

Actual Grant Award for CY	27812659.7
Total Fed Costs	27812659.7
Balance	0
Award Request for next year	
Total (Balance + Request)	0

CY 2011	Rate	Total Costs	Federal	State
Qualified HCBS	0.7972		0	0
Demonstration HCBS	0.7972	34099728	27184303.16	6915424.838
Supplemental	0.5944		0	0
Administrative - Normal	0.5	1256713	628356.5	628356.5
Administrative - 75%	0.75		0	0
Administrative - 90%	0.9		0	0
Federal Evaluation Supports	1		0	0
Other	1		0	0
State Evaluation (if approved)	0.5		0	0
Total		35356441	27812659.66	7543781.338

Actual Grant Award for CY	27812659.7
Total Fed Costs	27812659.7
Balance	0
Award Request for next year	
Total (Balance + Request)	0

Appendix J – CLASS MFP Quality Management Strategy

The following acronyms are used in the attached quality management strategies:

- ANE - Abuse, Neglect, and Exploitation
- A&I - DADS Access and Intake Division
- CDSA - Consumer Directed Service Agency
- CFO - Chief Financial Officer
- CMS - Centers for Medicare and Medicaid Services
- DADS - Department of Aging and Disability Services
- DMFM - Discovery Method and Frequency of Measurement
- EQRO - External Quality Review Organization
- HCSSA - Home and Community Support Services Agency
- HHSC - Health and Human Services Commission
- ICF/MR - Intermediate Care Facility for Persons with Mental Retardation
- ISP - Individual Service Plan
- LAR - Legally Authorized Representative
- LOC - Level of Care
- MCO - Managed Care Organization
- MMIS - Medicaid Management Information System
- MN - Medical Necessity
- NF - Nursing Facility
- P/F - Provider/Facility
- PS - DADS Provider Services Division
- QAI - DADS Quality Assurance and Improvement Office
- RE - Responsible Entity
- RS - DADS Regulatory Services Division
- PS - DADS Provider Services Division
- TMHP - Texas Medicaid and Healthcare Partnership

Quality Focus Area 1 - Level of Care and Participant Access

Following the acceptance of an offer of CLASS Program services by an applicant or his/her LAR or family, a CLASS provider case manager and registered nurse collect documentation of the individual's eligibility for an ICF/MR Level of Care (LOC) VIII and perform necessary assessments to complete the LOC form. For an initial LOC determination the case manager must submit supporting medical documentation establishing the presence of a related condition. DADS staff must approve or deny the level of care submitted. A new LOC must be completed and submitted annually along with the annual renewal of a participant's ISP.

Assurance 1.1: An evaluation of level of care (LOC) is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

Quality Indicator (QI): Percent of initial LOCs reviewed by DADS.

Responsible Entity (RE): Provider Services (PS).

Discovery Method and Frequency of Measurement (DMFM): CLASS Desk review, on-going.

Assurance 1.2: Enrolled participants are reevaluated at least annually or as specified in its approved waiver.

QI: PS reviews 100 percent of LOCs at least annually.

RE: DADS Provider Services (PS).

DMFM: CLASS Desk Review, on-going.

Assurance 1.3: The process and instruments described in the approved waiver are applied to determine LOC.

QI: Percent of time the LOC is determined using instruments described in the approved waiver, including one of the waiver-approved adaptive behavior instruments.

RE: DADS, CLASS provider.
DMFM: CLASS Desk Review, on-going.

Assurance 1.4: The State monitors LOC decisions and takes action to address inappropriate LOC determinations.

QI: Number of LOC determinations found to be incorrect when challenged by, or on behalf of, the applicant/participant.

RE: PS
DMFM: CLASS Desk Review.

Quality Focus Area 2 - Individual Service Plan (ISP)

CLASS provider agency case managers facilitate individual service planning. ISPs are developed using a person-directed planning process. The case manager convenes a service planning team that must also include the individual or the individual's LAR, the provider agency nurse or program director, a direct care worker, and, at the invitation of the individual or LAR, other individuals important to developing the service plan such as providers of non-waiver services and family or friends. The case manager is responsible for assuring the plan is reviewed at least quarterly and revised at least annually or whenever indicated by changes in the individual's service needs.

Assurance 2.1: Individual Service Plans (ISP) address participant's assessed needs and personal goals, either by waiver service or through alternate resources.

QI 2.1.1: Percent of ISPs that are signed by an individual, individual's family or LAR.

RE: DADS PS,
DMFM: CLASS Desk Review, P/F Monitoring reviews, annually.

QI 2.1.2: Percent of initial and annual ISPs submitted with justification of services.

RE: PS.
DMFM: CLASS Desk Review, P/F monitoring reviews, at initial enrollment, annually.

QI 2.1.3: Individual Service Plans (ISP) address participant's assessed needs and personal goals, either by waiver services or through alternate resources.

RE: PS. QI: Identified service changes on ISP amendments are submitted along with justification for changes.
DMFM: P/F monitoring review, annually.

Assurance 2.2: The State monitors ISP development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in the development of ISPs.

QI2.2.1: Percent of on-site program provider reviews that include monitoring of compliance with policies and procedures concerning ISP development.

RE: PS.
DMFM: P/F monitoring reviews, annually.

QI 2.2.2: Percent of program providers required to submit corrective action plans to correct non-compliance with policies and procedures concerning ISP development.

RE: PS.
DMFM: P/F monitoring reviews, annually

QI 2.2.3: Percent of respondents reporting that case managers asked about their preferences;

RE: Quality Assurance and Improvement (QA & I).
DMFM: NCI Survey, biennially.

Assurance 2.3: ISPs are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

QI 2.3.1: Percent of program providers required to submit corrective action plans to correct non-compliance with policies and procedures concerning ISP updates or revision.

RE: PS.
DMFM: P/F monitoring review, annually.

QI 2.3.2: Percent of respondents reporting that "needed" services were available.

RE: QAI.
DMFM: NCI Survey, biennially.

Assurance 2.4: Services are specified by type, amount, duration, scope, and frequency and are delivered in accordance with the service plan.

QI: Percent of monitored providers who provide all CLASS service components authorized in an individual's ISP.

RE: DADS PS.
DMFM: P/F monitoring review, annually.

Assurance 2 5: Participants are afforded choice: 1) between waiver services and institutional care and 2) between/among waiver services and providers.

QI: Percent of individuals' records evidencing individuals are afforded choice between waiver services and institutional care.

RE: PS.
DMFM: CLASS Desk Review, annually.

Quality Focus Area 3 - Qualified Providers

During P/F monitoring reviews and licensure reviews of CLASS Program providers, DADS staff sample personnel records to verify that all minimum provider qualifications are met and required training has been accomplished.

Assurance 3.1: The State verifies, on a periodic basis, that providers meet required licensing and/or certification standards and adhere to other state standards prior to furnishing waiver services.

QI: Percent of monitored/surveyed program providers that maintain HCSSA licensure.

RE: PS, Regulatory Services (RS).
DMFM: P/F monitoring reviews, annually and Licensure Surveys, every 3 years (HCSSA).

Assurance 3.2: The State verifies on a periodic basis that providers continue to meet required licensure and/or certification standards and/or adhere to other state standards.

QI: Percent of monitored/surveyed program providers that assure that personnel who provide services to individuals are qualified by licensing, certification, and State regulations.

RE: PS, RS.
DMFM: P/F monitoring reviews, annually.

Assurance 3.3: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

QI: Percent of monitored program providers who provide evidence that non-licensed providers of waiver services meet minimum background and training qualifications.

RE: PS, RS.
DMFM: P/F monitoring reviews, annually and CDSA Reviews, biennially.

Assurance 3.4: The State identifies and remediates situations where providers do not meet requirements.

QI: Percent of on-site program provider reviews resulting in required corrective action to address non-compliance with requirements related to provider qualifications.

RE: PS.
DMFM: P/F monitoring reviews, annually and CDSA Reviews, biennially.

Assurance 3.5: The State implements its policies and procedures for verifying that training is provided in accordance with state requirements and the approved waiver.

QI: Percent of accepted corrective action plans addressing non-compliance with training and qualifications of providers.

RE: PS.
DMFM: P/F monitoring reviews, annually.

Quality Focus Area 4 - Health and Welfare - Participant Safeguards

DFPS is responsible for investigating allegations of abuse, neglect, or exploitation of individuals enrolled in the CLASS Program. In accordance with state law, DADS maintains an Employee Misconduct Registry that includes the names of persons confirmed to have abused, neglected, or exploited an individual receiving services. In addition, in accordance with federal law, DADS 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. CLASS providers must consult these registries prior to offering employment to a non-licensed service provider and refrain from employing that person if either registry indicates the person was confirmed to have abused, neglected, or exploited an individual receiving services. State law prohibits program providers from employing a person whose criminal background indicates the person has been convicted of certain felonies. Program providers are required to complete pre-employment criminal background checks for each non-licensed applicant that will provide services to an individual enrolled in the CLASS Program.

Each CLASS provider agency is required to keep a log of complaints and complaint resolutions which will be monitored during on-site reviews by DADS' staff.

Assurance 4.1: There is continuous monitoring of the health and welfare of waiver participants and remediation actions are initiated when appropriate.

QI 4.1.1: Percent of program providers required to submit plans of correction related to health, safety, or welfare.

RE: PS.
DMFM: P/F monitoring reviews; annually.

QI 4.1.2: Percent of program providers whose plans of correction related to health, safety, or welfare were accepted.

RE: PS.
DMFM: P/F monitoring reviews, annually.

QI 4.1.3: Percent of program providers whose licenses were terminated due to non-compliance with requirements related to health and welfare.

DMFM: P/F monitoring reviews, annually.

Assurance 4.2: The State, on an on-going basis, identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation (ANE).

QI 4.2.1: Percent of program providers whose licenses were terminated due to non-compliance with requirements related to criminal background and registry checks.

RE: PS, RS.
DMFM: P/F monitoring reviews, annually; CDSA Reviews, biennially; and Licensure Surveys, every three years.

QI 4.2.2: Percent of providers presenting evidence that required criminal history and registry checks are performed in compliance with state requirements.

RE: PS, RS.
DMFM: P/F monitoring reviews, annually; CDSA Reviews, biennially; and Licensure Surveys, every three years.

QI 4.2.3: Percent of providers presenting evidence that participants are informed orally and in writing of process for filing complaints including processes for reporting ANE.

RE: PS, RS.
DMFM: P/F monitoring reviews, annually; CDSA Reviews, biennially; and Licensure Surveys, every three years (HCSSA).

Quality Focus Area 5 - Administrative Authority and Fiscal System Performance

In accordance with 42 CFR §431.10 (e), HHSC is the single state Medicaid agency and retains administrative authority over the waiver program. The initial waiver, subsequent amendments, CMS 372 reports and all state rules for waiver program operations are subject to the review and approval/disapproval of the Commission. Additionally, HHSC long-term care Medicaid staff is actively involved in the development of quality assurance activities at DADS. In September 2004, HHSC staff convened a meeting of senior staff at DADS to initiate base-lining and evaluation activities in regard to the new CMS waiver guidelines. At that meeting, HHSC staff presented the new CMS guidelines and related quality assurance information along with the direction that the operating agency review the new requirements and develop strategies to accomplish the required results. Since that time, HHSC and DADS staff have held regular status and update meetings directed at evaluating current quality systems and identifying and prioritizing enhancements. These meetings have resulted in plans to: enhance data reporting to HHSC; base-line current activities using the CMS sponsored waiver review matrix developed by the Muskie School of Public Service; to initiate joint on-site reviews of program providers; and evaluate the development of a quality management strategy that spans more than one waiver and potentially other types of long-term care services. HHSC's involvement and oversight in the development of enhanced waiver quality assurance mechanisms under the new CMS guidelines will assure HHSC oversight of all areas of waiver operations.

Assurance 5: The Medicaid agency or operating agency conducts routine, ongoing oversight of the waiver program.

QI 5.1: The operating agreement identifying policy-setting and oversight responsibilities is on file.

RE: DADS, HHSC.
DMFM: State Medicaid Agency Review, on-going.

QI 5.2: The operating agreement is reviewed for updates.

RE: HHSC.
DMFM: State Medicaid Agency Review, annually

QI 5.3: The operating agreement is current.

RE: HHSC.
DMFM: State Medicaid Agency Review, at least annually.

QI 5.4: The need to update operating agreements is identified.

RE: HHSC.
DMFM: State Medicaid Agency Review, on-going.

QI 5.5: The operating agreement has been updated. The operating agreement is under review by State Medicaid Agency legal staff. Elements of the new waiver process as well as name changes of the agencies under recent state law are being considered for inclusion in the update.

RE: HHSC.
DMFM: HHSC, on-going.

QI-6: The State Medicaid Agency monitors implementation of the agreement to assure provisions are executed.

RE: HHSC.
DMFM: Review of actions taken under the State Medicaid Agency's administrative authority, on-going.

QI-7: The operating agency reports the results of its monitoring activities to the State Medicaid Agency.

RE: HHSC and DADS.
DMFM: Review of reports by State Medicaid Agency, on-going.

QI-8: The operating agency submits the results of its monitoring to the State Medicaid Agency annually via the CMS 372 report.

RE: DADS.
DMFM: Review of 372s submitted, annually.

6. Financial Accountability

Program providers enter billing claims into the Claims Management System, which assigns the correct reimbursement rate associated with the billing code entered by a program provider. The Claims Management System automatically rejects any claim that is entered with an unauthorized billing code or for a service not included in a participant's authorized ISP. On a monthly basis, Provider Services Contracts tracks the money recouped due to percent of correctly coded claims reimbursed according to reimbursement methodology billing errors.

Assurance 6: Participant claims are coded and paid according to the waiver reimbursement methodology.

QI-6.1: Percent of correctly coded claims reimbursed according to reimbursement methodology.

RE: PS.

DMFM: Claims Management System, on-going.

QI-6.2: Codes used to bill participant claims are appropriate for the service provided.

RE: DADS.

DMFM: Amount of dollars recouped from providers as a result of P/F reviews when claims for services to participants were found in error due to incorrect coding.

RE: PS.

DMFM: P/F Monitoring reviews, annually.

Appendix K – Consolidated Waiver Program MFP Quality Management Strategy

The following acronyms are used in the attached quality management strategies:

- ANE - Abuse, Neglect, and Exploitation
- A&I - DADS Access and Intake Division
- CDSA - Consumer Directed Service Agency
- CFO - Chief Financial Officer
- CMS - Centers for Medicare and Medicaid Services
- DADS - Department of Aging and Disability Services
- DMFM - Discovery Method and Frequency of Measurement
- EQRO - External Quality Review Organization
- HCSSA - Home and Community Support Services Agency
- HHSC - Health and Human Services Commission
- ICF/MR - Intermediate Care Facility for Persons with Mental Retardation
- ISP - Individual Service Plan
- LAR - Legally Authorized Representative
- LOC - Level of Care
- MCO - Managed Care Organization
- MMIS - Medicaid Management Information System
- MN - Medical Necessity
- NF - Nursing Facility
- P/F - Provider/Facility
- PS - DADS Provider Services Division
- QAI - DADS Quality Assurance and Improvement Office
- RE - Responsible Entity
- RS - DADS Regulatory Services Division
- PS- DADS Provider Services Division
- TMHP - Texas Medicaid and Healthcare Partnership
- Quality Focus Area 1 - Level of Care (LOC) and Participant Access

Desired Outcome: Participants have access to home and community-based services and supports in their community. Following the acceptance of an offer of CWP Waiver Program services by a participant or his/her legally authorized representative (LAR) or family, a HCSSA documents the participant's eligibility and completes the assessment form. For the NF waiver, the HCSSA must complete and submit the form electronically to the Texas Medicaid and Healthcare Partnership (TMHP), DADS MMIS agent, who determines the participant's level of care (LOC). For the ICF/MR waiver, the HCSSA submits the form to DADS staff, who approve or deny the LOC. Enrollment in CWP is prohibited without an approved LOC. A renewal of a participant's service plan is also prohibited if the Participant's LOC is not current.

Assurance 1 1.1: An evaluation of level of care (LOC) is provided to all applicants for whom there is a reasonable indication that services may be needed in the future.

Quality Indicator (QI): Percent of initial LOCs reviewed.

Responsible Entity (RE): NF: TMHP; ICF/MR: DADS - PS
Discovery Method and Frequency of Measurement (DMFM): NF: TMHP's Long Term Care Portal (electronic system); ICF/MR: manually by DADS PS staff, Ongoing

Assurance 1.2: Enrolled participants are reevaluated at least annually or as specified in its approved waiver.

QI: 100 percent of LOCs are reviewed.

RE: NF: TMHP; ICF/MR: DADS - PS
DMFM: NF: TMHP's Long Term Care Portal (electronic system); ICF/MR: manually by DADS PS staff, Ongoing

Assurance 1.3: The process and instruments described in the approved waiver are applied to determine LOC.

QI: Percent of time the assessment form is used to determine LOC.

RE: NF: TMHP; ICF/MR: DADS - PS
DMFM: NF: TMHP's Long Term Care Portal (electronic system); ICF/MR: manually by DADS PS staff, Ongoing

Assurance 1.4: The State monitors LOC decisions and takes action to address inappropriate LOC determinations.

QI: Percent of LOC determinations found to be incorrect, when challenged.

RE: NF: TMHP; ICF/MR: DADS – PS
Discovery Method and Frequency of Measurement: NF: DADS A&I; ICF/MR: DADS PS staff, Ongoing

Assurance 1.5: Information and Referral: Participants and families can readily obtain information concerning the availability of services, how to apply.

QI: Percent of participants indicating satisfaction with information provided regarding availability of services and how to apply.

RE: DADS-QAI; DMFM: PES Survey, biennially;

Assurance 1.6: Intake and eligibility determination processes are understandable and user friendly.

QI: Percent of participants who felt the determination process was understandable and user friendly.

Responsible Entity: DADSQAI; DMFM: PES Survey, biennially;

Assurance 1.7 Services are initiated promptly when the applicant is determined eligible and selects services.

QI: Percent of service plans that are initiated within one month of plan authorization.

RE: DADS-QAI;.
DMFM: QAI Data Mart – Quarterly;

Quality Focus Area 2–Individual Service Plan

Desired Outcome: Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community. The HCSSA facilitates individual service planning. Service plans (plans of care) are developed using a person-directed planning process. The HCSSA coordinator convenes a service planning team that must include the participant and the participant's legally authorized representative (LAR) and, at the invitation of the participant or LAR, other individuals important in developing the service plan such as providers of waiver or non-waiver services and family or friends. The HCSSA is responsible for assuring the plan is reviewed and revised at least annually and whenever indicated by changes in the participant's service needs.

Assurance 2.1: Plans of Care address all participant's assessed needs (including health and welfare risk factors) and personal goals, either by type of service or other means.

QI: Percent of participant records evidencing that the HCSSA initiates, coordinates, and facilitates the person-directed planning process to meet the desires and needs as identified by the participant and LAR;

QI: Percent of providers presenting evidence that a participant, participant's family or LAR participated in the development of support methodologies to address outcomes identified through the person-directed planning process.

RE: DADS-A&I, DADS-RS; HCSSA

DMFM: On-Site HCSSA Review, DADS-RS completes during the first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter, DADS-A&I completes by the 11th month of first year of the contract period and then every 24 months thereafter; HCSSA Quality Assessment and Performance Improvement (QAPI) program.

Assurance 2.2: The State monitors service plan development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in the development of service plans.

QI: Percent of participants whose service plan evidences development of the service plan in accordance with State policy and procedure; Percent of people reporting that case managers asked about their preferences.

RE: DADS-A&I, DADS-RS; DADS-QAI; HCSSA.

DMFM: On-Site HCSSA Review, DADS-RS completes during the first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter, DADS-A&I completes by the 11th month of first year of the contract period and then every 24 months thereafter; HCSSA QAPI program, annually; PES Survey, every other year (biennially).

Assurance 2.3: Service plans are updated/revised when warranted by changes in the waiver participant's needs.

QI: Percent of participant records evidencing updated/revised service plan when participant needs warrant changes.

Responsible Entity: DADS-A&I; DADS-RS.

DMFM: On-Site HCSSA Review, DADS-RS completes during the first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter, DADS-A&I completes by the 11th month of first year of the contract period and then every 24 months thereafter.

Assurance 2.4: Services are specified by type, amount, duration, scope, and frequency and are delivered in accordance with the service plan.

QI: Percent of service plans that provide all program components authorized in a participant's service plan; Percent of people reporting that "needed" services were available.

RE: DADS-A&I; DADS-RS, and DADS-QAI.

DMFM: On-Site HCSSA Review, DADS-RS completes during the first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter, DADS-A&I completes by the 11th month of first year of the contract period and then every 24 months thereafter; PES Survey, every other year (biennially)

Assurance 2.5: Participants are afforded choice:1) between waiver services and institutional care and 2) between/among waiver services and providers.

QI: Percent of participants or LARs that were given choice between waiver services and institutional care;

QI: Percent of providers who employ/contract with a service provider of the participant's or LARs choice if that service provider is qualified.

QI: Percent of providers who inform the participant or LAR of provider's obligation to assist and cooperate with the participant's or LARs request to transfer to another CWP Waiver Program provider.

RE: DADS-A&I, DADS-RS, HCSSA.

DMFM: On-Site HCSSA Review, DADS-RS completes during the first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter, DADS-A&I completes by the 11th month of first year of the contract period and then every 24 months thereafter; HCSSA QAPI program, annually; On-site Provider Review, annually.

Assurance 2.6: Participants have the authority and are supported to direct and manage their own services to the extent they wish.

QI: Percent of participants who are offered the ability to manage their own services; Percent of participants who choose to manage their own services.

RE: DADS-A&I

DMFM: On-Site HCSSA Review, DADS-A&I completes by the 11th month of first year of the contract period and then every 24 months thereafter; HCSSA QAPI program, annually; SAS System, Ongoing

Assurance 2.7: Ongoing Monitoring: Regular, systematic and objective methods – including obtaining the participant’s feedback – are used to monitor the participant’s well being, health status, and effectiveness of the service in enabling the individual to achieve his or her personal goals.

QI: Percent of participants surveyed who report satisfaction with their services and supports in terms of addressing health and well being, and enabling the participant to achieve his or her personal goals.

RE: DADS-QAI

DMFM: PES Survey biennially; Long Term Services and Supports Quality Review of CWP Program, biennially

Quality Focus Area 3-Qualified Providers - Capacity and Capabilities

Desired Outcome: There are sufficient service providers and they possess and demonstrate the capability to effectively serve participants. During on-site reviews of CWP providers, DADS staff sample personnel records to verify that all minimum provider qualifications are met and required training has been accomplished.

Assurance 3.1: The State verifies, on a periodic basis, that providers meet required licensing standards, contract requirements and adhere to other State standards.

QI: Percent of providers that are qualified by licensing, certification, or State regulations; percent of providers meeting HCSSA licensure requirements.

RE: DADS-RS, PS

DMFM: On-site provider Reviews, annually for ALFs; On-site HCSSA Reviews, DADS-RS completes during the first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter.

Assurance 3.2: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

QI: Percent of providers of waiver services meet minimum background/training qualifications; Percent of providers meeting HCSSA licensure requirements.

RE: DADS A&I

DMFM: On-site provider contract monitoring

Assurance 3.3: The State identifies and rectifies situations where providers do not meet requirements.

QI: Percent of provider reviews resulting in required corrective action to address non-compliance with requirements related to provider qualifications.

RE: DADS-RS, A&I;

DMFM: On-site provider Reviews, annually for ALFs, during the first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter for HCSSAs; On-site monitoring reviews, every 24 months (biennially)

Assurance 3.4: The State implements its policies and procedures for verifying that training is provided in accordance with state requirements and the approved program requirements.

QI: Percent of on-site reviews that include review of evidence that providers are qualified and trained as required by state rules and the waiver; Percent of on-site reviews of HCSSAs that include review of evidence that providers are qualified and trained as required by State rules.

RE: DADS-RS; DADS-A&I;

DMFM: On-site provider reviews, annually; On Site HCSSA Reviews, DADS-RS completes during the first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter, DADS-A&I completes by the 11th month of first year of the contract period and then every 24 months thereafter.

Quality Focus Area 4-Health and Welfare - Participant Safeguards

Desired Outcome: Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices. DFPS is statutorily responsible for investigating allegations of abuse, neglect, or exploitation of participants enrolled in the CWP Waiver Program. DFPS forwards to DADS a report of each of its investigations along with its determination that the allegation was confirmed or not confirmed or that results of the investigation were inconclusive. In accordance with state law, DADS maintains an Employee Misconduct Registry

that includes the names of persons DADS or DFPS has confirmed to have abused, neglected, or exploited a participant receiving services through a Home and Community-based Services Waiver Program. In addition, in accordance with federal law, DADS maintains a Nurse Aide Registry (NAR) that lists certified nurse aides. The NAR indicates if an aide has been confirmed to have abused, neglected, or exploited a resident of a licensed NF. 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 a participant. Texas state law prohibits providers from employing a person whose criminal background indicates the person has been convicted of certain felonies. Providers are required to complete pre-employment criminal background checks for each non-licensed applicant that will provide services to a participant enrolled in the CWP Waiver Program.

Assurance 4.1: The State, on an ongoing basis, identifies and addresses and seeks to prevent instances of abuse, neglect and exploitation.

QI: Percent of providers demonstrating that personnel are trained and knowledgeable of acts constituting ANE, the requirements to report allegations of ANE, and methods to prevent ANE;

QI: Percent of providers that comply with the requirement to not employ service providers ineligible due to information contained within criminal history checks, the nurse-aide registry or the employee misconduct registry

RE: DADS-RS; A&I.

DMFM: On-Site provider reviews, annually for ALFs, DADS-RS completes during the first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter, DADS-A&I completes by the 11th month of first year of the contract period and then every 24 months thereafter; On-site monitoring reviews, every 24 months (biennially)

Assurance 4.2: The State, on an ongoing basis, identifies and addresses and seeks to prevent instances of abuse, neglect and exploitation.

QI: Percent of providers that inform all participants and participants' families or LARs, instruct staff, and follow requirements in regard to ANE;

QI: Percent of providers that, upon confirmation of ANE by DFPS, take appropriate action to prevent recurrence of ANE;

QI: DADS staff reviews all reports of findings of ANE investigations and, if corrective action on the part of a waiver provider is warranted, follow up is conducted by DADS staff.

QI: Percent of providers reporting critical incidents monthly;

QI: Percent of participant records reviewed evidencing the participant or LAR was informed orally and in writing of the process for filing complaints about service coordination, waiver service provision, and complaints about ANE;

QI: Percent of complaints addressed by DADS.

RE: DADS-RS, A&I, and DADS-CRS.

DMFM: On-site provider Reviews, annually for ALFs, for HCSSAs, DADS-RS completes during the first year of operation, approximately 18 months after the initial survey and at least every 36 months thereafter, DADS-A&I completes by the 11th month of first year of the contract period and then every 24 months thereafter; On-site monitoring reviews, Every 24 months (biennially); Allegations of ANE Review, Ongoing; SAS System: Critical Incident Reporting subsystem, Monthly; DADS-CRS complaint data base – Ongoing.

QI: Percent of assisted living providers that comply with safeguards related to the use of restrictive interventions; Percent of complaints related to restrictive interventions.

RE: DADS-RS

DMFM: On-site program provider review – annually; HCSSA Complaint Log.

Quality Focus Area 5 - Administrative Authority and Fiscal System Performance

Desired Outcome - Administrative: The system supports participants efficiently and effectively and constantly strives to improve quality. In accordance with 42 CFR §431.10 (e), HHSC is the single state Medicaid agency and retains administrative authority over the waiver program. The initial waiver, subsequent amendments, CMS 372 reports and all state rules for waiver program operations are subject to the review and approval/disapproval of the commission.

Desired Outcome - Financial Accountability: Program providers enter billing claims into the MMIS billing system, which assigns the correct reimbursement rate associated with the billing code entered by a program provider. The

MMIS billing system automatically rejects any claim that is entered with an unauthorized billing code or for a service not included in a participant's authorized service plan.

Assurance 5.1: The Medicaid agency or operating agency conducts routine, ongoing oversight of the waiver program.

QI: The operating agreement identifying policy-setting and oversight responsibilities is on file.

RE: HHSC.

DMFM: Review by State Medicaid Agency, ongoing.

QI: The operating agreement is reviewed for updates.

RE: HHSC.

DMFM: Review by State Medicaid Agency, ongoing.

QI: The need to update operating agreements is identified.

RE: HHSC.

DMFM: Review by State Medicaid Agency, ongoing.

QI: The operating agreement has been updated.

RE: HHSC.

DMFM: Review by State Medicaid Agency, ongoing.

QI: The operating agreement is current.

RE: HHSC

DMFM: Annual review by State Medicaid Agency.

QI: The operating agency reports the results of its monitoring activities to the State Medicaid Agency.

RE: HHSC

DMFM: Review of actions taken under the State Medicaid Agency's administrative authority.

QI: The operating agency submits the results of its monitoring to the State Medicaid Agency annually via the CMS 372 report.

RE: HHSC

DMFM: Review of reports by the State Medicaid Agency, Review of the 372s submitted

Assurance 5.2: Consumer claims are coded and paid according to the waiver reimbursement methodology.

QI: Percent of correctly coded claims reimbursed according to reimbursement methodology.

RE: DADS-CFO

DMFM: Provider Claims System, Ongoing

Assurance 5.3: Codes used to bill participant claims are appropriate for the service provided.

QI: Percent of dollars reimbursed for services provided to a participant that are correctly coded.

RE: DADS-CFO, DADS A&I.

DMFM: On Site Billing and Payment Reviews, Biannually; On-Site HCSSA Contract Monitoring Reviews, annually; Desk reviews of requests for adaptive aids, minor home modifications and dental services, Ongoing System Performance

Assurance 5.4: The service system promotes the effective and efficient provision of services and supports by engaging in a systematic data collection and analysis of program performance and impact.

QI: Percent of accurate prior authorization of services.

RE: DADS QAI.

DMFM: QAI Data Mart, Quarterly.

QI: Percent of service utilization based on service plan and actual service utilized.

RE: DADS QAI

DMFM: QAI Data Mart, annually at a minimum

QI: There is a systemic approach to the continuous improvement of quality in the provision of services.

RE: DADS QAI.
DMFM: NCI Survey, biennially.

QI: Per Capita costs.

RE: DADS QAI
DMFM: QAI Data Mart, annually at a minimum

Appendix L – Star+Plus MFP Quality Management Strategy

The following acronyms are used in the attached quality management strategies:

- ANE - Abuse, Neglect, and Exploitation
- A&I - DADS Access and Intake Division
- CDSA - Consumer Directed Service Agency
- CFO - Chief Financial Officer
- CMS - Centers for Medicare and Medicaid Services
- DADS - Department of Aging and Disability Services
- DMFM - Discovery Method and Frequency of Measurement
- EQRO - External Quality Review Organization
- HCSSA - Home and Community Support Services Agency
- HHSC - Health and Human Services Commission
- ICF/MR - Intermediate Care Facility for Persons with Mental Retardation
- ISP - Individual Service Plan
- LAR - Legally Authorized Representative
- LOC - Level of Care
- MCO - Managed Care Organization
- MMIS - Medicaid Management Information System
- MN - Medical Necessity
- NF - Nursing Facility
- P/F - Provider/Facility
- PS - DADS Provider Services Division
- QAI - DADS Quality Assurance and Improvement Office
- RE - Responsible Entity
- RS - DADS Regulatory Services Division
- PS - DADS Provider Services Division
- TMHP - Texas Medicaid and Healthcare Partnership

Quality Focus Area 1 – Level of Care (LOC) and Participant Access

Desired Outcome: Participants have access to home and community-based services and supports in their community. Following the acceptance of an offer of Star+PLUS Program services by a participant or his/her legally authorized representative (LAR) or family member, a Managed Care Organization (MCO) collects documentation of the participant's eligibility for Level of Care I and completes the Assessment form. The MCO must complete and submit the form electronically to SPSU. SPSU staff approve or deny the level of care submitted. The SAS System prohibits the completion of a participant's enrollment without an approved level of care. The system also prohibits the renewal of a participant's plan of care if the participant's level of care is not current.

Assurance 1.1: An evaluation of level of care (LOC) is provided to all applicants for whom there is a reasonable indication that services may be needed in the future.

QI: Percent of initial LOC's reviewed by HHSC/HPO.

DMFM: SAS system
RE: HHSC/HPO

Assurance 1.2: Enrolled participants are reevaluated at least annually or as specified in its approved waiver.

AI: 100 percent of LOC's are reviewed.

DMFM: SAS system
HHSC/HPO

Assurance 1.3: The process and instruments described in the approved waiver are applied to determine LOC.

QI: Percent of time the assessment Form (2652A), as prescribed in Appendix D, is used to determine LOC.

DMFM: SAS system
RE: HHSC/HPO

Assurance 1.4: The state monitors level of care decisions and takes action to address inappropriate level of care determinations.

QI: Percent of LOC determinations found to be incorrect, when challenged.

DMFM: HHSC/HPO approval of LOC - ongoing
RE: HHSC/HPO

Assurance 1.5: Information and Referral; Participants and families can readily obtain information concerning the availability of services, how to apply.

QI: Percent of participants indicating satisfaction with information provided regarding availability of services and how to apply.

DMFM: EQRO, annually
RE: HHSC/HPO

Assurance 1.6: User Friendly Process; Intake and eligibility determination processes are understandable and user friendly.

QI: Percent of participants who felt the determination process was understandable and user friendly.

DMFM: Annual Survey
RE: HHSC/HPO

Assurance 1.7: Prompt Initiation; Services are initiated promptly when the applicant is determined eligible and selects services.

QI: Percent of POC's that are initiated within one month of plan authorization.

DMFM: Annual Reviews
RE: HHSC/HPO

Quality Focus Area 2 – Plan of Care and Participant-Centered Service Planning

Desired Outcome: Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community. The MCO facilitates individual service planning. Service plans (plans of care) are developed using a person-directed planning process. The MCO coordinator convenes a service planning team that must include the participant and the participant's legally authorized representative (LAR) and, at the invitation of the participant or LAR, other individuals important in developing the plan of care such as providers of waiver or non-waiver services and family or friends. The MCO is responsible for assuring the plan is reviewed and revised at least annually and whenever indicated by changes in the participant's service needs.

Assurance 2.1: Plans of Care address all participant's assessed needs (including health and safety risk factors) and personal goals, either by type of service or other means.

QI 1.1: Percent of participant records evidencing that the MCO initiates, coordinates, and facilitates the person-directed planning process to meet the desires and needs as identified by the participant and LAR.

QI 1.2: Percent of providers presenting evidence that an participant, participant's family or LAR participated in the development of support methodologies to address outcomes identified through the person-directed planning process.

DMFM: Annual on-site review
RE: HHSC/HPO

Assurance 2.2: The State monitors POC development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in the development of POCs. The State has the ability to monitor and review POCs on a daily basis.

QI 2.2.1: Percent of participants whose POC evidences development of the POC in accordance with State policy and procedure.

DMFM: Annual on-site review and at the time of any POC change.
RE: HHSC/HPO

AI 2.2.2: Percent of people reporting that service coordinators asked about their preferences.

DMFM: Annual Survey
RE: HHSC/HPO

Assurance 2.3: POCs are updated/revised when warranted by changes in the waiver participant's needs.

QI 2.3: Percent of participant records evidencing updated/revised POC when participant needs warrant changes.

RE: HHSC/HPO

Assurance 2.4: Services are specified by type, amount, duration, scope and frequency and are delivered in accordance with the POC.

QI 2.4.1: Percent of POC's that provide all program components authorized in a participant's POC.

QI 2.4.2: Percent of people reporting that "needed" services were available.

DMFM: Annual on-site MCO review
RE: HHSC/HPO

Assurance 2.5: Participants are afforded choice: 1) between waiver services and institutional care and 2) between/among waiver services and providers.

QI 2.5.1: Percent of participants or LARs that were given choice between waiver services and institutional care.

QI 2.5.2: Percent of providers who employ/contract with a service provider of the participant's or LARs choice if that service provider is qualified.

DMFM: Annual on-site review
RE: SAS System – Ongoing

Assurance 2.6: Participant Direction - Participants have the authority and are supported to direct and manage their own services to the extent they wish.

QI 2.6.1: Percent of participants who are offered the ability to manage their own services.

QI 2.6.2: Percent of participants who choose to manage their own services

DMFM: Annual on-site review,
RE: SAS System, HHSC/HPO

Assurance 2.7: Regular, systematic and objective methods – including obtaining the participant’s feedback – are used to monitor the participant’s well being, health status, and effectiveness of the service in enabling the individual to achieve his or her personal goals.

QI 2.7: Percent of participants surveyed who report satisfaction with their services and supports in terms of addressing health and well being, and enabling the participant to achieve his or her personal goals.

DMFM: Annual Survey
RE: HHSC/HPO

Quality Focus Area 3 - Qualified Providers - Capacity and Capabilities

Desired Outcome: There are sufficient service LTSS providers and they possess and demonstrate the capability to effectively serve participants. During on-site reviews of SPW Program providers, HHSC/HPO staff sample personnel records to verify that all minimum provider qualifications are met and required training has been accomplished.

Assurance 3.1: The State verifies, on a periodic basis, that providers meet required licensing and/or certification standards and adhere to other state standards.

QI: 3.1: Percent of providers that are qualified by licensing, certification, or state regulations.

QI 3.2: Percent of Providers meeting MCO requirements.

DMFM: On Site provider Reviews - annually
RE: HHSC/HPO

Assurance 3.2: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

QI: 3.2: Percent of providers of waiver services meet minimum background/training qualifications.

DMFM: On Site provider Reviews - Annually
RE: HHSC/HPO

Assurance 3.3: The State identifies and rectifies situations where providers do not meet requirements.

QI:3.3 Percent of provider reviews resulting in required corrective action to address non-compliance with requirements related to provider qualifications.

DMFM: On Site provider Reviews – Annually, On Site CDSA Reviews
RE: HHSC/HPO

Assurance 3.4: The state implements its policies and procedures for verifying that training is provided in accordance with state requirements and the approved program requirements.

QI 3.4: Percent of on-site reviews that include review of evidence that providers re qualified and trained as required by state rules and the waiver.

DMFM: On Site provider Reviews – Annually, Annual on-site MCO review.

Quality Focus Area 4 - Health and Welfare - Participant Safeguards

Desired Outcome: Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices. The Texas Department of Family and Protective Services (DFPS) is statutorily responsible for investigating allegations of abuse, neglect, or exploitation of elderly individuals and adults with disabilities, which may include participants enrolled in the Star+PLUS program. In accordance with state law, HHSC/HPO maintains an Employee Misconduct Registry that includes the names of persons HHSC/HPO has confirmed to have abused, neglected, or exploited a participant receiving services in a licensed ICF/MR or that DFPS has confirmed have committed ANE through a home and community-based services program, after due process has been completed. In addition, in accordance with federal law, HHSC/HPO 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 a participant receiving services. Texas state law prohibits providers and the MCO from employing a person whose criminal background indicates the person has been convicted of certain felonies. Providers and the MCO are required to complete pre-employment criminal background checks for each non-licensed applicant that will provide services to a participant enrolled in the Star+PLUS program.

Assurance 4.1: The state, on an ongoing basis, identifies and addresses and seeks to prevent instances of abuse, neglect and exploitation.

QI 4.1.1: Percent of providers demonstrating that personnel are trained and knowledgeable of acts constituting ANE, the requirements to report allegations of ANE, and methods to prevent ANE.

DMFM: On-Site Provider Reviews – Annually
RE: HHSC/HPO

QI 4.1.2: Percent of providers that comply with the requirement to not employ service providers ineligible due to information contained within criminal history checks, the nurse-aide registry or the employee misconduct registry.

DMFM: On Site provider Reviews – annually
RE: HHSC/HPO

QI 4.1.3: Percent of providers that inform all participants and participants' families or LARs, instruct staff, and follow requirements in regard to ANE.

QI 4.1.4: Percent of providers that, upon confirmation of ANE by DFPS, take appropriate action to prevent recurrence of ANE.

DMRM: Staff at HHSC/HPO reviews all reports of findings of ANE investigations and, if corrective action on the part of a waiver provider is warranted, follow up is conducted by HHSC/HPO staff.
RE: HHSC/HPO

QI 4.1.5: Percent of providers reporting critical incidents monthly.

DMFM: SAS System: Critical Incident Reporting subsystem
RE: HHSC/HPO

QI 4.1.6: Percent of participant records reviewed evidencing the participant or LAR was informed orally and in writing of the process for filing complaints about service coordination, waiver service provision, and complaints about ANE.

DMFM: Compliant review
RE: HHSC/HPO/Ombudsman

Assurance 4.2: Restrictive Interventions - Restrictive interventions - including chemical and physical restraints - are only used as a last resort and subject to rigorous oversight.

QI 4.2.1: Percent of assisted living providers that comply with safeguards related to the use of restrictive interventions.

QI 4.2.2: Percent of complaints related to restrictive interventions

DMFM: On-site program provider review – annually, HHSC/HPO Consumer Rights and Services complaint data base – ongoing, MCO Complaint Log, ongoing
RE: HHSC/HPO

Quality Focus Area 5 - Administrative and Fiscal System Performance

Desired Outcome: The system supports participants efficiently and effectively and constantly strives to improve quality. In accordance with 42 CFR §431.10 (e), Health and Human Services Commission is the single state Medicaid agency and retains administrative authority over the waiver program. The initial waiver, subsequent amendments, CMS 372 reports and all state rules for waiver program operations are subject to the review and approval/disapproval of the commission.

Assurance 5.1 - The Medicaid agency or operating agency conducts routine, ongoing oversight of the waiver program. The operating agreement identifying policy-setting and oversight responsibilities is on file.

QI 5.1.1: The Medicaid agency or operating agency conducts routine, ongoing oversight of the waiver program.

DMRM: State Medicaid Agency Review, Annually
RE: HHSC

QI 5.1.2: The operating agreement is current.

DMRM: State Medicaid Agency Review, Annually
RE: HHSC

QI 5.1.3: The operating agreement is reviewed for updates.

DMRM: State Medicaid Agency Review, Annually
RE: HHSC

QI 5.1.4: The operating agency reports the results of its monitoring activities to the State Medicaid Agency.

DMFM: Review of actions taken under the State Medicaid Agency's administrative authority, State Medicaid Agency Review, Annually
RE: HHSC

QI 5.1.5: The operating agency submits the results of its monitoring to the State Medicaid Agency annually via the CMS 372 report.

DMRM: Review of reports by the State Medicaid Agency.
RE: HHSC

Financial Accountability. Program providers enter billing claims into the MMIS billing system, which assigns the

correct reimbursement rate associated with the billing code entered by a program provider. The MMIS billing system automatically rejects any claim that is entered with an unauthorized billing code or for a service not included in a participant's authorized plan of care.

Assurance 5.2: Consumer claims are coded and paid according to the waiver reimbursement methodology.

QI 5.2.1: Percent of correctly coded claims reimbursed according to reimbursement methodology.

DMFM: Provider Claims System, on-going
RE: HHSC/HPO- CFO

Assurance 5.3: Codes used to bill participant claims are appropriate for the service provided.

QI 5.3: Percent of dollars reimbursed for services provided to a participant that are correctly coded.

DMFM: On Site Billing and Payment Reviews, desk reviews of request for adaptive aides, minor home modifications and dental services, Ongoing Systems Performance
RE: HHSC/HPO

Assurance 5.4: The service system promotes the effective and efficient provision of services and supports by engaging in a systematic data collection and analysis of program performance and impact.

QI 5.4.1: Percent of accurate prior authorization of services.

RE: HHSC/EQRO.
DMFM: EQRO, annually.

QI 5.4.2: Percent of service utilization based on service plan and actual service utilized.

RE: HHSC/EQRO
DMFM: EQRO, annually

Q 5.4.3: There is a systemic approach to the continuous improvement of quality in the provision of services.

RE: HHSC/EQRO.
DMFM: EQRO, annually.

QI 5.4.4: Per Capita costs.

RE: HHSC/EQRO
DMFM: EQRO, annually

Appendix M – Home and Community-Based Services MFP Quality Management Strategy

The following acronyms are used in the attached quality management strategies:

- ANE - Abuse, Neglect, and Exploitation
- A&I - DADS Access and Intake Division
- CDSA - Consumer Directed Service Agency
- CFO - Chief Financial Officer
- CMS - Centers for Medicare and Medicaid Services
- DADS - Department of Aging and Disability Services
- DMFM - Discovery Method and Frequency of Measurement
- EQRO - External Quality Review Organization
- HCSSA - Home and Community Support Services Agency
- HHSC - Health and Human Services Commission
- ICF/MR - Intermediate Care Facility for Persons with Mental Retardation
- ISP - Individual Service Plan
- LAR - Legally Authorized Representative
- LOC - Level of Care
- MCO - Managed Care Organization
- MMIS - Medicaid Management Information System
- MN - Medical Necessity
- NF - Nursing Facility
- P/F - Provider/Facility
- PS - DADS Provider Services Division
- QAI - DADS Quality Assurance and Improvement Office
- RE - Responsible Entity
- RS - DADS Regulatory Services Division
- PS - DADS Provider Services Division
- TMHP - Texas Medicaid and Healthcare Partnership

Quality Focus Area 1 – Level of Care and Participant Access

Desired Outcome: Individuals have access to home and community-based services and supports in their community.

Following the acceptance of an offer of HCS Program services by an individual or his/her legally authorized representative (LAR) or family, a local Mental Retardation Authority (MRA) collects documentation of the individual's eligibility for an ICF/MR Level of Care and completes the MR/RC Assessment form. The MRA must complete and submit the form electronically to DADS through the CARE System. DADS staff approves or denies the level of care submitted. The CARE System 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.

Responsible Entity	Focus Area	Quality Domain or Assurance	Quality Indicator	Discovery Method and Frequency of Measurement
DADS-A & I	Assurance 1	An evaluation of level of care (LOC) is provided to all applicants for whom there is a reasonable indication that services may be needed in the future.	Percent of initial LOCs reviewed by DADS.	CARE system Ongoing
DADS-A & I	Assurance 2	Enrolled participants are reevaluated at least annually or as specified in the approved waiver.	DADS reviews 100% of LOCs.	CARE system Ongoing
DADS-A & I	Assurance 3	The process and instruments described in the approved waiver are applied to determine LOC.	Percent of time the MR/RC Assessment Form, as contained in the approved waiver in Appendix D-3, is used to determine LOC. Percent of time persons performing level of care determinations meet the minimum qualifications specified in Appendix B-2.	CARE system Ongoing Supervisory Personnel Records
DADS-A & I	Assurance 4	The state monitors level of care decisions and takes action to address inappropriate level of care determinations.	Percent of LOC determinations found to be incorrect, when challenged by, or on behalf of, the applicant.	Secondary review by supervisory staff Ongoing
DADS-QAI	Assurance 5	Participants and families can readily obtain information concerning the availability of services, how to apply.	Percent of participants indicating satisfaction with information provided regarding availability of services and how to apply.	NCI Survey At minimum every three years
DADS-QAI	Assurance 6	Services are initiated promptly when the applicant is determined eligible and selects services.	Percent of service plans that are initiated within one month of plan authorization.	QAI Data Mart quarterly

Quality Focus Area 2 –Plan of Care and Participant-Centered Service Planning

Desired Outcome: Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his or her life in the community.

Service coordinators employed by an MRA facilitate individual service planning at the time of enrollment. The initial IPC is developed using a person-directed planning process. The service coordinator convenes a service planning team that must include the individual and, if applicable, the individual's legally authorized representative (LAR) and, at the invitation of the individual or LAR, other individuals important in developing the IPC such as providers of waiver or non-waiver services and family or friends. At the time of enrollment, the

individual or LAR chooses an HCS Program provider from all program providers serving their geographical area. This HCS Program provider assigns the individual a 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.

Responsible Entity	Focus Area	Quality Domain or Assurance	Quality Indicator	Discovery Method and Frequency of Measurement
DADS-RS and QAI staff	Assurance 1	Plans of Care address all participant's assessed needs (including health and safety risk factors) and personal goals, either by type of service or other means.	Percent of program provider reviews evidencing that the IPC reflects assessed needs and personal and family goals. Percent of people reporting that case managers asked about their preferences. Percent of program provider reviews that evidence compliance with safeguards related to the use of restrictive behavioral interventions. Percent of program provider reviews that evidence compliance with requirements concerning medication administration and monitoring and delegation of nursing tasks. Percent of program provider reviews that evidence compliance with requirements concerning maintenance of emergency plans.	On-site Certification Reviews Annually NCI Survey At minimum every three years On-site Certification Reviews annually On-site Certification Reviews Annually On-site Certification Reviews Annually
DADS-QAI	Assurance 2	Participants' preferences are taken into consideration during the service planning process.	Percent of people reporting that service coordinators/case managers asked about their preferences.	NCI Survey At minimum every three years
DADS-RS	Assurance 3	The State monitors IPC development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in the development of IPCs.	Percent of program provider reviews whose IPCs evidence development of the IPC in accordance with State policy and procedure.	On-site Program Provider Review Annually
DADS RS and QAI	Assurance 4	IPCs are updated/revised when warranted by changes in the waiver participant's needs.	Percent of program provider reviews evidencing updated or revised IPCs when individual needs warrant changes Percent of people reporting that "needed" services were available.	On-site Certification Reviews Annually NCI Survey At minimum every three years
DADS-RS	Assurance 5	Services are specified by type, amount, duration, scope and frequency and are delivered in accordance with the IPC.	Percent of program provider reviews that evidence that all program components authorized in an individual's IPC are provided.	On-site Program Provider Reviews Annually

Responsible Entity	Focus Area	Quality Domain or Assurance	Quality Indicator	Discovery Method and Frequency of Measurement
DADS RS, A&I	Assurance 6	Participants are afforded choice: 1) between waiver services and institutional care and 2) between/among waiver services and providers.	Percent of program provider reviews that evidence that the provider has informed the individual or LAR of the provider's obligation to assist and cooperate with the individual's or LAR's request to transfer to another HCS Program provider. Percent of individuals who receive an offer of HCS Program services by DADS who are afforded choice between waiver services and institutional care during program enrollment through the Verification of Freedom of Choice process..	On-site Certification Reviews Annually CARE System Ongoing
DADS-A & I			Percent of participants who choose to manage their own services.	CARE System Ongoing

Quality Focus Area 3 - Qualified Providers - Capacity and Capabilities

Desired Outcome: There are sufficient service providers and they possess and demonstrate the capability to effectively serve participants.

During initial on-site and annual certification reviews of HCS Program providers, DADS staff sample personnel records to verify that all minimum provider qualifications are met and required training has been accomplished.

Responsible Entity	Focus Area	Quality Domain or Assurance	Quality Indicator	Discovery Method and Frequency of Measurement
DADS-RS	Assurance 1	The State verifies, on a periodic basis, that providers meet required licensing and/or certification standards and adhere to other state standards.	Percent of program provider and CDSA reviews that evidence that service providers are qualified by licensing, certification, or state regulations.	On-site Program Provider Reviews Annually On-site CDSA Reviews biennially
DADS-RS	Assurance 2	The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.	Percent of program providers and CDSAs who have evidence that non-licensed providers of waiver services meet minimum background and training qualifications.	On-site Program Provider Reviews Annually On-site CDSA Reviews Biennially
DADS-RS	Assurance 3	The State identifies and rectifies situations where providers do not meet requirements.	Percent of program provider and CDSA reviews resulting in required corrective action to address non-compliance with	On-site Program Provider Reviews Annually

Responsible Entity	Focus Area	Quality Domain or Assurance	Quality Indicator	Discovery Method and Frequency of Measurement
			requirements related to provider qualifications.	On-site CDSA Reviews Biennially
DADS	Assurance 4	The state implements its policies and procedures for verifying that training is provided in accordance with state requirements and the approved program requirements.	Percent of on-site program provider and CDSA reviews that include review of evidence that service providers are qualified and trained as required by state rules and the waiver.	On-site Program Provider Reviews Annually On-site CDSA Reviews Biennially

Quality Focus Area 4 - Health and Welfare - Participant Safeguards

Desired Outcome: Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.

The Texas Department of Family and Protective Services (DFPS) is statutorily responsible for investigating allegations of abuse, neglect, or exploitation of individuals enrolled in the HCS Program. DFPS forwards to DADS a report of each of its investigations along with its determination that the allegation was confirmed or not confirmed or that results of the investigation were inconclusive.

In accordance with state law, DADS 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 from any of the following entities:

- in a licensed ICF/MR;
- Nursing facilities;
- Assisted living facilities;
- Adult foster care facilities;
- Adult day care facilities;
- Home and community support services agencies, which include hospice and home health agencies; and
- Persons exempt from licensing under the Health and Safety Code, §142.003(a)(19), which include Home and Community-based Services Program providers In addition, in accordance with federal law, DADS 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 and mental retardation authorities 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. Texas state law prohibits program providers and MRAs from employing a person whose criminal background indicates the person has been convicted of certain felonies. Program providers and MRAs are required to complete pre-employment criminal background checks for each non-licensed applicant that will provide services to an individual enrolled in the HCS Program.

subsequent amendments, CMS 372 reports and all state rules for waiver program operations are subject to the review and approval/disapproval of HHSC.

HHSC Medicaid LTC staff is scheduling and conducting on-site visits to provider agencies and will be monitoring DADS' provider reviews. Additionally, HHSC Medicaid LTC staff is actively involved in program design changes such as the implementation of consumer direction options and in the development of quality assurance activities. HHSC leads the state's Consumer Direction Task Force and monitors DADS implementation of consumer direction activities on an ongoing basis through quarterly meetings and annual reports. HHSC and DADS staff hold regular status and update meetings directed at evaluating current quality systems and identifying and prioritizing enhancements. These meetings have resulted in plans to: enhance data reporting to the Medicaid agency, base-line current activities using the CMS Quality framework matrix,; initiate joint on-site reviews of program providers, and evaluate the development of a quality management strategy that spans more than one waiver and potentially other types of long-term care services.

Responsible Entity	Focus Area	Quality Domain or Assurance	Quality Indicator	Discovery Method and Frequency of Measurement
Health and Human Service Commission (HHSC), the State Medicaid Agency	Assurance 1	The Medicaid agency or operating agency conducts routine, ongoing oversight of the waiver program.	The operating agreement identifying policy setting and oversight responsibilities is on file.	Review by State Medicaid Agency
			The operating agreement is reviewed for updates.	Review by State Medicaid Agency
			The operating agreement is current.	Review by State Medicaid Agency
			The need to update operating agreements is identified.	Review by State Medicaid Agency
			The operating agreement has been updated.	Review by State Medicaid Agency
			The operating agreement is under review by State Medicaid Agency Legal staff. Elements of the new waiver process as well as name changes of the agencies under recent state law are being considered for inclusion in the update.	Review by State Medicaid Agency
			The State Medicaid Agency monitors implementation of the agreement to assure provisions are executed.	Review of actions taken under the State Medicaid Agency's administrative authority.
			The operating agency reports the results of its monitoring activities to the State Medicaid Agency.	Review of reports by the State Medicaid Agency.
			The operating agency submits the	State Medicaid

			results of its monitoring to the State Medicaid Agency annually via the CMS 372 report.	Agency review of 372 reports submitted.
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Financial Accountability

Program providers enter billing claims into the CARE System, which assigns the correct reimbursement rate associated with the billing code entered by a program provider. The CARE System automatically rejects any claim that is entered with an unauthorized billing code or for a service not included in an individual's authorized IPC.

Responsible Entity	Focus Area	Quality Domain or Assurance	Quality Indicator	Discovery Method and Frequency of Measurement
DADS- PS	Assurance 1	State financial oversight exists to assure that claims are coded and paid in accordance with the reimbursement methodology specified in the approved waiver.	Percent of participant claims correctly coded and paid according to reimbursement methodology.	CARE System, Ongoing
			Amount of dollars recouped from providers as a result of billing and payment reviews when claims for services to participants were found in error due to incorrect coding.	On-site and desk billing and payment reviews, Ongoing
			Review of prior authorization desk review requests for adaptive aids, minor home modifications, and dental services.	Desk billing and payment reviews, Ongoing

Appendix N – Complaint and Incident Management Procedures

MEMORANDUM

Department of Aging and Disability Services Regulatory Services Policy * Internal Memorandum

TO: Regulatory Services
Regional Directors and State Office Managers

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Regulatory Services

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SUBJECT: **IM 07-12** – Revised Regulatory Services Guidelines Regarding Complaint/Incident Management for Triage and Prioritization (Replaces IM 06-35)

APPLIES TO: All Regulatory Services Provider Types

DATE: September 25, 2007

This IM replaces previous operational guidance to Regulatory Services staff regarding prioritization of complaints and provider self-reported incidents. Changes are highlighted on the attached document with ***bold italicized*** text.

BACKGROUND

In July 1998, the US General Accounting Office (GAO) was asked to assess progress made in improving the quality of care provided by nursing homes to elderly and disabled individuals and identify significant weaknesses in federal and state oversight. The GAO study found that weaknesses persisted in state survey, complaint, and enforcement activities.¹ In October 2000, the Centers for Medicare & Medicaid Services (CMS) implemented new, annual performance reviews to measure state performance in the timeliness of surveys and complaint investigations and the proper documentation of survey findings. In 2003, the Long Term Care-Regulatory Complaint and Intake Management Unit convened a workgroup to assess prioritization of complaints and provider self-reported incidents of all providers licensed by Regulatory Services. (The workgroup's goal was to align prioritization across program types as allowed by statute.) In November 2003, CMS provided direction to state survey agencies via S&C-04-09

¹ *Nursing Home Quality, Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight.* United States General Accounting Office Report to Congressional Requestors, July 2003.

Guidelines to Support Management of Complaints and Incidents and the National Implementation of the ASPEN Complaints/Incidents Tracking System (ACTS).

PURPOSE

The intent of this memorandum is to attempt to ensure that DADS' management of complaints and provider self-reported incidents:

- achieves predictability and consistency of intake data collection;
- ensures appropriate determination of priority assignment;
- aligns intake prioritization for all provider types licensed by Regulatory Services as allowed by statute; and
- ensures that triage and prioritization of complaints and incidents adheres to CMS' S&C-04-09.

The Consumer Rights and Services Complaint Intake Unit retains discretion to make a priority assignment outside of the direction provided herein, as long as the logic and rationale utilized in the triage and prioritization of the allegation for investigation maximizes the protection of consumer and resident health and safety.

If you have questions regarding the attached guidelines, please contact Consumer Rights and Services, Complaint Intake, at 512-438-2408.

Attachment

INTAKE PROCESS

Complaints regarding care, treatment, and services provided to consumers of long-term care services come from a variety of sources and in several formats. A complaint allegation (*an assertion that a requirement of licensure or certification has been violated*) can come directly from consumers or residents, family members, health care providers, advocates, law enforcement, or other state agencies. Report sources may be oral or written.

A self-reported incident is an official notification to the state survey and licensing agency from a Regulatory Services provider that the physical or mental health or welfare of a consumer or resident has been, or may be, adversely affected by mistreatment, neglect, or abuse. These reports also include injuries of unknown source and exploitation or misappropriation of consumer or resident property.

The information recorded in the complaint or provider self-reported incident intake reflects information furnished by the person reporting at the time of the intake concerning the nature of the alleged noncompliance and the extent of any alleged threat or potential threat to the health, safety, and well-being of consumers or residents.

TRIAGE PROCESS

Intake triage begins when the Consumer Rights and Services Complaint Intake Unit receives a complaint(s) or a provider self-reports an incident as required by DADS rules.

Intake triage ends when:

- The Complaint Intake Unit receives or has collected enough comprehensive information to make a prioritization decision; and
- The intake has been reviewed by a Complaint Intake quality monitor program specialist and sent to the Regulatory Services Compliance, Assessment, Regulatory Enforcement System (CARES) or the Home and Community Support Services Agency Information Technology (HCSSA IT) complaint and incident tracking system to schedule an on-site investigation.

The end of triage date is counted as day zero when calculating the “date to be investigated by.”

When Complaint Intake receives voice mail or written complaints, subsequent oral or written communication from the complainant may be necessary to obtain comprehensive information to complete the intake triage and prioritization. **Unless extenuating circumstances impede the collection of relevant information, the intake triage process is completed no more than two working days from Consumer Rights and Services Complaint Intake’s receipt of the complaint or incident. Should intake triage exceed two working days, the intake program specialist will document the rationale or circumstances for the delay in completing triage in the CARES or HCSSA IT intake general notes.**

INFORMATION TO BE COLLECTED FROM COMPLAINANTS

(If the complainant requests anonymity, an intake program specialist will explain confidentiality and document in the intake general notes that the complainant wished to remain anonymous despite an explanation of confidentiality.)

To the extent possible, the intake program specialist will collect the following information from the complainant:

- Complainant's name, address, and two means of telephone contact; the best time to contact the complainant; and the complainant's e-mail address. If the complainant provided one telephone number, the intake general notes will include documentation to reflect that the complainant provided only one means of telephone contact.
- Relationship of the complainant to the consumer or resident.
- Name and address of the facility or agency.
- How the complainant became aware of the problem(s): whether the complainant was present and witnessed the facility or agency alleged noncompliance or if the complainant heard about it from someone else.
- How many consumers or residents were involved and how they were affected by the provider's alleged noncompliance. The consumer's or resident's expected level of care or service needs; date of birth; Social Security number; payment source; unit, room, or floor number; significant medical history; decision-making capacity; cognitive status; special needs; and supervision level.
- Narrative specifics of the complainant's allegations; the date, time, and location of the allegation; and names of witnesses, alleged perpetrator(s), and anyone else the complainant believes may have information to share about their concerns.
- Adverse consequences or negative impact to the consumer's or resident's mental, physical, or psychosocial well-being or functional status; injuries; and any medical treatment required or provided and the location where the treatment was provided.
- The complainant's belief about the pervasiveness of the alleged noncompliance; how or why the complainant believes the noncompliance occurred (e.g., lack of staff, proficiency of staff, etc.); whether the complainant knew if any other consumer or resident might have had the same or similar problems.
- Any action taken by the complainant to date, such as reporting or discussing concerns with the provider or other individuals (e.g., police, ombudsman). If yes, what have they done and with whom have they spoken?
- The complainant's expectation or desire for resolution or remedy.

INFORMATION THAT IS PROVIDED TO THE COMPLAINANT

The intake specialist is responsible for providing the following information to the complainant:

1. Regulatory authority to investigate;
2. The anticipated time frame for Regulatory Services to investigate; and
3. Information and referral to other appropriate agencies that could provide assistance, including the name and telephone number of a contact person, if available.

ACKNOWLEDGMENT OF COMPLAINTS

- Complaints left on voice mail are monitored by Complaint Intake program specialists and returned the day received or within 24 hours. When the intake program specialist returns the voice mail, the date and time the complainant was contacted will be annotated in the CARES or HCSSA IT intake general notes.
- The intake program specialist will acknowledge and document in the CARES or HCSSA IT intake general notes that the complainant was informed that his/her complaint would be investigated.¹
- The Complaint Intake quality monitor program specialist will acknowledge complaints received by *mail, fax, or referral* by letter and will annotate the acknowledgment on the CARES or HCSSA IT intake general notes. (If the complainant is a consumer or resident who still resides in the facility, a complaint acknowledgement letter **is not** sent to the consumer or resident at the facility address.)
- The Complaint Intake quality monitor program specialist will acknowledge complaints received via *e-mail* and will annotate the electronic acknowledgement in the CARES or HCSSA IT intake general notes.

PROVIDER SELF-REPORTED INCIDENTS

The following information will be obtained for provider self-reported incidents:

- Reporting person's name and title;
- Facility or agency name, address, and telephone number; HCSSA license number or provider number;
- Name of the individual who reported the allegation to the facility or agency (e.g., resident, staff, family member);
- Date and time the provider first became aware of the reportable incident;
- Date, time, and location of the incident;

¹ Complaints against home health and hospice providers will be acknowledged by letter regardless of how the complaint was received. [40 TAC § 97.502]

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- Consumer(s) or resident(s) involved. Consumer's or resident's expected level of care and service needs; date of birth; Social Security number; payment source; unit, room, or floor number; significant medical history; decision-making capacity; cognitive status; special needs; and level of supervision;
- Narrative specifics of the incident;
- Name(s) of witness(es), alleged perpetrator(s), or anyone else the individual who reported the incident believes may have information to share about the incident;
- Adverse consequences or negative impact to the consumer's or resident's mental, physical, or psychosocial well-being or functional status; injuries; and any medical treatment required or provided and the location where the treatment was provided;
- The provider's immediate action(s) to date to protect the health and safety of the consumer or resident and prevent further reoccurrence (e.g., suspension or termination of employee, specific in-service training or retraining, change in consumer's or resident's care or service plan, change in consumer's or resident's level of supervision); and
- Anyone else the provider notified of the incident (e.g., police, ombudsman, other state agency).

PRIORITY DEFINITIONS

On-or-before 24 hours² (applies to all provider types except HCSSA):

Immediate response by Regulatory Services is warranted because a provider allegedly created or allowed a present and ongoing situation in which the provider's noncompliance with one or more requirements of licensure or certification has failed to protect consumers/residents from abuse, neglect, or mistreatment or has caused, or is likely to cause, serious injury, harm, impairment, or death to a consumer or resident.

On-or-before 2 working days (applies to HCSSA only):

Immediate response by Regulatory Services is warranted because a HCSSA provider allegedly created or allowed a present and ongoing situation in which the provider's noncompliance with one or more requirements of licensure or certification has failed to protect consumers or has caused, or is likely to cause, serious injury, harm, impairment, or death to a consumer.

On-or-before 14 calendar days (applies to all provider types except HCSSA):

The present or ongoing threat of continued abuse, neglect, or mistreatment has been removed. Consumer(s)/resident(s) is no longer in imminent danger; however, the provider's alleged noncompliance with one or more requirements of licensure or certification may have or has a high potential to cause harm that impacts a consumer's/resident's mental, physical, or psychosocial status and is of such consequence that a rapid response by Regulatory Services is indicated. There is

² The investigation must be initiated no later than midnight of the next calendar day following completion of triage and prioritization and the routing of the intake to the region via CARES or HIT.

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evidence or suspicion that system(s) failure contributed to or brought on the threat. Usually, specific rather than general information (e.g., descriptive identifiers, individual names, date/time/location of occurrence, description of harm) will factor into the assignment of this level of priority.

10 working days (applies to HCSSA only):

Alleged provider noncompliance may have or has a high potential to cause harm that affects a consumer's mental, physical, or psychosocial well-being and is of such consequence that a rapid response by Regulatory Services is indicated. Complaint allegation(s) may assert that one or more of the following occurred:

- Nursing care was not delivered as planned to a consumer with present and ongoing need for nursing care;
- There was a break in service for skilled services for Community Care for the Aged and Disabled-Community Based Alternatives (CCAD-CBA), Community Living Assistance and Support Services (CLASS), or Deaf Blind/Multiple Disability (DBMD) waiver consumers;
- Agency personnel were not available to consumers during normal operating hours;
- The consumer sustained harm due to improper or inadequate care or service;
- Immediate threat to health and safety has been removed, but the situation poses a continued threat to the consumer and other consumers.

On-or-before 30 calendar days (applies to all provider types except HCSSA):

A provider's alleged noncompliance with one or more requirements of licensure or certification has caused or may cause harm that is of limited consequence and does not significantly impair the consumer's/resident's mental, physical, or psychosocial status.

On-or-before 45 calendar days (applies to all provider types except ADC, and applies to HCSSA Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Community Health Accreditation Program (CHAP) deemed agencies with CMS regional office authorization):

A provider's alleged noncompliance with one or more requirements of licensure or certification has a low potential for more than minimal harm or may result in physical, mental, or psychosocial harm that would not directly impact consumer/resident health and safety and functional status; this priority may also be assigned for alleged violations of regulations that do not directly impact consumer/resident health and safety.

45 working days (applies to HCSSA only):

Allegation(s) against HCSSA provider may assert that one or more of the following exist:

- Alleged noncompliance with one or more requirements of licensure or certification that has a low potential for more than minimal harm or may result in physical,

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mental, or psychosocial harm that would not directly impact consumer health and safety;

- Financial insolvency without alleged impact on consumers; or
- Inaccurate clinical records.

90 working days (applies to HCSSA only):

Complaint allegation(s) may assert that an agency is providing home health services (hiring and sending out nurses to provide skilled nursing services or hiring and sending out aides to provide personal assistance services) without a license.

Next On-site (applies to HCSSA only):

Complaint allegation(s) against HCSSA provider may assert that one or more of the following occurred:

- Discharge without proper notice;
- Illegal remuneration (solicitation – kickbacks);
- Billing irregularities;
- Personal Assistance Services not being provided when the situation does not pose a serious threat to the consumer's health and safety; or
- Consumer rights violations.

Professional Review (applies to all provider types except HCSSA):

A provider who has cause to believe that the physical or mental health or welfare of a consumer(s)/resident(s) has been, or may be, adversely affected by mistreatment, neglect, or abuse must self-report the incident to the state survey agency immediately on learning of the alleged conduct or conditions. This report could include injuries of unknown source and exploitation/misappropriation of consumer/resident property.

Complaint Intake Unit staff assign a Professional Review priority³ when a provider self-reports an incident to Regulatory Services, and the provider's oral report indicates that the provider's immediate corrective action is reasonably likely to ensure that abuse, neglect, mistreatment, or injury to a consumer(s)/resident(s) will not occur again, or at least not while the provider conducts its investigation and the provider's written investigation report is received and reviewed by a Complaint Intake program specialist.

A review of the Provider Investigation Report by a Complaint Intake nurse specialist will include an assessment of the provider's description of the incident, the provider's summary and analysis of the investigation procedures, the provider's conclusion whether the allegation is supported by the provider's professional judgment, and the recommendation(s) or the corrective action(s) taken by the provider as a result of the investigation findings.

³ Regulatory Service staff can review provider self-reported incidents prioritized Professional Review by creating an ad hoc report through CARES Intake Custom Report module.

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Based on review of the facility investigation report, if further investigation is warranted to assess whether the provider's abuse prohibition policies ensure compliance with regulatory requirements, the Complaint Intake Unit will send the intake to the region's CARES compliance review bin to schedule an on-site investigation.

Administrative Review/Off-site Investigation (applies to HCSSA only):

A complaint that does not warrant an on-site investigation may be given an off-site administrative review (e.g., written/verbal communication or documentation) to determine if further action is necessary. The State Agency may review the information at the next on-site survey.

Desk Review (applies to HCSSA only):

Effective October 1, 2004, desk reviews are used for off-site investigation of HCSSA self-reported incidents. If further investigation is warranted to ensure compliance with federal, state, or local laws, an on-site investigation is scheduled at the request of regional staff. Whether investigation is by desk review or on-site, it must be completed on or before 120 working days.

Financial (applies to Medicaid-certified NFs):

Complaints against a Medicaid-certified nursing facility are referred to Provider Services for investigation when one of the following may exist:

- The facility has failed to properly manage a resident's trust fund; or
- The facility has failed to reimburse pro-rata monies due a resident when a resident is admitted to a Medicare bed or has been discharged.

Withdrawn (applies to all provider types):

This category details complaint allegations withdrawn in accordance with S&CC Memo 03-08.

Not Required/Not Applicable (applies to all provider types):

Regulatory Services determines it has no jurisdiction to investigate a complaint or a referral, or a report to another agency, board, or entity is required.

REGULATORY SERVICES PRIORITIZATION TIME FRAMES BY PROVIDER TYPE

Nursing Facility

Time Frames Related to Federal Guidelines	Regulatory Services Prioritization Time Frame
Immediate Threat – 2 working days (CMS S&C-04-09 and SOM Chapter 5 <i>Rev. 18, 03-17-06</i>)	On-or-before 24 hours
Non-Immediate Threat (High) – 10 working days (CMS S&C-04-09 and SOM Chapter 5 <i>Rev. 18, 03-17-06</i>)	On-or-before 14 calendar days
Non-Immediate Threat (Medium) (CMS S&C-04-09 and SOM Chapter 5 <i>Rev. 18, 03-17-06</i>)	On-or-before 30 calendar days
Non-Immediate Threat (Low) (CMS S&C-04-09 and SOM Chapter 5 <i>Rev. 18, 03-17-06</i>)	On-or-before 45 calendar days
Desk Review/Off-site Investigation	Professional Review
Referral – Immediate/Other	Financial
No Action Necessary	Withdrawn
No Action Necessary	Not Required

Assisted Living

Time Frames Related to Federal Guidelines	Regulatory Services Prioritization Time Frame
NA	On-or-before 24 hours
NA	On-or-before 14 calendar days
NA	On-or-before 30 calendar days
NA	On-or-before 45 calendar days
NA	Professional Review
NA	Withdrawn
NA	Not Required

Adult Day Care

Time Frames Related to Federal Guidelines	Regulatory Services Prioritization Time Frame
NA	On-or-before 24 hours
NA	On-or-before 14 calendar days
NA	On-or -before 30 calendar days Health & Safety Code Section 103.008 (b)
NA	Professional Review
NA	Withdrawn
NA	Not Required

**Intermediate Care Facilities for Persons with Mental Retardation
or Related Conditions**

Time Frames Related to Federal Guidelines	Regulatory Services Prioritization Time Frame
Immediate Threat – 2 working days (CMS S&C-04-09 and SOM Chapter 5 Rev. 18, 03-17-06)	On-or-before 24 hours
Non-Immediate Threat (High) (CMS S&C-04-09 and SOM Chapter 5 Rev. 18, 03-17-06)	On-or-before 14 calendar days
Non-Immediate Threat (Medium) (CMS S&C-04-09 and SOM Chapter 5 Rev. 18, 03-17-06)	On-or-before 14 calendar days
Non-Immediate Threat (Low) (CMS S&C-04-09 and SOM Chapter 5 Rev. 18, 03-17-06)	On-or-before 45 calendar days
Desk Review/Off-site Investigation	Professional Review
No Action Necessary	Withdrawn
No Action Necessary	Not Required

Home Health and Hospice

Time Frames Related to Federal Guidelines	Regulatory Services Prioritization Time Frame
Immediate Threat – 2 working days (CMS S&C- 04-09 and SOM Chapter 5 Rev. 18, 03-17-06)	On-or-before 2 working days
Non-Immediate Threat (High) 10 working days (CMS S&C-04-09 and SOM Chapter 5 Rev. 18, 03-17-06)	On-or-before 10 working days
Non-Immediate Threat (Medium) (CMS S&C-04-09 and SOM Chapter 5 Rev. 18, 03-17-06)	On-or-before 45 working days
NA	On-or-before 90 working days
Non-Immediate Threat (Low) (CMS S&C-04-09 and SOM Chapter 5 Rev. 18, 03-17-06)	On-or-before 45 calendar days (deemed providers only) ⁴

⁴ Complaints against providers with Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Community Health Accreditation Program (CHAP) deemed status require CMS Regional Office (RO) approval and cannot be prioritized in excess of 45 calendar days (SOM 3262).

Time Frames Related to Federal Guidelines	Regulatory Services Prioritization Time Frame
Administrative Review/Off-site Investigation (SOM Chapter 5 Rev. 18, 03-17-06)	Next On-site ⁵ ⁶
Desk Review /Off-site Investigation	Desk Review
No Action Necessary	Withdrawn
No Action Necessary	Not Applicable/Not Warranted

ADDITIONAL ISSUES TO CONSIDER WHEN TRIAGING & PRIORITIZING INTAKES

Harm level:

1. Did harm or injury occur? How significant was it? Did it impair the consumer's or resident's functioning?
2. Did the consumer(s) or resident(s) require treatment?
3. Did the consumer(s) or resident(s) experience physical or psychological discomfort without significant change in their physical or psychosocial well-being?
4. Did the provider exercise reasonable judgment in assessing and minimizing the threat to consumer or resident health and safety?

Quality and completeness of the information provided:

1. How much first-hand knowledge did the complainant have?
2. Is the information vague or specific?
3. Has there been a pattern of similar complaints?

Time frame of the allegation:

1. How recently did the allegation(s) occur?
2. Has there been a previous allegation(s) or provider self-reported incident(s) investigated regarding the same consumer(s) or resident(s)?
3. Is there a pattern of outstanding complaints or provider self-reported incidents regarding the same concerns or involving the same consumer(s) or resident(s)?

⁵ Allegations of Abuse/Neglect/Exploitation are referred to Department of Family and Protective Services (DFPS) in accordance with Memorandum of Understanding (MOU)-05/20/02.

⁶ *Next on-site is defined as the very next time a survey is conducted at the agency that the complaint is against.*

Triage Triggers

Provider Service Type Priority

		SNF/NF	ICF-MR/RC	ALF	ADC	HCSSA
<p>The provider's noncompliance caused, or is likely to cause, serious injury, harm, impairment, or death to a consumer/resident. The threat to consumer/resident health and safety is still present and ongoing.</p>	YES →	On-or-before 24 hours	On-or-before 24 hours	On-or-before 24 hours	On-or-before 24 hours	2 working days
	↓ NO					
<p>Serious and immediate threat to consumer/resident health and safety has been removed. A consumer/resident has been seriously injured, and there continues to be a high potential for harm that will impact consumer's/resident's mental, physical, or psychosocial well-being.</p>	YES →	On-or-before 14 calendar days	10 working days			
	↓ NO					
<p>A consumer/resident has been harmed; potential for no more than minimal harm. The consumer/resident did not experience significant discomfort or impairment in his/her mental or physical status.</p>	YES →	On-or-before 30 calendar days	On-or-before 14 calendar days	On-or-before 30 calendar days	On-or-before 30 calendar days	45 working days (non-deemed); 45 calendar days (deemed)
	↓ NO					
<p>There has been no known negative consumer/resident outcome with low potential for more than minimal harm; alleged violations that do not directly impact consumer/resident health and safety.</p>	YES →	On-or-before 45 calendar days	On-or-before 45 calendar days	On-or-before 45 calendar days	On-or-before 30 calendar days	45 working days (non-deemed); 45 calendar days (deemed)