Youth Empowerment Services Waiver

(YES)

Policy and Procedure Manual

January 2016

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YES WAIVER PROGRAM OVERVIEW 1000

BACKGROUND AND HISTORY

Texas strives to provide a continuum of appropriate services and supports for families with youth who have serious emotional disturbance (SED). The Youth Empowerment Services (YES) Waiver provides comprehensive home and community-based mental health services to youth, ages 3 to 18, up to a youth's 19th birthday, at risk of institutionalization and/or out-of-home placement due to their SED. The program provides flexibility in the funding of intensive community-based services and supports for youth and their families.

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

OBJECTIVE AND GOALS OF THE YES WAIVER

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

The goals of the Waiver are to:

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

SERVICES

The services available through the Waiver are:

1. Adaptive Aids and Supports;
2. Community Living Supports (CLS);
3. Employment Assistance;
4. Family Supports;

5. Minor Home Modifications;
6. Non-Medical Transportation;
7. Paraprofessional Services;
8. Pre-Engagement Service (for non-Medicaid applicants);
9. Respite (In-Home and Out-of-Home);
10. Specialized Therapies:
    a. Animal-Assisted Therapy;
    b. Art Therapy;
    c. Music Therapy;
    d. Nutritional Counseling; and
    e. Recreational Therapy;
11. Supported Employment;
12. Supportive Family-Based Alternatives; and
13. Transitional Services.

VARIANCE OF SERVICES

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

MEDICAID SERVICES

Youth enrolled in the Waiver are enrolled in Medicaid and therefore entitled to all Medicaid State Plan behavioral health services, as well as services specific to the Waiver. Youth participating in the Waiver are authorized into Level of Care–YES (LOC–YES) in the Texas Resilience and Recovery (TRR) mental health system. For more information about LOC-YES, see the TRR Utilization Management Guidelines, available at:

http://www.dshs.state.tx.us/layouts/contentpage.aspx?pageid=8589977112&id=8589977075&terms=utilization+management

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

1. Intensive Case Management (utilized for the coordination of Waiver services);
2. Psychiatric Evaluation;
3. Psychological Services;
4. Counseling;
5. Crisis Services; and

6. Rehabilitation Services.

CONTACT INFORMATION

Further information regarding the Waiver is available through DSHS:

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

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

COMPLAINTS

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

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

Complaints can also be submitted in writing to:

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

NOTICE OF RIGHT TO FAIR HEARING

Within seven business days of an individual being denied eligibility for or participation in, or terminated from the YES Waiver, the local mental health authority (LMHA) must send the Denial of Eligibility letter and Fair Hearing Request form to the individual and LAR, in accordance with 25 TAC §419.8, available at:

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

CONSISTENCY WITH LAW

No policy or portion of any policy in this manual is operative if it is determined to be inconsistent with applicable law or rule.

In accordance with 25 TAC §419.3, to participate in the YES Waiver (Waiver), a youth must meet the following criteria:

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

AGE RANGE

The approved age range for a Waiver participant is 3 to 18 years of age, up to a youth's 19th birthday.

INELIGIBILITY

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

FOSTER CARE

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

DUAL PROGRAM ENROLLMENT

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

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

To participate in the YES Waiver (Waiver) program, an individual must:

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

DEMOGRAPHIC ELIGIBILITY MET

1. When the LMHA determines that an individual meets the demographic criteria, the LMHA is responsible for the following: Within seven business days:
   a. A licensed practitioner of the healing arts (LPHA) meets with the individual and LAR to complete the Texas Resilience and Recovery (TRR) Uniform Assessment.
   b. The LMHA's Utilization Management office authorizes the individual into LOC–YES.
   c. The Clinical Eligibility Determination Form is completed.
   d. The Enrollment Packet, except for the Authorization of Services letter, is completed. The Enrollment Packet is available at: http://www.dshs.state.tx.us/mhsa/yes/
   e. The participant and LAR are provided with a copy of the Department of State Health Services Handbook of Consumer Rights: Mental Health Services, available at: http://www.dshs.state.tx.us/mhsa-rights/
2. Within an additional five business days, the LMHA must enter the clinical eligibility documentation into Clinical Management for Behavioral Health Services (CMBHS).

DEMOGRAPHIC ELIGIBILITY NOT MET

Within seven business days of determining that an individual does not meet the demographic criteria, the LMHA must:

1. Send the individual and LAR the Denial of Eligibility letter and Fair Hearing Request form; and
2. Provide referrals to other services and to the LMHA in the individual's county of residence.

Clinical eligibility for the YES Waiver (Waiver) requires an individual to have serious functional impairment or acute psychiatric symptomatology, as determined by the specific domain scores from the Child and Adolescent Needs and Strengths (CANS) Assessment and the Clinical Eligibility Determination (CED) Form.

In addition, a reasonable expectation must exist that, without Waiver services, the individual would qualify for inpatient care under the Texas Medicaid inpatient psychiatric admission guidelines.

QUALIFICATIONS TO PERFORM CLINICAL ASSESSMENT

The qualifications to perform clinical assessments are in accordance with the following:

INITIAL

The initial clinical eligibility assessment must be performed by a licensed professional of the healing arts (LPHA).

REASSESSMENT

A clinical eligibility reassessment can be performed by a QMHP-CS; however, an LPHA must review and confirm the recommendation and make his or her own recommendation regarding the level of care.

CANS ASSESSMENT CRITERIA

An individual must meet the clinical level of care criteria in accordance with Criteria A through E.

CRITERIA A

The individual must score at the identified levels on the following domains on the CANS Assessment:

1. Score a 0 or 1 on Life Domain Functioning – Developmental; or
2. Score a 2 or 3 on Life Domain Functioning – Developmental; and
    a. Score a 0, 1, or 2 on Developmental Needs: Cognitive; and
    b. Score a 0 or 1 on Developmental Needs: Developmental.

CRITERIA B

The individual must score at the identified levels on one or more of the following domains on the CANS Assessment:

1. Score a 3 on Child Risk Behaviors: Suicide Risk;
2. Score a 3 on Child Risk Behaviors: Self-Mutilation;
3. Score a 3 on Child Risk Behaviors: Self Harm;
4. Score a 2 or 3 on Child Risk Behaviors: Danger to Others;
5. Score a 2 or 3 on Child Risk Behaviors: Sexual Aggression;
6. Score a 2 or 3 on Child Risk Behaviors: Fire Setting;

7. Score a 2 or 3 on Child Risk Behaviors: Delinquency;

8. Score a 2 or 3 on Caregiver Strengths and Needs: Involvement with Care;

9. Score a 2 or 3 on Caregiver Strengths and Needs: Family Stress;

10. Score a 2 or 3 on Caregiver Strengths and Needs: Safety;

11. Score a 2 or 3 on Life Domain Functioning: School; and

    a. Score a 2 or 3 on Life Domain Functioning: School Module – School Behavior;

12. Score a 2 or 3 on Life Domain Functioning: School Module – School Attendance; and

    a. Score a 1 on Psychiatric Hospitalization; and

    b. Score 1, 2, or 3 on Psychiatric Hospitalization: Psychiatric Hospitalization Module – Time Since Most Recent Discharge.

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

CRITERIA D A Medicaid-eligible youth must meet at least one of the following Texas Medicaid Inpatient Psychiatric Admission criteria:

1. The youth is presently a danger to self, demonstrated by at least one of the following:

    a. Recent suicide attempt or active suicidal threats with a deadly plan and an absence of appropriate supervision or structure to prevent suicide;

    b. Recent self-mutilating behavior or active threats of same with likelihood of acting on the threat and an absence of appropriate supervision or structure to prevent self-mutilation; i.e., intentionally cutting, burning, or the like;

    c. Active hallucinations or delusions directing or likely to lead to serious self-harm or debilitating psychomotor agitation or retardation resulting in a significant inability to care of self; or

    d. Significant inability to comply with prescribed medical health regimens due to concurrent Axis I psychiatric illness and such failure to comply is potentially hazardous to the life of the individual.

2. The youth is a danger to others. This behavior should be attributable to the individual's specific SED/mental health diagnosis in accordance with the current Diagnostic and Statistical Manual (DSM) and can be adequately treated only in a hospital setting. Danger is presented by:

   a. Recent life-threatening action or active homicidal threats of same with a deadly plan and availability of means to accomplish the plan with the likelihood of acting on the threat;

   b. Recent serious assaultive or sadistic behavior or active threats of same with the likelihood of acting on the threat and an absence of appropriate supervision or structure to prevent assaultive behavior; or

   c. Active hallucinations or delusions directly or likely to lead to serious harm of others.

3. The youth exhibits acute onset of psychosis or severe thought disorientation, or there is significant clinical deterioration in the condition of the youth with chronic psychosis, rendering him or her unmanageable and unable to cooperate in treatment. This youth is in need of assessment and treatment in a safe and therapeutic setting.

4. The youth has a severe eating or substance abuse disorder, which requires 24-hour a day medical observation, supervision, and intervention.

5. The proposed treatment or therapy requires 24-hour a day medical observation, supervision, and intervention.

6. The youth exhibits severe disorientation to person, place, or time.

7. The youth's evaluation and treatment cannot be carried out safely or effectively in other settings due to severely disruptive behaviors, including, but not limited to, physical, psychological, or sexual abuse.

8. The youth requires medication therapy or complex diagnostic evaluation where his or her level of functioning precludes cooperation with the treatment regimen.

CRITERIA E

The youth's admitting diagnosis must be a SED/mental health diagnosis in accordance with the current (excluding a single diagnosis of substance abuse, mental retardation, autism or pervasive development disorder).

EXCEPTION

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

AFTER CLINICAL ASSESSMENT

Following the clinical eligibility determination by DSHS, the LMHA must either complete the enrollment process for Waiver services, or complete the process to get the individual into the appropriate Texas Resilience and Recovery (TRR) level of care other than LOC-YES, as applicable.

TEXAS RESILIENCE AND RECOVERY SERVICES

In accordance with 25 TAC §412.322 and §412.407, after the individual is authorized into LOC–YES by the LMHA's Utilization Management office, TRR services that are available in LOC–YES can begin:

1. The Wraparound Facilitator must be assigned within two business days; and
2. The first face-to-face meeting must occur within seven business days.

DURATION OF LOC–YES

Authorization for TRR services through LOC–YES occurs independently from enrollment into the YES Waiver. An LOC-YES authorization is 90 days.

YES ENROLLMENT PROCESS

For the enrollment process for an individual with Medicaid, see policy 2100.1 of this manual.

For the enrollment process for an individual without Medicaid, see policy 2100.2 of this manual.

CLINICAL ELIGIBILITY NOT MET

Within seven business days of clinical eligibility being denied, the LMHA must:

1. Send the individual and legally authorized representative the Denial of Eligibility letter and Fair Hearing Request form;
2. Provide referrals to other services; and
3. Complete the process to get the individual into the appropriate TRR level of care other than LOC-YES.

An individual is required to obtain and maintain Medicaid to in order to receive YES Waiver (Waiver) services.

FINANCIAL CRITERIA

An individual must meet the applicable federal financial participation limits to obtain Medicaid benefits in one of the Medicaid Eligibility Groups, as follows:

1. Low-income families with children, as provided in §1931 of the Social Security Act ("Act);
2. Supplemental Security Income (SSI) recipients;
3. Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act; and
4. All state plan groups, EXCEPT:
   a. Early Aged Widow(er) – §1634(b);
   b. Disabled Widow(er) – §1634 (d);
   c. Disabled Adult Children – §1634(c); and
   d. Foster Care Groups under §1902(a)(10)(A)(i)(I) and §1902(a)(10)(A)(ii)(XVII).

INDIVIDUAL WITH MEDICAID

An individual who meets Waiver eligibility through an existing Medicaid benefit will continue his or her enrollment in their current Medicaid program. An individual may be enrolled in either a fee-for-service plan or managed care plan.

STATE OF TEXAS ACCESS REFORM (STAR)

Following approval of participation in the Waiver, an individual who is receiving SSI/Medicaid and is enrolled in the State of Texas Access Reform (STAR) program will continue to receive those services.

TYPE OF ASSISTANCE (TA)10

An individual who is approved to participate in the Waiver under Type of Assistance (TA)10 will have a traditional, fee-for-service Medicaid plan rather than STAR.

INDIVIDUAL WITHOUT MEDICAID

An individual who is otherwise not eligible to receive Medicaid must obtain Medicaid to participate in the Waiver. The individual must meet the SSI disability requirements under the special income limit group.

Parental income and resources are not included in determining a youth's special income limit.

Individuals eligible under the special income limit group are identified as TA10 (program code "ME waiver" in the Texas Integrated Eligibility Redesign System (TIERS)). The special income limit for

Medicaid in institutions is equal to 300 percent of the SSI full Federal Benefit Rate (FBR).

If an individual receives a Social Security or Railroad Retirement benefit, or previously received SSI benefits and was denied Medicaid for reasons other than not meeting disability requirements, the disability requirement for the special income limit group will be considered met. For all others, the Health and Human Services Commission (HHSC) will seek a disability determination.

An individual who is applying for Medicaid benefits under the special income limit group cannot begin Waiver services prior to the submission of his or her Medicaid application to HHSC.

DISABILITY DETERMINATION

When a disability determination is required for an individual who is applying for Medicaid, the local mental health authority (LMHA) must assist the individual and LAR with completing and submitting the applicable forms and documents online at:

https://yourtexasbenefits.com/ssp/SSPHome/ssphome.jsp

Failure to submit all applicable disability documentation will result in a delay in Medicaid eligibility determination.

QUALIFIED INCOME TRUST

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

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

An individual who receives a Waiver service and who also has a QIT, is required to pay a copay, as determined by HHSC. A Waiver provider must collect the co-pay prior to billing DSHS for services.

MEDICAID APPLICATION

For specific information regarding the Medicaid application, forms, and supporting documentation requirements, see MEDICAID APPLICATION, policy 2100 of this manual.

YES ENROLLMENT PROCESS

For the enrollment process for an individual with Medicaid, see policy 2100.1 of this manual.

For the enrollment process for an individual without Medicaid, see policy 2100.2 of this manual.

NONRESPONSIVE INDIVIDUAL

If the individual has Medicaid, but the LMHA does not receive a response from the individual and LAR regarding enrolling in the YES program, the LMHA must make at least two phone calls and send at least two letters to the LAR within a 30 calendar day period. If the LMHA still does not receive a response from the LAR, then the LMHA sends the Letter of Withdrawal.

MEDICAID APPLICATION

The legally authorized representative (LAR) is responsible for completing and submitting all applicable Medicaid forms and supporting documentation online at: yourtexasbenefits.com.

FORMS

The LAR must submit the following forms:

FORM H1200

The Application for Assistance, available at: http://www.dads.state.tx.us/forms/H1200/.

FORM H3034

The Socio-Economic Report, available at: http://www.dads.state.tx.us/forms/H3034/

FORM H3035

The Medical Information Release/Disability Determination is available at: http://www.dads.state.tx.us/forms/H3035/

SUPPORTING DOCUMENTS

Supporting documentation includes, but is not limited to:

1. School records, such as:
   a. Admission, Review, and Dismissal (ARD) report;
   b. Individual Education Program (IEP) report; or
   c. Section 504 report;
2. Form DDS 9954A - Speech and Language Report;
3. Form DDS 9954 – School Activity Report;
4. Bank statements, if participant has access to account or participant name is listed on the account;
5. Copy of trust fund document, if applicable;
6. Copy of participant's life insurance policy, if applicable;
7. Medical history;
8. Psychiatric diagnosis; and
9. Psychiatric hospital discharge paperwork, if applicable.

Form DDS 9954A and Form 9954 are available at: http://www.dshs.state.tx.us/mhsa/yes/

NOTIFICATION TO DEPARTMENT OF STATE HEALTH SERVICES

Within 30 days of the LAR submitting the Medicaid application and supporting documentation, the local mental health authority (LMHA) must notify the Department of State Health Services (DSHS), via email to the YES Waiver Medicaid inbox, that the application has been submitted.

DETERMINATION OF MEDICAID BENEFITS

Upon receipt of a completed Medicaid application, the Health and Human Services Commission (HHSC) makes a determination of Medicaid benefits within:

1. 45 days, when disability determination is not required; or
2. 90 days, when a disability determination is required.

NOTICE OF APPROVAL OR DENIAL

Notice of the approval or denial of Medicaid is sent directly to the LAR. The LAR is responsible for notifying the LMHA of the approval or denial of Medicaid for the individual.

APPROVAL

Upon approval of Medicaid benefits, HHSC establishes the Medicaid Effective Date (MED) in the Texas Integrated Eligibility Redesign System (TIERS).

MEDICAID EFFECTIVE DATE (MED)

The Medicaid Effective Date (MED) under the special income limit group is based upon the date Medicaid benefits begin for Waiver services, and is consistent with the individual's service authorization. DSHS will provide HHSC with the effective date of Waiver services.

The MED shall be dated back to the first day of the month of the Medicaid application. Example: A Medicaid application signed on June 17 would have a MED of June 1, if it is determined that all eligibility requirements are met for the month of June.

DENIAL

Within seven business days of Medicaid denial, the LMHA must:

1. Send the Denial of Eligibility letter for the YES Waiver and Fair Hearing Request form; and
2. Provide referrals to other services.

PRE-ENGAGEMENT SERVICES

The LMHA is permitted to bill for Pre-engagement services, in accordance with BILLING, PRE-ENGAGEMENT SERVICES, policy 2600.9 of this manual.

MAINTAINING MEDICAID

Waiver services are Medicaid services; therefore a participant is required to maintain Medicaid benefits so long as he or she is participating in the Waiver.

The LMHA must assist a participant and LAR in renewing Medicaid benefits in accordance with HHSC rules.

CLINICAL ELIGIBLITY DETERMINATION

APPROVED

A clinical eligibility determination (CED) authorized by the Department of State Health Services (DSHS), is valid for 365 days from the CED date in Clinical Management for Behavioral Health (CMBHS).

After DSHS authorizes the clinical eligibility, the Wraparound Facilitator is responsible for the following:

1. Within ten business days:
   a. Provide the Authorization of Services letter to the participant and LAR; and
   b. Continue the Wraparound process by completing the Individual Plan of Care (IPC) and the Crisis Safety Plan.
2. Within an additional five business days:
   a. Confirm Medical Eligibility Verification (MEV) in CMBHS; and
   b. Submit the initial service authorization request for YES Waiver services, in accordance with SERVICE AUTHORIZATION REQUEST, policy 2200.4 of this manual.

MEDICAID ELIGIBILITY VERIFICATION

Prior to completing the initial service authorization request, the LMHA must verify the participant's Medicaid Eligibility. To verify Medicaid eligibility, a MEV request must be submitted to CMBHS. Instructions on submitting a MEV request to CMBHS are available at: http://www.dshs.state.tx.us/mhsa/yes/

INITIAL SERVICE AUTHORIZATION REQUEST

After the initial service authorization request is authorized by DSHS, the Wraparound Facilitator must verify a provider's ability to submit claims for Waiver services by checking in CMBHS for one of the following and notify the provider accordingly:

1. TMHP authorization number; or
2. "DSHS Authorized" for youth in a General Revenue (GR) funded program.

DENIED

If an individual's CED is denied by DSHS, within seven business days the LMHA must:

1. Send the individual and legally authorized representative the Denial of Eligibility letter and Fair Hearing Request form;
2. Provide referrals to other services; and

3. Complete the process to get the individual into the appropriate Texas Resilience and Recovery (TRR) level of care other than LOC-YES.

FAILURE TO PARTICIPATE IN SERVICES

If a participant and legally authorized representative (LAR) do not participate in Waiver services for a period of 60 days, the LMHA may consider sending the Letter of Withdrawal.

Prior to sending the Letter of Withdrawal, the LMHA must complete and document a good faith effort to engage the participant and LAR. A minimum of two phone calls and two letters within the 60-day period constitutes a good faith effort.

CLINICAL ELIGIBLITY DETERMINATION

APPROVED

A clinical eligibility determination (CED) authorized by the Department of State Health Services (DSHS), is valid for 365 days from the CED date in Clinical Management for Behavioral Health (CMBHS).

After DSHS authorizes the CED, the local mental health authority (LMHA) is responsible for:

1. Assisting the legally authorized representative (LAR) with the Medicaid application process; and
2. Continuing the Wraparound process by having the Wraparound Facilitator develop the Crisis Safety Plan.

DENIED

If an individual's CED is denied by DSHS, within seven business days the LMHA must:

1. Send the individual and LAR the Denial of Eligibility letter and Fair Hearing Request form;
2. Provide referrals to other services; and
3. Complete the process to get the individual into the appropriate Texas Resilience and Recovery (TRR) level of care other than LOC-YES.

MEDICAID APPLICATION

PENDING

For an individual whose Medicaid application is pending, if 90 days elapses before YES Waiver (Waiver) services begin (not including TRR services provided in LOC–YES), the LPHA must enter an updated CED into CMBHS before the initial service authorization will be approved by DSHS.

APPROVED

If the individual's Medicaid application is approved by the Health and Human Services Commission (HHSC), the LPHA must submit the CED Form to DSHS within seven business days.

The Wraparound Facilitator then completes the process of enrolling the individual into the Waiver. [See ENROLLMENT PROCESS FOR INDIVIDUAL WITH MEDICAID, policy 2100.1 of this manual.]

DENIED

If the individual's Medicaid application is denied by HHSC, within seven business days the LMHA must:

1. Send the Denial of Eligibility letter and Fair Hearing Request form; and
2. Provide referrals to other services.

PRE-ENGAGEMENT SERVICES

The LMHA can submit a claim to Medicaid for reimbursement for pre-engagement services, in accordance with BILLING, PRE-ENGAGEMENT SERVICES, policy 2600.9 of this manual.

FREEDOM OF CHOICE

In accordance with federal rule, a participant and legally authorized representative (LAR) have the freedom to choose:

1. To receive services through either an institutional program or through the YES Waiver (Waiver);
2. Which comprehensive waiver provider (CWP) to receive services from, if enrolled in the Waiver; and
3. When available, which individual direct service provider to receive services from, if enrolled in the Waiver.

INSTITUTIONAL PROGRAM OR YES WAIVER PROGRAM

The participant and LAR's choice to receive services through either an institutional program or through the Waiver program must be documented on the Freedom of Choice form, as part of the Enrollment Packet. The Freedom of Choice form must be maintained in the participant's case record in accordance with RECORD KEEPING, policy 2500.3 of this manual.

The Freedom of Choice form is available at:

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

COMPREHENSIVE WAIVER PROVIDER

The participant and LAR have the freedom to choose a Department of State Health Services approved CWP within their county of residence, from which to receive Waiver services.

The local mental health authority (LMHA) assists the participant and LAR in selecting a CWP by:

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

The participant and LAR's choice of CWP must be documented on the Provider Selection Form, as part of the Enrollment Packet. The Provider Selection Form must be maintained in the participant's case record in accordance with RECORD KEEPING, policy 2500.3 of this manual.

The Provider Selection Form is available at:

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

INDIVIDUAL DIRECT SERVICE PROVIDER

The participant and LAR have the freedom to choose individual direct service providers from the CWP's provider network.

PARTICIPANT RESPONSIBILITIES

Prior to the receipt of Waiver services, the LMHA must review the Participant Agreement with the participant and LAR to explain the

expectations and responsibilities they must fulfill during participation in the Waiver.

RELEASE OF INFORMATION

The participant, LAR, a LMHA representative, and a CWP representative must all sign a release of information form to permit the LMHA and the CWP to exchange information about the participant's services, progress, and other information deemed necessary by the Child and Family Team.

COMPLAINTS

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

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

Complaints can also be submitted in writing to:

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

ABUSE, NEGLECT, OR EXPLOITATION

Complaints involving allegations of abuse, neglect, or exploitation must be immediately referred to the Department of Family and Protective Services (DFPS) at 1-800-252-5400. [See REPORTING ABUSE, NEGLECT, OR EXPLOITATION, policy 2200.7 of this manual.]

PROVIDER NETWORK

A local mental health authority (LMHA) is required to develop and maintain a provider network which meets network adequacy criteria. Network adequacy requires:

1. Contracted qualified providers of the YES Waiver service array;
2. Services on the IPC are provided free of conflict of interest and not by an individual developing the IPC or by the LMHA with direct oversight of the individual developing the IPC, except as the provider of last resort
3. Ideally, no more than 20% of YES services in the individual plan of care (IPC) are provided directly by the LMHA, unless the LMHA is the provider of last resort;
4. Participant access to all services on a service authorization within ten business days of the date of authorization by the Department of State Health Services, or later at the request of the participant and/or legally authorized representative;
5. Participant choice of qualified provider of individual Waiver services; and
6. Participant access to qualified providers within 30 miles of the participant's residence.
7. As the provider of last resort, serve as a comprehensive YES provider for the local service area in the absence of alternate qualified comprehensive providers contracted through the Department of State Health Services that have demonstrated sufficient capacity.

INQUIRY LIST

The local mental health authority (LMHA) must establish and maintain an inquiry list of individuals interested in YES Waiver (Waiver) program services in its service area.

A copy of the LMHA's up-to-date inquiry list must be submitted to the Department of State Health Services (DSHS) on the last business day of each month.

DSHS approves the inquiry list management policy for each service area in the Waiver.

PHONE LINE

The LMHA must establish and maintain a no-charge phone line which operates as:

1. A direct Waiver Inquiry phone number; or
2. An agency-wide phone number equipped with an operating system which provides a Waiver Inquiry option for callers.

Phone messages received on the Waiver inquiry phone line must be returned within 24 hours or one business day.

REGISTRATION

Waiver slots are filled on a first-come, first-serve basis based upon the chronological date and time the phone call or voice message is received.

An individual's registration on the inquiry list is permitted only by the individual or the individual's legally authorized representative (LAR) contacting the LMHA directly.

An individual will not be placed on the inquiry list if contact to the LMHA is from a referral agency acting on behalf of the individual or LAR.

PROGRAM INFORMATION

The LMHA must provide general information about the Waiver to an interested individual or LAR, including, but not limited to:

1. Description of Waiver services;
2. Demographic eligibility criteria;
3. Clinical eligibility criteria; and
4. Medicaid eligibility criteria.

The LMHA must inform the individual and LAR that if the individual is enrolled in the Waiver, he or she is not eligible to participate in another Medicaid home and community-based 1915(c) waiver or 1915(i) program at the same time.

NOTIFICATION OF SLOT AVAILABILITY

DSHS manages available slots on a regional basis, in accordance with Waiver requirements.

When a participant slot is available or is projected to be available within 30 days, the LMHA must notify the next individual and LAR on the list.

REMOVAL FROM INQUIRY LIST

If an individual and LAR are not interested in receiving Waiver services, or do not return the phone call to the LMHA within seven business days, the LMHA must send the Letter of Withdrawal.

The local mental health authority (LMHA) must ensure that prior to providing Waiver services and/or participating on Child and Family Team, all LMHA staff members and direct service providers receive program training in accordance with the following:

YES WAIVER

LMHA staff and direct service providers must receive YES Waiver (Waiver) training from the Department of State Health Services (DSHS) that consists of:

1. Waiver overview and background;
2. Waiver service array;
3. Provider qualifications;
4. Service authorization request development; and
5. Use of Clinical Management for Behavioral Health Services (CMBHS).

SYSTEMS OF CARE AND WRAPAROUND

Within the first three months of hire, each LMHA providing direct service to YES participants must complete the following online trainings on the Introduction to Systems of Care and the Wraparound Initiative service delivery method:

1. What's This Thing Called Wraparound?;
2. Team Roles in Wraparound; and
3. Overview of the Youth Empowerment Services (YES) Waiver.

The online trainings and additional information are available at: http://www.txsystemofcare.org/

INVOLUNTARY RESTRAINT

LIMITED USE OF PHYSICAL RESTRAINT

The limited use of physical restraints is permitted in the delivery of YES Waiver (Waiver) services only when:

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

Use of restraints must be used in accordance with 25 TAC §415, Subchapter F, available at:

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

When used, restraints must be used for the shortest period of time necessary and terminated upon the participant demonstrating release behaviors specified by the ordering physician.

TRAINING

In accordance with law, the LMHA must ensure staff members and direct service providers receive annual training in the safe use of physical restraints. Training must focus on maintaining the safety, well-being, and dignity of participants who are physically restrained.

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

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

REPORTING

The LMHA must report the use of physical restraints on a participant to DSHS as a critical incident. [See CRITICAL INCIDENT REPORTING, policy 2200.6 of this manual.]

PROHIBITED RESTRAINTS

In accordance with 25 TAC §415.254 and §415.256, the use of chemical and mechanical restraints and seclusion are prohibited.

POLICIES AND PROCEDURES

The LMHA is responsible for training all staff members, volunteers, interns, and direct service providers on the LMHA's policies and procedures, including, but not limited to: reporting of abuse, neglect or exploitation, behavior management, crisis and safety planning, critical incident reporting, restraint, and first aid and CPR, in accordance with 25 TAC §412.304, available at:

http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=412&rl=304;

and 25 TAC §412.316, available at:

http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=2&p_dir=&p_rloc=140409&p_tloc=&p_ploc=&pg=1&p_tac=140409&ti=25&pt=1&ch=412&rl=316&dt=&z_chk=1222500&z_contains=first%20aid%20and%20CPR

The YES Waiver (Waiver) utilizes the National Wraparound Implementation Center (NWIC) model as the intensive case management delivery method for Waiver participants. [See PROGRAM TRAINING REQUIREMENTS, policy 2200.2 of this manual.]

WRAPAROUND FACILITATOR

In accordance with NWIC requirements, the Wraparound Facilitator (Facilitator) is responsible for coordinating and leading the Child and Family Team meetings to:

1. Develop goals;
2. Identify needs and desired outcomes;
3. Develop crisis and safety plans;
4. Develop the Individual Plan of Care (IPC);
5. Conduct periodic review of the participant's IPC; and
6. Develop and submit Waiver service authorization requests.

[See SERVICE AUTHORIZATION REQUEST, policy 2200.4 of this manual.]

CHILD AND FAMILY TEAM

The Child and Family Team meets to discuss and review the effectiveness of Waiver services toward the participant's identified needs and desired outcomes.

INITIAL MEETING

The initial Child and Family Team meeting must occur within seven business days of the LMHA completing the Clinical Eligibility Determination. Required to be in attendance are the:

1. Facilitator;
2. Participant; and
3. Legally authorized representative (LAR).

MONTHLY MEETINGS

After the initial meeting, the Child and Family Team must meet on a monthly basis. Required to be in attendance are the:

1. Facilitator;
2. Participant;
3. LAR;
4. CWP, or designee; and
5. Family Supports.

90-DAY MEETINGS

The Child and Family Team must meet every 90 days, at minimum, to review the service authorization. Required to be in attendance are:

1. Facilitator
2. Participant;
3. LAR;
4. CWP, or designee; and
5. Family Supports.

OTHER ATTENDEES

Other attendees who may, but are not required to, attend Child and Family Team meetings are other formal supports, such as professional therapists and informal supports such as other family members or friends.

OVERSIGHT OF INTENSIVE CASE MANAGEMENT ACTIVITIES

The local mental health authority (LMHA) oversees the Facilitator's efforts to ensure that:

1. Child and Family Team meetings are occurring as required;
2. The service authorization is aligned with the IPC developed using the Wraparound process;
3. Revisions to the service authorization occur as necessary;
4. The participant is receiving at least one billable Waiver service per month; and
5. The Facilitator's documentation demonstrates compliance with applicable law, rule, and policy.

REASSESSMENT

The LMHA completes the Texas Resilience and Recovery (TRR) Uniform Assessment every 90 days. This assessment does not impact clinical eligibility for the YES Waiver.

The clinical eligibility evaluation for continued YES Waiver eligibility is completed annually. [See CLINICAL CRITERIA AND ASSESSMENT, policy 2000.2 of this manual.]

DOCUMENTATION AND RECORD KEEPING REQUIREMENTS

The Facilitator must document Waiver services in accordance with 25 TAC §414, Subchapter I, regarding Intensive Case Management and this manual. [See RECORD KEEPING, policy 2500.3 of this manual.]

INITIAL SERVICE AUTHORIZATION REQUEST

An initial service authorization request is required to obtain authorization for YES Waiver services from the Department of State Health Services (DSHS). The initial service authorization request is based on the IPC and can be completed without every member of the Child and Family Team present, or in the absence of the comprehensive Waiver provider (CWP).

After development of the initial service authorization request, the CWP, or designee, is required to be present at all subsequent Child and Family Team meetings in which the IPC will be revised. Service authorization requests will be revised in accordance with changes to the IPC.

DEVELOPMENT

Development of the initial service authorization request includes:

1. Identifying the types of Waiver services;
2. Identifying annual quantity of Waiver services;
3. Calculating annual cost of proposed services;
4. Identifying State Plan Services;
5. Identifying non-Waiver services (i.e., DSHS general revenue flexible funds).

EFFECTIVE DATE

The effective date of the service authorization corresponds with the individual's Clinical Eligibility Determination.

END DATE

The end date of the service authorization is the end date of the Clinical Eligibility Determination (CED).

ANNUAL RENEWAL SERVICE AUTHORIZATION REQUEST

CLINICAL ELIGIBILITY REASSESSMENT

Prior to completing an annual renewal service authorization request, an annual Clinical Eligibility assessment must be performed to determine whether the participant meets continues to meet clinical eligibility to participate in the Waiver. [See CLINICAL CRITERIA AND ASSESSMENT, policy 2000.2 of this manual.] Clinical eligibility documentation must be entered into CMBHS prior to the expiration of the current CED.

Within ten business days of the annual CED being authorized by DSHS, the Wraparound Facilitator (Facilitator) must submit annual renewal service authorization request based on the IPC developed during the Child and Family Team meeting.

DEADLINE

The provision of services without an active (not expired) service authorization is not reimbursable. The annual renewal service authorization request should be entered into CMBHS in a timely manner to allow for those services to be authorized without between an expired service authorization and an annual service authorization.

EFFECTIVE DATE	The effective date of the annual service authorization corresponds with the individual's annual Clinical Eligibility Determination.
END DATE	The end date of the service authorization is the end date of the CED.
DEPARTMENT OF STATE HEALTH SERVICES REVIEW	All service authorization request types (initial, revision, and annual renewal) must be entered into CMBHS and placed in 'Ready for Review' status within five business days of completing the IPC with the Child and Family Team. Within five business days of the service authorization request being entered into CMBHS, DSHS must authorize or deny the request. Clarification or questions regarding the service authorization request from the DSHS authorizer are placed in the 'Note' section and the request is placed into 'Draft' status (not authorized).
CHANGES TO SERVICE AUTHORIZATION REQUEST	Changes to the request must be communicated to DSHS prior to authorization or denial of the request. Any changes made by the Facilitator must be placed back in 'Ready for Review' status within five business days of the request being placed into 'Draft' status by DSHS.
MONITORING	The LMHA is responsible for monitoring the status of the service authorization request in CMHBS.
COMPREHENSIVE WAIVER PROVIDER COPY	Within three business days of the DSHS authorization date of the service authorization, the LMHA must provide a copy of the service authorization to the CWP.
DENIAL	If a service authorization request is denied for any reason, DSHS must provide a reason for the denial in the 'Reviewer Notes' section CMBHS.
APPEAL	The LMHA is permitted to appeal a denial of a service authorization request by submitting an appeal service authorization request to DSHS within 14 business days of the date of denial in CMBHS.
BILLABLE SERVICES	Waiver services are provided and billed according to the units specified in the service authorization, and in accordance with the billing policies for each specific Waiver service. [See BILLING policies, beginning at 2600, of this manual.]

YES Waiver services are designed to meet needs associated with serious emotional disturbance (SED) and are not sufficient to meet the needs associated with intellectual or developmental disability (IDD) and Pervasive Developmental Disorder (PDD). The local mental health authority (LMHA) must ensure that a YES Waiver participant with a co-occurring IDD or PDD diagnosis is offered services which address both his or her SED and his or her IDD or PDD.

ASSESSMENT

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

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

WAIVER SERVICES

Community-based services and supports received through the YES Waiver address the participant's needs that arise as a result of, and are specific to, his or her SED.

As YES Waiver services do not meet the needs that arise as a result of the IDD or PDD diagnoses identified above, families should be informed of programs and resources, including 1915(c) waivers that address the needs associated with a primary IDD or PDD diagnosis.

SERVICE AUTHORIZATION

The service authorization for a participant with a co-occurring IDD diagnosis must identify non-Waiver services the participant needs in relation to his or her IDD diagnosis. These must be documented in Clinical Management for Behavioral Health Services (CMBHS) at 'Other Non-Waiver Medicaid State Plan Services' or 'Non-Waiver Services–Services Provided by Other Funding Sources'.

A local mental health authority (LMHA), comprehensive Waiver provider (CWP), and direct service provider are required to report all critical incidents that result in substantial disruption of program operation involving or potentially affecting a YES Waiver (Waiver) participant.

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

CRITICAL INCIDENT REPORT

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

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

The Critical Incident Report is available at:

http://www.dshs.state.tx.us/mhsa/yes/YES-Forms.aspx

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

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

FOLLOW UP

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

TEMPORARY INPATIENT SERVICES

In the event a Waiver participant must be placed in temporary inpatient services for a maximum of 90 days, the participant will not receive Waiver services while hospitalized; however, the participant's eligibility to remain in the Waiver will not be affected, so long as the LMHA monitors the participant on a monthly basis, and concludes that he or she will need to receive Waiver services upon discharge from the hospital.

REPORTING ADMISSION AND DISCHARGE

Upon the participant's admission and discharge from a hospital, the LMHA must complete and submit the Critical Incident Report to DSHS within 72 hours of being notified of the hospitalization or discharge.

UPDATING OF PLANS AND SERVICE AUTHORIZATION

Within seven business days of the participant's discharge from the inpatient psychiatric setting, the Facilitator must meet with the participant and LAR to review and update the crisis and safety plan.

Within 30 calendar days of the participant's discharge from the hospital or institution, the Child and Family Team must meet to review the service authorization.

CRITICAL INCIDENTS RELATED TO ABUSE, NEGLECT, OR EXPLOITATION

Critical incidents related to abuse, neglect, or exploitation (ANE) are handled in accordance with REPORTING ABUSE, NEGLECT, OR EXPLOITATION, policy 2200.7 of this manual.

RISK ASSESSMENT

DSHS will conduct a risk assessment of LMHAs and comprehensive waiver providers (CWP) on a quarterly basis. The assessment includes a review of any reported critical incidents and/or events.

Data gathered from risk assessments is reported to the Texas Health and Human Services Commission annually.

REPORTING POLICY

The local mental health authority (LMHA) must develop, implement, and enforce a written policy which trains all direct service staff members on requirements for reporting abuse, neglect, or exploitation (ANE).

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

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

FILING A REPORT

Reports of abuse or indecency with a youth are made to:

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

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

EMERGENCIES

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

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

ALLEGATIONS OF ABUSE, NEGLECT, OR EXPLOITATION (ANE)

Allegations of ANE must be reported by the LMHA to the appropriate investigative authority immediately.

Within one business day following an allegation of ANE, the LMHA must submit the Client Abuse and Neglect Reporting form to DFPS. The form is available at:

http://www.dshs.state.tx.us/mhsa/yes/YES-Forms.aspx

INVESTIGATIVE AUTHORITY

Investigative authority over allegations of ANE is in accordance with the following:

DFPS	DFPS has investigative authority of ANE involving Waiver participants when the alleged perpetrator(s) is: 1. An employee of the LMHA; 2. An employee of an agent of the LMHA; 3. An employee of a subcontractor of the LMHA; or 4. A parent or primary caregiver.
LAW ENFORCEMENT	Law enforcement has investigative authority of allegations of ANE involving Waiver participants when the alleged perpetrator is any other entity or any other person not under DFPS' investigative authority.

When the Child and Family Team determines that it is in the best interest of a YES Waiver (Waiver) participant to transition out of Waiver services to a less-intensive service array, and/or can utilize natural and community supports to achieve his or her goals and objectives, the local mental health authority (LMHA) must oversee the development a transition plan.

NOTIFICATION OF TRANSITION

The LMHA must notify the CWP of a participant's upcoming transition out of Waiver services.

PLAN DEVELOPMENT

The transition plan must be developed in consultation with the participant, legally authorized representative (LAR), current comprehensive Waiver provider, and future providers.

The transition plan must include:

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

TERMINATION OF SERVICES

The LMHA must submit a copy of the transition plan to DSHS at least 30 days prior to the date of the participant's termination from the Waiver.

TERMINATION SERVICE AUTHORIZATION REQUEST

A termination service authorization request must be entered into Clinical Management for Behavioral Health Services (CMBHS) within ten business days of the participant's termination from the Waiver.

The local mental health authority (LMHA) must establish a plan to transition to adult services for any participant who turns 19 years of age while receiving Waiver services.

NOTIFICATION OF TRANSITION

The LMHA must notify the comprehensive Waiver provider (CWP) and the Department of State Health Services (DSHS) at least six months prior to the participant's aging out of YES Waiver (Waiver) services.

PLAN DEVELOPMENT

At least six months prior to the participant's 19th birthday, development of the transition must begin, in consultation with the participant, legally authorized representative (LAR), current comprehensive Waiver provider (CWP), and future providers.

The transition plan must include:

1. A summary of the mental health community services and treatment the youth received as a Waiver participant;
2. The assistance that will be provided to the participant as part of the transition plan;
3. Strategies for the transition;
4. The participant's current status (e.g., diagnosis, medications, level of functioning) and unmet needs;
5. Information from the participant and the legally authorized representative (LAR) regarding the participant's strengths, preferences for mental health community services, and responsiveness to past interventions;
6. A service plan that indicates the mental health and other community services the participant will receive as an adult; and
7. Adequate time for both current and future providers to transition the participant into adult services without a disruption in services.

TERMINATION OF SERVICES

The participant's transition out of, and termination from, the Waiver must be completed on the last day of the month preceding the participant's 19th birthday.

The LMHA must submit a copy of the transition plan to DSHS at least 30 days prior to the participant's date of termination from the Waiver.

TERMINATION SERVICE AUTHORIZATION REQUEST

A termination service authorization request must be entered into Clinical Management for Behavioral Health Services (CMBHS) within ten business days of the participant's termination from the Waiver.

The local mental health authority (LMHA) is responsible for coordinating the transfer of YES Waiver (Waiver) services for a participant who:

1. Chooses a different provider within his or her Waiver service are; or
2. Moves to a different Waiver service area in the state.

COORDINATION OF TRANSFER

CHILD AND FAMILY TEAM MEETING

The Wraparound Facilitator (Facilitator) must have a Child and Family Team meeting to discuss termination of services with the current CWP and the selection of a new CWP. The current CWP must communicate critical issues or family needs to either the receiving CWP or the LMHA. The Facilitator must inform the family of any approved services that may not continue after the transfer to the new CWP is complete.

ESTIMATE OF REMAINING UNITS OR DOLLAR AMOUNT

The CWP must provide the LMHA with an estimate of outstanding units of YES Waiver services, if applicable. The exact amount of units is not required.

The CWP must also provide the LMHA with an estimate of outstanding dollar amounts for the cost of adaptive aids and supports or minor home modifications, if applicable. The exact dollar amount is not required.

TERMINATION OF SERVICE AUTHORIZATION

The LMHA must terminate the current service authorization in CMBHS and include:

1. The reason for the transfer;
2. The date of termination;
3. The name of the new CWP and CWP representative; and
4. An estimated total dollar amount of services used as of the date of the transfer in the ‘Note’ section.

CREATE NEW INITIAL SERVICE AUTHORIZATION

The LMHA must then create a new initial service authorization in CMBHS and include:

1. The start date, which will be 1 day later than the Child and Family Team meeting. Indicate the reason in the ‘Note’ section as ‘Changing comprehensive Waiver provider”;
2. The end date of the original service authorization in the ‘Note’ section; and

3. An estimated total dollar amount of services used as of the date of the transfer in the 'Note' section.

RECEIVING PARTICIPANT TRANSFER

The LMHA receiving the participant transfer must:

1. Review the transfer packet.
2. Contact the participant and LAR to schedule a face-to-face meeting within seven business days of receiving the transfer.
3. Complete the process necessary to authorize the participant in LOC-YES.
4. Appoint a Wraparound Facilitator.
5. Identify the Child and Family Team.
6. Determine whether the current IPC will be kept as written or revised, or whether a new IPC will be developed.
7. Review and revise the participant's crisis and safety plan, as needed.
8. Submit a new service authorization for Waiver services within ten business days in CMBHS.

RELOCATION OUTSIDE OF TEXAS

A participant who moves out of the state is no longer eligible to participate in the Waiver and must be terminated from the Waiver program. The LMHA must inform the participant and LAR that Waiver services will be terminated. [See TERMINATION OF WAIVER SERVICES, policy 2200.11 of this manual.]

The LMHA must complete and submit a termination service authorization request in the Clinical Management for Behavioral Health Services (CMBHS), documenting the reason for and the effective date of the termination.

REASONS FOR TERMINATION

A participant will be terminated from the YES Waiver (Waiver) in the event:

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

TERMINATION SERVICE AUTHORIZATION REQUEST

A termination service authorization request must be entered into Clinical Management for Behavioral Health Services (CMBHS) within ten business days of the participant's termination from the Waiver.

If the participant and LAR refuse services, move, are not engaged in Waiver services and the Wraparound process, are unable to sign the termination service authorization request, or the participant is in a residential treatment facility for more than 90 consecutive days, the Wraparound Facilitator must provide documentation in the 'Notes on IPC Type' section of the termination service authorization request.

To increase awareness of the home and community-based services that are available to youth with a serious emotional disturbance (SED) through the YES Waiver (Waiver), the local mental health authority (LMHA) must develop and implement a strategic outreach and marketing plan.

OUTREACH STRATEGIES

Strategies the LMHA is required to utilize for outreach and marketing includes, but is not limited to:

1. Posting an overview of the Waiver on the LMHA's Web site;
2. Utilizing marketing materials available through the Department of State Health Services (DSHS);
3. Establishing a Waiver Inquiry phone line [See INQUIRY LIST, policy 2200.1 of this manual];
4. Working with stakeholders in the LMHA's service area to identify potential participants;
5. Presenting information about the Waiver at community events; and
6. Conducting presentations for staff of behavioral health centers, social service agencies, school districts, behavioral health consortia, private hospitals, juvenile justice centers, managed care organizations, and other potential referral sources.

OUTREACH MATERIAL APPROVAL

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

NOTICE OF OPEN ENROLLMENT (NOE)

The Department of State Health Services (DSHS) must post a Notice of Open Enrollment (NOE) to request applications for entities interested in providing all services covered under the YES Waiver (Waiver).

The NOE must describe the eligibility requirements for an entity to become a credentialed comprehensive Waiver provider (CWP). An interested entity must meet, and maintain, the eligibility requirements contained in the NOE throughout the application and selection process.

The interested entity must submit the application in accordance with the instructions provided in the NOE.

CREDENTIALING

CWPs are credentialed by DSHS through a desk review and an on-site review. The local mental health authority (LMHA) is not responsible for, nor has a role in, credentialing CWPs.

DESK REVIEW

Upon receiving the application and other required documents, DSHS must complete a review of all submitted materials within ten business days.

DSHS notifies the entity via email that the desk review is complete and to schedule the on-site review.

ON-SITE REVIEW

DSHS will conduct the on-site review after completion of the desk review. The on-site review includes, but is not limited to, a tour of the facility, interviews with pertinent staff, and the review and verification of:

1. Facility and staff availability;
2. Staff credentialing and privilege;
3. Quality assurance/management;
4. Clinical operations;
5. Treatment records;
6. Facility safety;
7. Facility appearance;
8. Record keeping;
9. Confidentiality practices;
10. Utilization program;
11. Organization of administration;
12. Staffing plan; and
13. Medication safety.

APPROVAL PROVIDER AGREEMENT	Following successful completion of the desk review and on-site review, DSHS will enter into a Medicaid Provider Agreement with the approved CWP.
YES PROVIDER TYPE	The CWP will receive an approval letter from DSHS, to enable the CWP to apply for and obtain its YES Waiver-specific provider type. Upon receipt of the approval letter from DSHS, the CWP must contact Texas Medicaid Healthcare Partnership (TMHP) to enroll as a Waiver provider; however, Waiver services must not begin until the Waiver provider type has been determined by TMHP. [See BILLING, ENROLLMENT IN TEXAS MEDICAID HEALTHCARE PARTNERSHIP, policy 2600 of this manual.]
PROGRAM TRAINING	Prior to providing Waiver services and/or participating on a Child and Family Team, a CWP staff member must receive program training in accordance with PROGRAM TRAINING REQUIREMENTS, policy 2300.2 of this manual.
CREDENTIALING	Once all program training requirements are met, the CWP credentialing process is considered complete by DSHS and the CWP is permitted to begin Waiver services.
LICENSING AND COMPLIANCE	DSHS monitors CWPs for compliance with licensing requirements. At any time harmful or non-compliant practices are identified, corrective action will be taken to bring the CWP back into compliance.

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

Criminal history and background checks must be conducted in accordance with 25 TAC §414, Subchapter K, available at:

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

DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS)

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

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

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

NURSE AIDE REGISTRY

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

EMPLOYEE MISCONDUCT REGISTRY

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

DOCUMENTATION

Upon becoming credentialed as a CWP by DSHS, and in accordance with 25 TAC §414, Subchapter K, a CWP is required to maintain a documented process for keeping criminal history checks and abuse registry checks up to date on all individuals who are providing Waiver services, including subcontractors.

NOTIFICATION OF CHANGE IN CRIMINAL HISTORY

The CWP must notify DSHS of any changes to the criminal history and/or abuse registry check for any individual who has been involved in providing Waiver services, in writing, within three business days of the CWP discovering the change in the criminal history or abuse registry.

The comprehensive Waiver provider must ensure that prior to providing Waiver services and/or participating on Child and Family Team, all comprehensive Waiver provider staff member and direct service providers receive program training in accordance with the following:

YES WAIVER

The CWP must receive YES Waiver (Waiver) training from the Department of State Health Services (DSHS) that consists of:

1. Waiver overview and background;
2. Waiver service array;
3. Provider qualifications;
4. Service authorization request development; and
5. Use of Clinical Management for Behavioral Health Services (CMBHS).

SYSTEMS OF CARE AND WRAPAROUND

Within the first three months of hire, each CWP staff member and direct service provider must complete the following online trainings on the Introduction to Systems of Care and the Wraparound Initiative service delivery method:

1. What's This Thing Called Wraparound?;
2. Team Roles in Wraparound; and
3. Overview of the Youth Empowerment Services (YES) Waiver.

The online trainings and additional information are available at: http://www.txsystemofcare.org/

RESTRAINT

LIMITED USE OF PHYSICAL RESTRAINT

The limited use of physical restraints is permitted in the delivery of YES Waiver (Waiver) services only when:

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

Use of restraints must be used in accordance with 25 TAC §415, Subchapter F, available at:

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

When used, restraints must be used for the shortest period of time necessary and terminated upon the participant demonstrating release behaviors specified by the ordering physician.

TRAINING

The CWP must ensure staff members are trained in the safe use of physical restraints. Training must focus on maintaining the safety, well-being, and dignity of participants who are physically restrained.

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

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

REPORTING

The CWP must report the use of physical restraints on a participant to DSHS as a critical incident. [See CRITICAL INCIDENT REPORTING, policy 2200.6 of this manual.]

PROHIBITED RESTRAINTS

In accordance with 25 TAC §415.254 and §415.256, the use of chemical and mechanical restraints and seclusion are prohibited.

POLICIES AND PROCEDURES

The CWP is responsible for training all staff members, volunteers, interns, and direct service providers on the CWP's policies and procedures, including, but not limited to: reporting of abuse, neglect or exploitation (ANE), behavior management, crisis and safety planning, critical incident reporting, restraint, and first aid and CPR, in accordance with 25 TAC §412.304, available at:

http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=412&rl=304;

and 25 TAC §412.316, available at:

http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=2&p_dir=&p_rloc=140409&p_tloc=&p_ploc=&pg=1&p_tac=140409&ti=25&pt=1&ch=412&rl=316&dt=&z_chk=1222500&z_contains=first%20aid%20and%20CPR

COMPREHENSIVE WAIVER PROVIDER
GENERAL RESPONSIBILITIES 2300.3

OVERVIEW

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

STAFFING

The CWP is responsible for:

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

SERVICE DELIVERY

The CWP is responsible for:

1. Training and supervising all staff and/or subcontractors in the provision of Waiver services.
2. Attending Child and Family Team meetings.
3. Providing services and supports, by staff or subcontractors, in appropriate locations that are in the best interest of the participant.
4. Appropriately matching the skill set of a direct service staff member with the most recent assessment of a participant.
5. Implementing services that are authorized in the participant's YES Waiver service authorization.
6. Monitoring services for consistency with the participant's service authorization and verifying authorization prior to the provision of services.
7. Monitoring proper implementation and provision of Waiver services in accordance with the participant's service authorization.
8. Training staff and/or subcontractors on the Wraparound process.

9. Notifying the Wraparound Facilitator of significant changes in the participant's situation or needs.

TRAINING

The CWP is responsible for:

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

DOCUMENTATION

The CWP is responsible for:

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

BILLING

The CWP is responsible for:

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

OPERATIONS

The CWP is responsible for:

1. Complying with all rules and regulations of the DSHS.
2. Complying with all licensure rules and regulations and maintaining current licenses.
3. Reporting suspected fraudulent practices in accordance with DSHS rules.
4. Completing and submitting critical incident reports. [See CRITICAL INCIDENT REPORTING, policy 2200.6 of this manual.]
5. Reporting allegations of abuse, neglect, and exploitation (ANE). [See REPORTING ABUSE, NEGLECT, OR EXPLOITATION, policy 2200.7 of this manual.]
6. Implementing a procedure for reporting a complaint against the CWP or its staff and/or subcontractors.

AGREEMENT

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

The agreement must include the following:

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

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

VERIFICATION OF QUALIFICATIONS

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

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

DOCUMENT RETENTION

The CWP must retain a copy of all current, amended, or revised subcontractor agreements. [See RECORD KEEPING, policy 2500.3 of this manual.]

SUBCONTRACTOR RESPONSIBILITIES

An individual or agency entering into a subcontractor agreement to provide Waiver services is responsible for:

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

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

SCOPE

The comprehensive Waiver provider (CWP) will ensure that medications are administered only by individuals with authority to do so by the nature and scope of their license, certification, and/or practice.

This policy shall also apply to a local mental health authority (LMHA) that administers medication.

PRESCRIPTION MEDICATION ADMINISTRATION

The CWP is responsible for administering prescription medication to a Waiver participant who is unable to self-administer medication. To administer prescription medication to a YES Waiver participant, the CWP shall:

1. Obtain a signed authorization from the participant's legally authorized representative (LAR);
2. Ensure medication is in its closed, original container, and includes the:
   a. Participant's full name;
   b. Participant's date of birth;
   c. Name of the prescribing doctor or other licensed health professional; and
   d. Expiration date.
3. Ensure medication is administered in accordance with a physician or other licensed health professional's instructions and label directions;
4. Ensure expired medications are not administered to the participant;
5. Administer the medication only to the participant for whom it is intended; and
6. Notify the LAR of any expired prescription medication.

SELF-ADMINISTRATION

A participant is permitted to self-administer prescription medication under the supervision of a CWP direct service staff member. To permit a participant to self-administer medication, the CWP must:

1. Obtain a signed authorization from the participant's LAR;
2. Ensure medication is in its closed, original container, and includes the:
   a. Participant's full name;
   b. Participant's date of birth;

c. Name of the prescribing doctor or other licensed health professional; and

d. Expiration date;

3. Ensure medication is administered in accordance with a physician or other licensed health professional's instructions and label directions;

4. Ensure the participant is not self-administering expired medication;

5. Ensure the participant is administering only to him or herself; and

6. Notify the LAR of any expired prescription medication.

DOCUMENTATION

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

1. Full name of participant taking the medication;

2. Name of the medication;

3. Date, time, and amount of medication given or taken; and

4. Full name of the direct service staff member administering the medication or supervising the participant's self-administration.

The CWP must retain records of medication administration for three months following the date of the administration. [See RECORD KEEPING, policy 2500.3 of this manual.]

UNUSED MEDICATION

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

NONPRESCRIPTION MEDICATION

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

ADMINISTRATION ERRORS

The CWP is required to report any medication administration error to DSHS as a critical incident. [See CRITICAL INCIDENT REPORTING, policy 2200.6 of this manual.]

Medication errors that must be reported to DSHS include, but are not limited to:

1. Administering medication to the wrong person;

2. Administering the wrong medication;

3. Administering the wrong dosage;

4. Failing to administer medication at the prescribed time;
5. Failing to follow administration instructions properly; or
6. Failing to accurately document the administration.

STORAGE

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

COMPREHENSIVE WAIVER PROVIDER
TEMPORARY OUT-OF-HOME LIVING ARRANGEMENT 2300.6

DEFINITION

A temporary out-of-home living arrangement is defined as a temporary living arrangement, not funded through YES Waiver (Waiver) Respite or Supportive Family-Based Alternatives services, in which the participant is residing on a daily basis, away from the legally authorized representative (LAR), or outside of his or her own apartment or home, if a legally emancipated minor.

Examples of temporary out-of-home living arrangements include, but are not limited to: shelter, group home, residential treatment center, or other facility-based setting.

DURATION

A temporary out-of-home living arrangement is permitted to last up to 90 consecutive or cumulative days per service authorization year.

WAIVER STATUS

During the time a participant is in a temporary out-of-home living arrangement, he or she remains enrolled in the Waiver, but cannot receive Waiver services.

CASE MANAGEMENT

In the case of temporary out-of-home living arrangement Waiver participants should not be terminated from Waiver and therefore should maintain an authorization for LOC-YES. The provision of intensive case management (ICM) is allowable within 180 days of discharge from an institutional setting and must continue on a monthly basis in order to coordinate and document the participant's plan to transition back to residing with the LAR or back to the participant's home or apartment, if legally emancipated.

REPORTING TO THE DEPARTMENT OF STATE HEALTH SERVICES

Monthly status updates on the participant's planned transition from temporary out-of-home living arrangement must be provided to the Department of State Health Services (DSHS).

Temporary out-of-home living arrangements in an institutional setting must be reported to DSHS as a critical incident. [See CRITICAL INCIDENT REPORTING, policy 2200.6 of this manual.]

The local mental health authority (LMHA) must contact DSHS when the participant is no longer residing in the temporary out-of-home living arrangement. If the participant has not received Waiver services for at least 90 days, the LMHA must submit an updated service authorization request to DSHS within 30 calendar days of the day the participant stopped residing in the temporary out-of-home living arrangement.

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

OUTREACH STRATEGIES

Strategies the CWP will utilize for outreach and marketing includes, but is not limited to:

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

OUTREACH MATERIAL APPROVAL

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

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

LOCAL MENTAL HEALTH AUTHORITY RESPONSIBILITIES

At least 30 calendar days prior to the date of termination, the local mental health authority (LMHA) must provide notice to the participant and legally authorized representative (LAR) that the CWP agreement with DSHS is being terminated.

COORDINATION OF TRANSFER OF PARTICIPANT

CHILD AND FAMILY TEAM MEETING

The Wraparound Facilitator (Facilitator) must have a Child and Family Team meeting to discuss termination of services with the current CWP and the selection of a new CWP. The current CWP must communicate critical issues or family needs to either the receiving CWP or the LMHA. The Facilitator must inform the family of any approved services that may not continue after the transfer to the new CWP is complete.

ESTIMATE OF REMAINING UNITS OR DOLLAR AMOUNT

The CWP must provide the LMHA with an estimate of outstanding units of YES Waiver services, if applicable. The exact amount of units is not required.

The CWP must also provide the LMHA with an estimate of outstanding dollar amounts for the cost of adaptive aids and supports or minor home modifications, if applicable. The exact dollar amount is not required.

TERMINATION OF SERVICE AUTHORIZATION

The LMHA must terminate the current service authorization in CMBHS and include:

1. The reason for the transfer;
2. The date of termination;
3. The name of the new CWP and CWP representative; and
4. An estimated total dollar amount of services used as of the date of the transfer in the ‘Note’ section.

CREATE NEW INITIAL SERVICE AUTHORIZATION

The LMHA must then create a new initial service authorization in CMBHS and include:

1. The start date, which will be 1 day later than the Child and Family Team meeting. Indicate the reason in the ‘Note’ section as ‘Changing comprehensive Waiver provider”;

2. The end date of the original service authorization in the 'Note' section; and

3. An estimated total dollar amount of services used as of the date of the transfer in the 'Note' section.

COMPREHENSIVE WAIVER PROVIDER RESPONSIBILITIES

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

SERVICE LIMITATIONS

A YES Waiver (Waiver) service authorization is 365 days, per participant. The cost limit for all Waiver services that can be provided to a participant in a year is $35,804.

Only one Waiver service is permitted to be provided at a time. Community living supports (CLS), family supports, and paraprofessional services are permitted to be present and to bill for time providing service as part of the Child and Family Team meeting, if participant has an identified need for service(s) at that time.

A participant's legally authorized representative (LAR) and other primary caregivers are permitted to receive family support services while the participant is receiving another Waiver service.

SERVICE COORDINATION

The Child and Family Team determine the frequency and duration of each service provided to the participant.

Services are initially arranged by the Wraparound Facilitator (Facilitator). The Waiver provider will arrange the subsequent service schedule in accordance with the service authorization.

The Facilitator must meet with the participant and LAR every 30 calendar days to determine effectiveness of services. [See INTENSIVE CASE MANAGEMENT–WRAPAROUND, policy 2200.3 of this manual.]

Revisions and/or adjustments to a participant's individual plan of care (IPC) and subsequent revisions to the service authorization must be coordinated by the Facilitator, in collaboration with the provider, participant, and LAR.

SERVICE DOCUMENTATION

Documentation requirements for service authorization requests, the Wraparound Plan/IPC, progress notes, and provision of services, are described in each individual service policy, beginning at policy 2400 of this manual.

Documentation requirements for billing are detailed in the billing policies for each individual service, beginning at policy 2600.3 of this manual.

GROUP SETTING SERVICES

Certain Waiver services are permitted to be provided in a group setting, if identified as clinically appropriate by the Child and Family Team and must consist of no more than six individuals, excluding service providers.

The following Waiver services are permitted to be provided in a group setting:

1. Community Living Supports (CLS);
2. Family Supports;

3. Paraprofessional Services; and

4. Specialized Therapies.

BILLING

For information on billing for group setting services, see specific policy for each of the four services above.

TYPES OF ADAPTIVE AIDS AND SUPPORTS

There are five types of Adaptive Aids and Services (AA&S):

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

CONSUMABLE GOODS

Consumable goods include, but are not limited to: psycho-educational materials and art supplies.

WRAPAROUND PLAN

The Wraparound Plan must describe:

1. The participant's identified need, linked to his or her serious emotional disturbance (SED);
2. How the good will be used by the participant, including strategies or action steps; and
3. How the good will assist the participant in achieving his or her identified goals.

SERVICE AUTHORIZATION REQUEST

An AA&S service authorization request for a consumable good must include:

1. An estimated maximum dollar cost for the purchase of the requested good;
2. A link between the use of the requested good(s), the participant's identified need, and his or her SED; and
3. A statement that the requested good is being purchased through Medicaid as a last resort.

PROGRESS NOTES

Progress notes documenting the use of consumable goods, which are reviewed by DSHS, must include:

1. Participant name;
2. Service name and description;
3. Specific skill(s) received and method used to train participant in skill(s);
4. Participant response to use of consumable good; and
5. Participant progress or lack of progress.

PROVISION OF SERVICE DOCUMENTATION

Documentation of the provision of service, which is reviewed by DSHS, must include:

1. Use of the good(s);
2. An invoice or receipt for the purchase of the material(s), which is in compliance with Waiver policies and procedures;
3. Proof that at least three bids or prices were solicited for goods costing over $500.

DURABLE GOODS

Durable goods include, but are not limited to: exercise equipment, sports equipment, and musical instruments.

WRAPAROUND PLAN

The Wraparound Plan must describe how:

1. The chosen good addresses the participant's identified need, linked to his or her severe emotional disturbance;
2. The chosen good will be used by the participant, including strategies or action steps;
3. The chosen good will assist the participant in achieving his or her identified goals; and
4. Use of the chosen good will be monitored.

SERVICE AUTHORIZATION REQUEST

An AA&S service authorization request for a durable good must include:

1. An estimated maximum dollar cost for the purchase of the requested good;
2. A link between the use of the requested good(s), the participant's identified need, and his or her SED; and
3. A statement that the requested good is being purchased through Medicaid as a last resort; and
4. Whether sports equipment, including safety equipment, is needed by the participant or the participant already has the necessary equipment.

For musical instruments, the provider must verify the intent of continued participation in and the number of months of music class or therapy, prior to the purchase of the instrument.

PROGRESS NOTES

Progress notes documenting the use of durable goods, which are reviewed by DSHS, must include:

1. Participant name;

2. Service name and description;
3. Specific skill(s) received and method used to train participant in skill(s);
4. Participant response to service being provided; and
5. Participant progress or lack of progress.

PROVISION OF SERVICE DOCUMENTATION

Documentation of the provision of service, which is reviewed by DSHS, must include:

1. Use of the good(s);
2. An invoice or receipt for the purchase of the material(s), in the participant's case record, in accordance with RECORD KEEPING, policy 2500.3 of this manual; and
3. Verification of soliciting at least three bids or prices for goods costing over $500.

LESSONS, CLASSES, AND SEASONAL ACTIVITIES

Lessons, classes, and seasonal activities include, but are not limited to: karate classes, guitar lessons, and playing team sports.

WRAPAROUND PLAN

The Wraparound Plan must describe how the lesson, class, or seasonal activity:

1. Addresses the participant's identified need, linked to his or her severe emotional disturbance; and
2. Will assist the participant in achieving his or her identified goals.

SERVICE AUTHORIZATION REQUEST

An AA&S service authorization request for lessons, classes, or seasonal activities must include:

1. An estimated maximum dollar cost that adequately pays for participation in the requested activity;
2. A link between the use of the requested good(s), the participant's identified need, and his or her SED; and
3. The date range of the requested; lesson, class, or seasonal activity, not to exceed 90 days;
4. A statement that the cost for participating in the lesson, class, or seasonal activity is being purchased through Medicaid as a last resort; and
5. An assurance that the health and safety and background checks will be completed prior to the provision of service.

PROGRESS NOTES

Progress notes documenting the provision of lessons, classes, or seasonal activities, which are reviewed by DSHS, must include:

1. Participant name;
2. Service name and description;
3. Start and end date of lesson, class, or seasonal activity;
4. Service location(s);
5. Specific skills participant received and method used to train participant in skill(s);
6. Participant response to service being provided;
7. Participant progress or lack of progress;
8. Summary of activities during the service; and
9. Direct service provider's signature and credentials.

PROVISION OF SERVICE DOCUMENTATION

Documentation of the provision of service, which is reviewed by DSHS, must include:

1. Participation in the lessons, classes, or activities;
2. An invoice or receipt for the purchase of the material(s), which is in compliance with Waiver policies and procedures;
3. Verification of soliciting at least three bids or prices for goods costing over $500;
4. Proof of completed health and safety and background checks; and
5. Proof that service provider has at least one year of documented experience in the area of expertise.

MEMBERSHIPS

Memberships include, but are not limited to: Young Men's Christian Association (YMCA), Girl Scouts, Boys and Girls Clubs.

WRAPAROUND PLAN

The Wraparound Plan must describe how the membership:

1. Addresses the participant's identified need, linked to his or her SED; and
2. Will assist the participant in achieving his or her identified goals.

SERVICE AUTHORIZATION REQUEST

An AA&S service authorization request for a membership must include:

1. An estimated maximum dollar cost that adequately pays for the requested membership;
2. A link between the use of the requested good(s), the participant's identified need, and his or her SED; and
3. A statement that the cost for participating in the lesson, class, or seasonal activity is being purchased through Medicaid as a last resort;
4. The date range of the requested membership, not to exceed 90 days; and
5. An assurance that the health and safety and background checks will be completed prior to the provision of service.

PROGRESS NOTES

Progress notes documenting the effectiveness of the membership in the participant's treatment, which are reviewed by DSHS, must include:

1. Participant name;
2. Date of contact with the participant;
3. Start and stop time of the service;
4. Service name and description;
5. Service location;
6. Benefit of membership in treatment of participant's SED;
7. Participant response to service being provided;
8. Participant progress or lack of progress; and
9. Summary of activities and behaviors during the service.

PROVISION OF SERVICE DOCUMENTATION

Documentation of the provision of service, which is reviewed by DSHS, must include:

1. Use of the membership;
2. An invoice or receipt for the purchase of the membership, which is in compliance with Waiver policies and procedures;
3. Proof of completed health and safety and background checks; and

4. Proof that service provider has at least one year of documented experience in the area of expertise.

CAMPS

Camps include, but are not limited to: American Camp Association member camps; or camps sponsored by a university or a nationally recognized organization.

WRAPAROUND PLAN

The Wraparound Plan must describe:

1. A link between the camp, the participant's identified need, and his or her SED; and
2. How the camp will assist the participant in achieving his or her identified goals.

The Wraparound Plan must also include documentation that the Wraparound Facilitator:

1. Provided the camp with information on participant's SED;
2. Obtained a release of information form the legally authorized representative for camp;
3. Provided the camp with a copy of the participant's crisis and safety plan; and
4. Prepared the participant for the camp prior to camp attendance.

SERVICE AUTHORIZATION REQUEST

An AA&S service authorization request for an overnight camp must include:

1. The type of camp;
2. An estimated maximum dollar cost that adequately pays for attendance at the camp;
3. A link between the camp, the participant's identified need, and his or her SED; and
4. Confirmation of the requested camp's accreditation by the American Camp Association; sponsorship of a university or nationally recognized organization; or, for other types of camps, an assurance that the health and safety and background checks will be completed prior to the provision of service.

PROGRESS NOTES

Progress notes are required for the provision of services at a camp. Progress notes must include:

1. Participant name;
2. Start and stop date of the camp;

3. Camp name and description;
4. Camp location;
5. Specific skill(s) received and method used to train participant in skill(s);
6. Participant response to camp attendance;
7. Participant progress or lack of progress;
8. Summary of activities, meals, and behaviors camp; and
9. Direct service provider's signature and credentials.

PROVISION OF SERVICE DOCUMENTATION

Documentation of the provision of service, which is reviewed by DSHS, must include:

1. Attendance at the camp;
2. An invoice or receipt for the purchase of the camp, which is in compliance with Waiver policies and procedures; and
3. Proof of the camp's American Camp Association accreditation; documentation of sponsorship by a university or nationally recognized organization; or a completed health and safety and background check.

SERVICE AUTHORIZATION REQUEST–REVISIONS AND ANNUAL RENEWALS

When completing a 90-day service authorization revision request or an annual renewal service authorization request, the local mental health authority (LMHA) must include continued use of a previously approved AA&S, if applicable, and describe the benefits of continuing the AA&S to meet the participant's identified need(s) and goal(s).

BILLING

Information regarding billable and non-billable services, payment rate, and required documentation for submitting a claim for AA&S is detailed in BILLING, ADAPTIVE AIDS AND SUPPORTS, policy 2600.3 of this manual.

PARTICIPANT HEALTH AND SAFETY

Ensuring the health and safety of a YES Waiver (Waiver) participant is a top priority. A comprehensive Waiver provider (CWP) must take reasonable measures to protect a participant from abuse, neglect, and exploitation (ANE) and to ensure the safety of the physical location of adaptive aids and supports (AA&S).

Decisions regarding the participant's activities will be based on a reasonable and prudent parent standard, in accordance with the Department of Family and Protective Services' (DFPS) Minimum Standards for Child-Placing Agencies.

PLACES OF PUBLIC USE

Locations for AA&S that are public places must be safe for human use. A legally authorized representative (LAR), LAR's designee, or a local mental health authority (LMHA) or CWP staff member will be held to a reasonable and prudent parent standard when accompanying the participant to places of public use, including, but not limited to: museums, parks, and zoos.

SHORT-TERM ACTIVITIES

A participant engaging in a short-term activity or one-time event must be accompanied by, and under the constant supervision of, the LAR, LAR's designee, a LMHA staff member, or a CWP staff member.

ONGOING ACTIVITIES

When a participant is engaging in an ongoing activity for a specific service, lesson, or encounter, for a limited number of hours per week or month, the CWP must:

1. Complete a criminal history and background check, in accordance with 25 TAC §414, Subchapter K, of any person who will have substantial, or potentially substantial, contact with the participant; and
2. Conduct a check of the Nurse Aide Registry and the Employee Misconduct Registry, in accordance with the Department of Aging and Disability Services (DADS), of any person who will have substantial, or potentially substantial, contact with the participant. Consolidated results for the Nurse Aide Registry and the Employee Misconduct Registry are available at:

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

BUSINESSES WITHIN CITY LIMITS

The CWP must obtain a copy of the certificate of occupancy of a business providing a Waiver service that is located within city limits.

If for any reason a business within a city limit does not have a certificate of occupancy, the CWP must provide justification to DSHS in the service authorization for choosing that particular service provider and why the business does not have a certificate of occupancy. The CWP must also complete the Building Safety and Environmental Health Checklist.

BUSINESSES OUTSIDE OF CITY LIMITS	The CWP must complete the Building Safety and Environmental Health Checklist when a business located outside of city limits is chosen as a Waiver service provider.
NOTIFICATION OF CHANGE IN CRIMINAL HISTORY	The CWP must notify DSHS of any changes to the criminal history and/or abuse registry check for any individual who has been involved in providing Waiver services, in writing, within three business days of the CWP discovering the change in the criminal history or abuse registry.

SERVICE DESCRIPTION

Community living supports (CLS) facilitate a YES Waiver (Waiver) participant's independence and integration into the community, while providing assistance to the family caregiver in the disability-related care of the participant.

LIMITATION

CLS cannot be provided at the same time as:

1. Employment assistance;
2. Non-medical transportation;
3. Respite services
4. Supported employment; or
5. Supportive family-based alternatives.

SKILLS TRAINING

FOR PARTICIPANT

CLS provide a curriculum based skills training to a participant for skills that are affected by the participant's serious emotional disturbance (SED), as identified in the Wraparound Plan.

Training can be related to activities of daily living, such as personal hygiene, household chores, and socialization. CLS may also promote communication, relationship-building skills, and integration into community activities. These supports must be targeted at enabling the participant to attain or maintain his or her maximum potential. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings.

FOR FAMILY CAREGIVER(S)

In addition to training skills for the participant, CLS may also provide skills training to the family caregiver, depending upon the participant's age, the nature of the SED, the role of medications, and the self-administration of medications, if applicable.

Instructions on basic parenting skills and other forms of guidance can be provided to the participant's primary caregivers to assist in coping with and managing the participant's SED.

PROVIDER QUALIFICATIONS

CLS services must be provided by a credentialed Qualified Mental Health Professional–Community Services (QMHP–CS) or QMHP–CS equivalent, defined as an individual who:

1. Has a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major, as determined by the local mental health authority (LMHA), in accordance with 25 TAC §412.316(d), in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development,

physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention;

2. Is a registered nurse (RN);

3. Has completed an alternative credentialing process identified by the Department of State Health Services; or

4. Has a master's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention; and

5. Has had a criminal history and background check. [See CRIMINAL HISTORY AND BACKGROUND CHECK, policy 2300.1 of this manual.]

Information regarding competency and credentialing in 25 TAC §412.316(d) is available at:

http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=412&rl=316

WRAPAROUND PLAN

The Wraparound Plan must describe:

1. The skills training that will be provided to participant, as they relate to achieving the participant's identified goal(s);

2. The strategies and/or action steps that will be used to assist the participant in achieving the identified goal(s); and

3. The type, scope, and duration of the service.

PROGRESS NOTES

Progress notes are required for the provision of CLS services and must include:

1. Participant name;

2. Date of contact with the participant;

3. Start and stop time of contact with the participant;

4. Service name and description;

5. Service location;

6. Training methods used, if applicable (e.g. instructions, modeling, role play, feedback, repetition)

7. Title of curriculum being used, if applicable
8. Wraparound plan objective(s) that was the focus of the service;
9. Use of adaptive aids and supports, if applicable;
10. Transportation services, if applicable;
11. Participant response to CLS service being provided;
12. Progress or lack of progress in achieving Wraparound Plan goals;
13. Summary of activities, meals, and behaviors during the service; and
14. Direct service provider's signature and credentials.

NON FACE-TO-FACE CONTACT WITH PARTICIPANT

When CLS services provided to a participant are not face-to-face, the provider must document in the progress notes:

1. Date of the contact;
2. Description of the contact; and
3. Direct service provider's signature and credentials.

CONTACT WITH OTHER PARTIES

When CLS services are provided face-to-face, or provided over the phone with someone other than the participant, such as, but not limited to, the legally authorized representative (LAR), the provider must document in the progress notes:

1. Date of the contact;
2. Person with whom the contact was made;
3. Description of the contact;
4. Outcome(s) of the contact; and
5. Direct service provider's signature and credentials.

PROVISION OF SERVICE DOCUMENTATION

The provider must document the provision of service by maintaining up-to-date progress notes, which are reviewed by the Department of State Health Services.

PROGRAM TRAINING

Prior to providing Waiver services and/or participating on a Child and Family Team, a CLS must receive program training in accordance with PROGRAM TRAINING REQUIREMENTS, policy 2200.2 or 2300.2 of this manual, as applicable.

BILLING

Information regarding unit designation, payment rate, and required documentation for submitting a claim for CLS is detailed in BILLING, COMMUNITY LIVING SUPPORTS, policy 2600.4 of this manual.

SERVICE DESCRIPTION

Assistance provided to a YES Waiver participant, identified during the person-centered planning process, to help the participant locate paid employment at or above minimum wage in an integrated employment setting in the community and meet the participant's personal and career goals.

Employment assistance includes:

1. Identifying the participant's employment preferences, job skills, and requirements for a work setting and work conditions;
2. Locating prospective employers offering employment compatible with the participant's identified preferences, skills, and requirements; and
3. Contacting a prospective employer on behalf of the participant and negotiating his or her employment.

LIMITATIONS

Employment assistance cannot be provided at the same time as:

1. Community living supports;
2. Non-medical transportation;
3. Paraprofessional services;
4. Respite; or
5. Supported employment.

TRANSPORTATION

Transporting the participant to help him or her locate paid employment in the community is a billable activity within this service.

INCENTIVES, SUBSIDIES, AND CERTAIN EXPENSES

This service does not include incentive payments, subsidies, or unrelated vocational training expenses such as:

1. Incentive payments made to an employer to encourage hiring the participant;
2. Payments that are passed through to the participant;
3. Payment for supervision, training, support, and adaptations typically available to other workers without disabilities filling similar positions in the business; or
4. Payments used to defray the expenses associated with starting up.

PROVIDER QUALIFICATIONS

A provider of employment assistance must:

1. Be at least 18 years of age;

2. Maintain a current driver's license, and insurance if transporting the participant;
3. Have a criminal history and background check. [See CRIMINAL HISTORY AND BACKGROUND CHECK, policy 2300.1 of this manual.]; and
4. Have one of the following:
   a. A bachelor's degree in rehabilitation, business, marketing, or a related human services field and six months of paid or unpaid experience providing services to people with disabilities;
   b. An associate's degree in rehabilitation, business, marketing, or a related human services field and one year of paid or unpaid experience providing services to people with disabilities; or
   c. A high school diploma or certificate of high school equivalency (GED credentials) and two years of paid or unpaid experience providing services to people with disabilities.

WRAPAROUND PLAN

The Wraparound Plan must describe the type, scope, and duration of the service.

PROGRESS NOTES

The provider must document the provision of employment assistance by maintaining progress notes detailing the activity the participant engaged in with the service provider, which will be reviewed by the Department of State Health Services (DSHS).

PROVISION OF SERVICE DOCUMENTATION

Documentation of employment assistance must include:

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

PROGRAM TRAINING

Prior to providing Waiver services and/or participating on a Child and Family Team, an employment assistance provider must receive program training in accordance with PROGRAM TRAINING REQUIREMENTS, policy 2200.2 or 2300.2 of this manual, as applicable.

BILLING

Information regarding unit designation, payment rate, and required documentation for submitting a claim for employment assistance is

detailed in BILLING, EMPLOYMENT ASSISTANCE, policy 2600.5 of this manual.

SERVICE DESCRIPTION

Family Support providers are individuals who are skilled and experienced in providing primary care to a youth with emotional and behavioral health challenges.

Family Supports provide peer mentoring and encouragement to the primary caregiver(s); engage the family in the treatment process; model self-advocacy skills; provide information, referral and non-clinical skills training; maintain engagement; and assist in the identification of natural/non-traditional and community support systems.

PROVIDER QUALIFICATIONS

A family support provider must:

1. Have a high school diploma, or a high school equivalency certificate issued in accordance with the law of the issuing state;
2. Have a criminal history and background check. [See CRIMINAL HISTORY AND BACKGROUND CHECK, policy 2300.1 of this manual];
3. Have at least:
   a. One cumulative year of receiving mental health community services for a mental health disorder; or
   b. One cumulative year of experience navigating the mental health system as the parent or primary caregiver of a youth receiving mental health community services; and
4. Be under the direct clinical supervision of a master's level therapist.

WRAPAROUND PLAN

The Wraparound Plan must:

1. Describe the strategies and/or action steps that will be used to encourage and assist in family and caregiver engagement; and
2. Identify natural and/or non-traditional and community support systems.

PROGRESS NOTES

Progress notes are required for the provision of family support services and must include:

1. Participant name;
2. Date of contact with the participant;
3. Start and stop time of contact with the participant;

4. Service name and description;
5. Service location;
6. Specific skills received and method used to train participant in skill(s);
7. Use of adaptive aids and supports, if applicable;
8. Transportation services, if applicable;
9. Participant response to service being provided;
10. Participant progress or lack of progress; and
11. Direct service provider's signature and credentials.

NON FACE-TO-FACE CONTACT WITH PARTICIPANT

When family support services provided to a participant are not face-to-face, the provider must document in the progress notes:

1. Date of the contact;
2. Description of the contact; and
3. Direct service provider's signature and credentials.

CONTACT WITH OTHER PARTIES

When family support services are provided face-to-face, or provided over the phone with someone other than the participant, such as, but not limited to, the legally authorized representative (LAR), the provider must document in the progress notes:

1. Date of the contact;
2. Person with whom the contact was made;
3. Description of the contact;
4. Outcome(s) of the contact; and
5. Direct service provider's signature and credentials.

PROVISION OF SERVICE DOCUMENTATION

The provider must document the provision of service by maintaining up-to-date progress notes, which are reviewed by the Department of State Health Services.

PROGRAM TRAINING

Prior to providing Waiver services and/or participating on a Child and Family Team, a family support provider shall receive program training in accordance with PROGRAM TRAINING REQUIREMENTS, policy 2200.2 or 2300.2 of this manual, as applicable.

BILLING

Information regarding unit designation, payment rate, and required documentation for submitting a claim for family supports is detailed in BILLING, FAMILY SUPPORTS, policy 2600.6 of this manual.

SERVICE DESCRIPTION

Minor home modifications include home accessibility or safety–physical adaptations to the participant's residence that are necessary to ensure the health, welfare, and safety of the participant. Minor home modifications include, but are not limited to:

1. Alarm systems;
2. Alert systems; and
3. Other safety devices.

WRAPAROUND PLAN

The Wraparound Plan must describe how the chosen modification:

1. Addresses the participant's identified need, linked to his or her serious emotional disturbance (SED);
2. Will be used, including strategies or action steps; and
3. Will assist the participant in achieving his or her identified goal(s).

SERVICE AUTHORIZATION REQUEST

A service authorization request for a minor home modification must include:

1. The type of modification;
2. An estimated maximum dollar cost that adequately pays for the requested modification;
3. A link between the use of the requested modification and the participant's identified need;
4. An assurance that the requested home modification meets any required standards and/or codes, if applicable; and
5. A statement that the requested modification is being purchased through Medicaid as a last resort.

PROVISION OF SERVICE DOCUMENTATION

Documentation of the provision of service, which is reviewed by the Department of State Health Services, must include:

1. The receipt of purchase, a copy of which must be in the participant's case record [See RECORDKEEPING, policy 2500.3 of this manual];
2. Verification of soliciting at least three bids or prices for a modification costing over $500;
3. A brief explanation of any home modification which falls outside of the scope of an existing warranty;
4. A copy of the warranty information for the modification, if available; and

5. Proof that the requested home modification meets required standards and/or codes, if applicable.

BILLING

Information regarding payment rate, requisition fees, and required documentation for submitting a claim for family supports is detailed in BILLING, MINOR HOME MODIFICATIONS, policy 2600.7 of this manual.

SERVICE DESCRIPTION

Non-medical transportation enables a YES Waiver (Waiver) participant to gain access to Waiver and other community services, activities, and resources. When possible, family, neighbors, friends, or community agencies which can provide non-medical transportation at no charge must be utilized.

Non-medical transportation is offered in addition to, not instead of, medical transportation required under the State Plan, in accordance with Chapter 42 of the Code of Federal Regulations (CFR), §431.53.

PROVIDER QUALIFICATIONS

A provider of non-medical transportation must:

1. Be over the age of 18;
2. Have a valid Texas driver's license and insurance appropriate to the vehicle used to provide the transportation; and be a:
   a. Member of the Waiver provider agency staff; or
   b. Direct service provider subcontracted with the Waiver provider agency; and
3. Have a criminal history and background check. [See CRIMINAL HISTORY AND BACKGROUND CHECK, policy 2300.1 of this manual].

RELATIVES AS PROVIDERS

A participant's legally authorized representative is not permitted to be reimbursed by Medicaid for the provision of non-medical transportation.

A relative of a Waiver participant must meet all provider qualifications above in order to be reimbursed by Medicaid for the provision of non-medical transportation.

WRAPAROUND PLAN

The Wraparound Plan must describe how the use of non-medical transportation will assist the participant in achieving his or her identified goal(s), as linked to his or her serious emotional disturbance (SED).

PROGRESS NOTES

The provider must document the provision of non-medical transportation by maintaining progress notes detailing the activity the participant engaged in with the service provider, which will be reviewed by the Department of State Health Services (DSHS).

PROVISION OF SERVICE DOCUMENTATION

Documentation of non-medical transportation in a transportation log or alternative mileage log must include:

1. Date of contact;
2. Start and stop time of contact;

3. Name of service provider; and

4. Direct service provider's signature and credentials.

A sample transportation log is available on the DSHS Web site at:

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

BILLING

Information regarding unit designation, payment rate, and required documentation for submitting a claim for non-medical transportation is detailed in BILLING, NON-MEDICAL TRANSPORTATION, policy 2600.8 of this manual.

SERVICE DESCRIPTION

There are three types of paraprofessional services:

1. Skilled mentoring and coaching;
2. Paraprofessional aide; and
3. Job placement.

SKILLED MENTORING AND COACHING

Skilled mentoring and coaching:

1. Addresses participant's symptom-related problems that may interfere with the individual's functioning and living, working, and learning environment;
2. Provides opportunities for the participant to acquire and improve skills needed to function as appropriately and independently as possible;
3. Facilitates the participant's community integration; and
4. Increases the participant's community tenure.

Examples of skilled mentoring and coaching include training in symptom management, personal hygiene, nutrition, food preparation, exercise, money management, and community.

PARAPROFESSIONAL AIDE

Paraprofessional aide services consist of training the participant in:

1. The importance of taking medications as prescribed;
2. Self-administration of medication;
3. Determining the effectiveness of the medication(s);
4. Identifying side-effects of medication(s); and
5. Contraindications for medications that are prescribed.

JOB PLACEMENT

Employment related services provide support and skills training that are not job-specific and focus on developing skills to reduce or manage the symptoms of the participant's serious emotional disturbance (SED) that interfere with his or her ability to make vocational choices or obtain or retain employment.

Examples of job placement services include instruction in dress, grooming, socially and culturally appropriate behaviors, and etiquette necessary to obtain and retain employment; and training in task focus, maintaining concentration, task completion, and planning and managing activities to achieve participant's goals.

PROVIDER QUALIFICATIONS

A provider of paraprofessional services must:

1. Be at least 18 years of age;
2. Have received:

a. A high school diploma; or

b. A high school equivalency certificate issued in accordance with the law of the issuing state;

3. Have a minimum of one year of documented full-time experience working with the SED population. Experience may be considered if the documented experience includes activities that are comparable to services specified under the service description;

4. Have a criminal history and background check. [See CRIMINAL HISTORY AND BACKGROUND CHECK, policy 2300.1 of this manual];

5. Demonstrate competency in the provision and documentation of the specified or comparable service; and

6. Be under the direct clinical supervision of a master's level therapist.

SETTINGS

Paraprofessional services may be provided in the participant's residence or in community settings, including, but not limited to:

1. Libraries;

2. Parks; and

3. Museums.

WRAPAROUND PLAN

The Wraparound Plan must describe:

1. Which paraprofessional service that will be provided to participant, as they relate to achieving the participant's identified goal(s);

2. The strategies and/or action steps that will be used to assist the participant in achieving the identified goal(s); and

3. The type, scope, and duration of the service.

PROGRESS NOTES

Progress notes are required for the provision of paraprofessional services and must include:

1. Participant name;

2. Date of contact with the participant;

3. Start and stop time of contact with the participant;

4. Service name and description;

5. Service location;

6. Specific skills received and method used to assist in skill acquisition;
7. Use of adaptive aids and supports, if applicable;
8. Transportation services, if applicable;
9. Participant response to service being provided;
10. Participant progress or lack of progress; and
11. Direct service provider's signature and credentials.

NON FACE-TO-FACE CONTACT WITH PARTICIPANT

When paraprofessional services provided to a participant are not face-to-face, the provider must document in the progress notes:

1. Date of the contact;
2. Description of the contact; and
3. Direct service provider's signature and credentials.

CONTACT WITH OTHER PARTIES

When paraprofessional services are provided face-to-face, or provided over the phone with someone other than the participant, such as, but not limited to, the legally authorized representative (LAR), the provider must document in the progress notes:

1. Date of the contact;
2. Person with whom the contact was made;
3. Description of the contact;
4. Outcome(s) of the contact; and
5. Direct service provider's signature and credentials.

PROVISION OF SERVICE DOCUMENTATION

The provider must document the provision of paraprofessional services by maintaining up-to-date progress notes, which are reviewed by the Department of State Health Services.

PROGRAM TRAINING

Prior to providing Waiver services and/or participating on a Child and Family Team, a provider of paraprofessional services must receive program training in accordance with PROGRAM TRAINING REQUIREMENTS, policy 2200.2 or 2300.2 of this manual, as applicable.

BILLING

Information regarding unit designation, payment rate, and required documentation for submitting a claim for paraprofessional services is detailed in BILLING, PARAPROFESSIONAL SERVICES, policy 2600.9 of this manual.

SERVICE DESCRIPTION

A comprehensive Waiver provider may bill, one time, for reimbursement for case management services provided in an effort to enroll an individual into the Waiver who is not Medicaid-eligible, or who becomes Medicaid-eligible because he or she enrolls in the Waiver under the special home and community Waiver group.

Case management services may refer to assessments, youth and family contacts, assistance obtaining paperwork necessary for determining Medicaid eligibility, and any other services necessary for Waiver eligibility and enrollment.

INDIVIDUAL ENROLLS IN WAIVER

If the individual enrolls in the Waiver, the pre-engagement service begin date will be the date enrollment activities began. The pre-engagement service end date will be the date on which the individual enrolls in the Waiver.

INDIVIDUAL DOES NOT ENROLL IN WAIVER

If the individual does not enroll in the Waiver, the final pre-engagement service date will be the date on which the individual notifies the comprehensive waiver provider of the decision not to enroll.

PROVIDER QUALIFICATIONS

Pre-engagement services must be provided by a credentialed Qualified Mental Health Professional–Community Services (QMHP–CS) or QMHP–CS equivalent, defined as an individual who:

1. Has a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major, as determined by the local mental health authority (LMHA), in accordance with 25 TAC §412.316(d), in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention;
2. Is a registered nurse (RN);
3. Has completed an alternative credentialing process identified by the Department of State Health Services; or
4. Has a master's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention; and

5. Has had a criminal history and background check. [See CRIMINAL HISTORY AND BACKGROUND CHECK, policy 2300.1 of this manual.]

Information regarding competency and credentialing in 25 TAC §412.316(d) is available at:

http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=412&rl=316

PROGRESS NOTES

Progress notes are required for the provision of pre-engagement services and must include:

1. Participant name;
2. Date of contact with the participant;
3. Start and stop time of contact with the participant;
4. Service name and description;
5. Service location;
6. Progress or lack of progress in achieving Wraparound Plan goals;
7. Summary of activities, meals, and behaviors during the service; and
8. Direct service provider's signature and credentials.

PROVISION OF SERVICE DOCUMENTATION

The provider must document the provision of pre-engagement services by maintaining up-to-date progress notes, which will be reviewed by the Department of State Health Services.

BILLING

Information regarding unit designation, payment rate, and required documentation for submitting a claim for pre-engagement services is detailed in BILLING, PRE-ENGAGEMENT SERVICES, policy 2600.10 of this manual.

SERVICE DESCRIPTION

In-home respite service is provided on a short-term basis because of the absence of, or need for relief for, the legally authorized representative (LAR) or other primary caregiver of a Waiver participant.

LIMITATIONS

A maximum of 720 consecutive or cumulative hours (30 days) of respite service of any type, or combination of any type, can be provided to a participant, each service plan year.

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

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

SETTINGS

In-home respite service is provided:

1. Within the State of Texas; and
2. In the private residence of:
   a. The participant; or
   b. A relative of the participant other than the parents, spouse, legal guardian, or LAR.

SAFETY CHECKLIST

The Waiver provider agency must complete a Building Safety and Environmental Health Checklist prior to the provision of in-home respite service, available at: http://www.dshs.state.tx.us/mhsa/yes/

CRISIS AND SAFETY PLAN

The Waiver provider agency must provide a copy of the participant's crisis and safety plan to the respite provider.

PROVIDER QUALIFICATIONS

An in-home respite provider:

1. Must be at least 18 years of age;
2. Must have a current Texas driver's license;
3. Must have a criminal history and background check. [See CRIMINAL HISTORY AND BACKGROUND CHECK, policy 2300.1 of this manual]; and
4. May be a relative of the participant other than the parents, spouse, legal guardian, or LAR.

WRAPAROUND PLAN

The Wraparound Plan must describe the type, scope, and duration of the service.

PROGRESS NOTES

Progress notes are required for the provision of in-home respite service and must include:

1. Participant name;
2. Date of contact with the participant;
3. Start and stop time of contact with the participant;
4. Service name and description;
5. Service location;
6. Participant response to respite service being provided;
7. Summary of activities, meals, and behaviors during the service; and
8. Direct service provider's signature and credentials.

PROVISION OF SERVICE

The provider must document the provision of in-home respite service by maintaining up-to-date progress notes, which will be reviewed by the Department of State Health Services.

PROGRAM TRAINING

Prior to providing respite services, an in-home respite provider must receive program training in accordance with PROGRAM TRAINING REQUIREMENTS, policy 2200.2 or 2300.2 of this manual, as applicable.

BILLING

Information regarding unit designation, payment rate, and required documentation for submitting a claim for in-home respite is detailed in BILLING, RESPITE, IN-HOME, policy 2600.11 of this manual.

SERVICE DESCRIPTION

Out-of-home respite service at a camp is provided on a short-term basis because of the absence of, or need for relief for, the legally authorized representative or other primary caregiver of a YES Waiver participant.

LIMITATIONS

A maximum of 720 consecutive or cumulative hours (30 days) of respite service of any type, or combination of any type, can be provided to a participant, each service plan year.

Respite at a camp cannot be provided at the same time as supportive family-based alternatives or community living supports.

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

PROVIDER QUALIFICATIONS

Day or overnight camp respite service is provided only by camps that are licensed by the Department of State Health Services (DSHS) or camps that are accredited by the American Camp Association.

DEPARTMENT OF STATE HEALTH SERVICES

Out-of-home respite service is provided by camps that are licensed by DSHS, in accordance with 25 TAC §265.11–§265.24, available at:

http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=265&sch=B&rl=Y

AMERICAN CAMP ASSOCIATION

Out-of-home respite service is also provided by camps that are accredited by the American Camp Association. Accreditation requirements and standards for the American Camp Association are available at:

http://www.acacamps.org/accreditation

CRISIS AND SAFETY PLAN

The Waiver provider agency must provide a copy of the participant's crisis and safety plan to the respite provider.

WRAPAROUND PLAN

The Wraparound Plan must describe the type, scope, and duration of the service.

PROGRESS NOTES

Progress notes are required for the provision of respite service provided by a camp and must include:

1. Participant name;

2. Date of contact with the participant;
3. Start and stop time of contact with the participant;
4. Service name and description;
5. Service location;
6. Summary of activities, meals, and behaviors during the service; and
7. Direct service provider's signature and credentials.

PROVISION OF SERVICE

The provider must document the provision of respite service by maintaining up-to-date progress notes, which will be reviewed by the Department of State Health Services.

BILLING

Information regarding unit designation, payment rate, and required documentation for submitting a claim for respite provided by a camp is detailed in BILLING, RESPITE, OUT-OF-HOME: CAMP, policy 2600.12 of this manual.

SERVICES
RESPITE
OUT-OF-HOME: LICENSED CHILD CARE CENTER 2400.12

SERVICE DESCRIPTION

Out-of-home respite service at a licensed child care center (LCCC) is provided on a short-term basis because of the absence of, or need for relief for, the legally authorized representative or other primary caregiver of a YES Waiver participant.

Respite provided by a LCCC is divided into preschool age and school age groups, in accordance with the following:

PRESCHOOL AGE

Preschool age respite is provided for youth ages three to five years old.

SCHOOL AGE

School age respite is provided for youth ages six to 18 years of age, up to a youth's 19th birthday.

LIMITATIONS

A maximum of 720 consecutive or cumulative hours (30 days) of respite services of any type, or combination of any type, can be provided to a participant, each service plan year.

Respite at a LCCC cannot be provided at the same time as supportive family-based alternatives or community living supports.

PROVIDER QUALIFICATIONS

Respite service provider must be a child care center licensed by the Department of Family and Protective Services, in accordance with 40 TAC, Chapter 746, available at:

http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=40&pt=19&ch=746

WRAPAROUND PLAN

The Wraparound Plan must describe the type, scope, and duration of the service.

PROGRESS NOTES

Progress notes are required for the provision of respite service provided by a LCCC and must include:

1. Participant name;
2. Date of contact with the participant;
3. Start and stop time of contact with the participant;
4. Service name and description;
5. Service location;
6. Summary of activities, meals, and behaviors during the service; and
7. Direct service provider's signature and credentials.

PROVISION OF SERVICE

The provider must document the provision of respite service by maintaining up-to-date progress notes, which will be reviewed by the Department of State Health Services.

PROGRAM TRAINING

Prior to providing respite services, a LCCC respite provider must receive program training in accordance with PROGRAM TRAINING REQUIREMENTS, policy 2200.2 or 2300.2 of this manual, as applicable.

BILLING

Information regarding unit designation, payment rate, and required documentation for submitting a claim for respite service provided by a LCCC is detailed in BILLING, RESPITE, OUT-OF-HOME: LICENSED CHILD CARE CENTER, policy 2600.13 of this manual.

SERVICES
RESPITE
OUT-OF-HOME: LICENSED CHILD CARE CENTER
TEXAS RISING STAR PROVIDER 2400.13

SERVICE DESCRIPTION

Out-of-home respite service at a licensed child care center, Texas Rising Star (TRS) Provider, is provided on a short-term basis because of the absence of, or need for relief for, the legally authorized representative or other primary caregiver of a YES Waiver participant.

Respite provided by a TRS Provider is divided into preschool age and school age groups, in accordance with the following:

PRESCHOOL AGE

Preschool age respite is provided for youth ages three to five years old.

SCHOOL AGE

School age respite is provided for youth ages six to 18 years of age, up to a youth's 19th birthday.

LIMITATIONS

A maximum of 720 consecutive or cumulative hours (30 days) of respite service of any type, or combination of any type, can be provided to a participant, each service plan year.

Respite provided by a TRS Provider cannot be provided at the same time as supportive family-based alternatives or community living supports.

PROVIDER QUALIFICATIONS

A TRS respite provider must be:

1. Licensed as a child care center by the Department of Family and Protective Services, in accordance with 40 TAC, Chapter 746, available at:

   http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=40&pt=19&ch=746; and

2. Certified as a TRS Provider by the Texas Workforce Commission (TWC), in accordance with TWC certification criteria, available at:

   http://www.twc.state.tx.us/files/twc/texas-rising-star-provider-certification-guidelines-twc.pdf

WRAPAROUND PLAN

The Wraparound Plan must describe the type, scope, and duration of the service.

PROGRESS NOTES

Progress notes are required for the provision of TRS Provider respite services and must include:

1. Participant name;

2. Date of contact with the participant;
3. Start and stop time of contact with the participant;
4. Service name and description;
5. Service location;
6. Summary of activities, meals, and behaviors during the service; and
7. Direct service provider's signature and credentials.

PROVISION OF SERVICE

The provider must document the provision of respite service by maintaining up-to-date progress notes, which will be reviewed by the Department of State Health Services.

PROGRAM TRAINING

Prior to providing respite services, a TRS respite provider must receive program training in accordance with PROGRAM TRAINING REQUIREMENTS, policy 2200.2 or 2300.2 of this manual, as applicable.

BILLING

Information regarding unit designation, payment rate, and required documentation for submitting a claim for TRS Provider respite is detailed in BILLING, RESPITE, OUT-OF-HOME: LICENSED CHILD CARE CENTER, TEXAS RISING STAR PROVIDER, policy 2600.14 of this manual.

SERVICES
RESPITE
OUT-OF-HOME: LICENSED CHILD CARE HOME 2400.14

SERVICE DESCRIPTION

Out-of-home respite service at a licensed child care home (LCCH) is provided on a short-term basis because of the absence of, or need for relief for, the legally authorized representative or other primary caregiver of a YES Waiver participant.

Respite provided by a LCCH is divided into preschool age and school age groups, in accordance with the following:

PRESCHOOL AGE

Preschool age respite is provided for youth ages three to five years old.

SCHOOL AGE

School age respite is provided for youth ages six to 18 years of age, up to a youth's 19th birthday.

LIMITATIONS

A maximum of 720 consecutive or cumulative hours (30 days) of respite service of any type, or combination of any type, can be provided to a participant, each service plan year.

Respite at a LCCH cannot be provided at the same time as supportive family-based alternatives or community living supports.

PROVIDER QUALIFICATIONS

Respite service provider must be a child care home licensed by the Department of Family and Protective Services, in accordance with 40 TAC, Chapter 747, available at:

http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=40&pt=19&ch=747

WRAPAROUND PLAN

The Wraparound Plan must describe the type, scope, and duration of the service.

PROGRESS NOTES

Progress notes are required for the provision of respite service provided by a LCCH and must include:

1. Participant name;
2. Date of contact with the participant;
3. Start and stop time of contact with the participant;
4. Service name and description;
5. Service location;
6. Summary of activities, meals, and behaviors during the service; and
7. Direct service provider's signature and credentials.

PROVISION OF SERVICE

The provider must document the provision of respite service by maintaining up-to-date progress notes, which will be reviewed by the Department of State Health Services.

PROGRAM TRAINING

Prior to providing respite services, a LCCH respite provider must receive program training in accordance with PROGRAM TRAINING REQUIREMENTS, policy 2200.2 or 2300.2 of this manual, as applicable.

BILLING

Information regarding unit designation, payment rate, and required documentation for submitting a claim for respite service provided by a LCCH is detailed in BILLING, RESPITE, OUT-OF-HOME: LICENSED CHILD CARE HOME, policy 2600.15 of this manual.

SERVICE DESCRIPTION

Out-of-home respite service at a licensed child care home, Texas Rising Star (TRS) Provider, is provided on a short-term basis because of the absence of, or need for relief for, the legally authorized representative or other primary caregiver of a YES Waiver participant.

Respite provided by a TRS Provider is divided into preschool age and school age groups, in accordance with the following:

PRESCHOOL AGE

Preschool age respite is provided for youth ages three to five years old.

SCHOOL AGE

School age respite is provided for youth ages six to 18 years of age, up to a youth's 19th birthday.

LIMITATIONS

A maximum of 720 consecutive or cumulative hours (30 days) of respite service of any type, or combination of any type, can be provided to a participant, each service plan year.

Respite provided by a TRS Provider cannot be provided at the same time as supportive family-based alternatives or community living supports.

PROVIDER QUALIFICATIONS

A TRS respite provider must be:

1. Licensed as a child care center by the Department of Family and Protective Services, in accordance with 40 TAC, Chapter 747, available at:

   http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=40&pt=19&ch=747; and

2. Certified as a TRS Provider by the Texas Workforce Commission (TWC), in accordance with TWC certification criteria, available at:

   http://www.twc.state.tx.us/files/twc/texas-rising-star-provider-certification-guidelines-twc.pdf

WRAPAROUND PLAN

The Wraparound Plan must describe the type, scope, and duration of the service.

PROGRESS NOTES

Progress notes are required for the provision of TRS Provider respite services and must include:

1. Participant name;

2. Date of contact with the participant;
3. Start and stop time of contact with the participant;
4. Service name and description;
5. Service location;
6. Summary of activities, meals, and behaviors during the service; and
7. Direct service provider's signature and credentials.

PROVISION OF SERVICE

The provider must document the provision of respite service by maintaining up-to-date progress notes, which will be reviewed by the Department of State Health Services.

PROGRAM TRAINING

Prior to providing respite services, a TRS respite provider must receive program training in accordance with PROGRAM TRAINING REQUIREMENTS, policy 2200.2 or 2300.2 of this manual, as applicable.

BILLING

Information regarding unit designation, payment rate, and required documentation for submitting a claim for TRS Provider respite is detailed in BILLING, RESPITE, OUT-OF-HOME: LICENSED CHILD CARE HOME, TEXAS RISING STAR PROVIDER, policy 2600.16 of this manual.

SERVICES
RESPITE
OUT-OF-HOME: REGISTERED CHILD CARE HOME 2400.16

SERVICE DESCRIPTION

Out-of-home respite service at a registered child care home (RCCH) is provided on a short-term basis because of the absence of, or need for relief for, the legally authorized representative or other primary caregiver of a YES Waiver participant.

Respite provided by a RCCH is divided into preschool age and school age groups, in accordance with the following:

PRESCHOOL AGE

Preschool age respite is provided for youth ages three to five years old.

SCHOOL AGE

School age respite is provided for youth ages six to 18 years of age, up to a youth's 19th birthday.

LIMITATIONS

A maximum of 720 consecutive or cumulative hours (30 days) of respite service of any type, or combination of any type, can be provided to a participant, each service plan year.

Respite at a RCCH cannot be provided at the same time as supportive family-based alternatives or community living supports.

PROVIDER QUALIFICATIONS

Respite service provider must be a child care home registered with the Department of Family and Protective Services, in accordance with 40 TAC, Chapter 747, available at:

https://www.dfps.state.tx.us/Child_Care/About_Child_Care_Licensing/become_home_provider.asp

WRAPAROUND PLAN

The Wraparound Plan must describe the type, scope, and duration of the service.

PROGRESS NOTES

Progress notes are required for the provision of respite service provided by a RCCH and must include:

1. Participant name;
2. Date of contact with the participant;
3. Start and stop time of contact with the participant;
4. Service name and description;
5. Service location;
6. Summary of activities, meals, and behaviors during the service; and
7. Direct service provider's signature and credentials.

PROVISION OF SERVICE

The provider must document the provision of respite service by maintaining up-to-date progress notes, which will be reviewed by the Department of State Health Services.

PROGRAM TRAINING

Prior to providing respite services, a RCCH respite provider must receive program training in accordance with PROGRAM TRAINING REQUIREMENTS, policy 2200.2 or 2300.2 of this manual, as applicable.

BILLING

Information regarding unit designation, payment rate, and required documentation for submitting a claim for respite service provided by a RCCH is detailed in BILLING, RESPITE, OUT-OF-HOME: REGISTERED CHILD CARE HOME, policy 2600.17 of this manual.

SERVICE DESCRIPTION

Out-of-home respite service at a licensed child care home, Texas Rising Star (TRS) Provider, is provided on a short-term basis because of the absence of, or need for relief for, the legally authorized representative or other primary caregiver of a YES Waiver participant.

Respite provided by a TRS Provider is divided into preschool age and school age groups, in accordance with the following:

PRESCHOOL AGE

Respite for the preschool age group serves youth ages three to five years old.

SCHOOL AGE

Respite for the school age group serves youth ages six to 18 years of age, up to a youth's 19th birthday.

LIMITATIONS

A maximum of 720 consecutive or cumulative hours (30 days) of respite service of any type, or combination of any type, can be provided to a participant, each service plan year.

Respite provided by a TRS Provider cannot be provided at the same time as supportive family-based alternatives or community living supports.

PROVIDER QUALIFICATIONS

A TRS respite provider must be:

1. Registered as a child care home by the Department of Family and Protective Services, in accordance with 40 TAC, Chapter 747, available at:

   http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=40&pt=19&ch=747; and

2. Certified as a TRS Provider by the Texas Workforce Commission (TWC), in accordance with TWC certification criteria, available at:

   http://www.twc.state.tx.us/files/twc/texas-rising-star-provider-certification-guidelines-twc.pdf

WRAPAROUND PLAN

The Wraparound Plan must describe the type, scope, and duration of the service.

PROGRESS NOTES

Progress notes are required for the provision of TRS Provider respite services and must include:

1. Participant name;

2. Date of contact with the participant;
3. Start and stop time of contact with the participant;
4. Service name and description;
5. Service location;
6. Summary of activities, meals, and behaviors during the service; and
7. Direct service provider's signature and credentials.

PROVISION OF SERVICE

The provider must document the provision of respite service by maintaining up-to-date progress notes, which will be reviewed by the Department of State Health Services.

PROGRAM TRAINING

Prior to providing respite services, a TRS respite provider must receive program training in accordance with PROGRAM TRAINING REQUIREMENTS, policy 2200.2 or 2300.2 of this manual, as applicable.

BILLING

Information regarding unit designation, payment rate, and required documentation for submitting a claim for TRS Provider respite is detailed in BILLING, RESPITE, OUT-OF-HOME: REGISTERED CHILD CARE HOME, TEXAS RISING STAR PROVIDER, policy 2600.18 of this manual.

SERVICE DESCRIPTION

Out-of-home respite service at a residential child care is provided on a short-term basis because of the absence of, or need for relief for, the legally authorized representative or other primary caregiver of a YES Waiver participant.

Respite at a residential child care can be provided in the following Department of Family and Protective Services verified or licensed settings:

1. Foster home;
2. Child-placing agency; or
3. General Residential Operation.

LIMITATIONS

A maximum of 720 consecutive or cumulative hours (30 days) of respite service of any type, or combination of any type, can be provided to a participant, each service plan year.

Respite provided at a residential child care cannot be provided at the same time as supportive family-based alternatives or community living supports.

FOSTER FAMILY PROVIDER QUALIFICATIONS

Respite service provider must be a foster family verified with the Department of Family and Protective Services, in accordance with 40 TAC, Chapter 749, available at:

http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=40&pt=19&ch=749

WRAPAROUND PLAN

The Wraparound Plan must describe the type, scope, and duration of the service.

PROGRESS NOTES

Progress notes are required for the provision of respite service provided by a foster family and must include:

1. Participant name;
2. Date of contact with the participant;
3. Start and stop time of contact with the participant;
4. Service name and description;
5. Service location;

6. Summary of activities, meals, and behaviors during the service; and
7. Direct service provider's signature and credentials.

PROVISION OF SERVICE

The provider must document the provision of respite service by maintaining up-to-date progress notes, which will be reviewed by the Department of State Health Services.

CHILD PLACING AGENCY

PROVIDER QUALIFICATIONS

Respite service provider must be a child placing agency licensed with the Department of Family and Protective Services, in accordance with 40 TAC, Chapter 749, available at:

http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=40&pt=19&ch=749

WRAPAROUND PLAN

The Wraparound Plan must describe the type, scope, and duration of the service.

PROGRESS NOTES

Progress notes are required for the provision of respite service provided by a child placing agency and must include:

1. Participant name;
2. Date of contact with the participant;
3. Start and stop time of contact with the participant;
4. Service name and description;
5. Service location;
6. Summary of activities, meals, and behaviors during the service; and
7. Direct service provider's signature and credentials.

PROVISION OF SERVICE

The provider must document the provision of respite service by maintaining up-to-date progress notes, which will be reviewed by the Department of State Health Services.

GENERAL RESIDENTIAL OPERATION (GRO)

PROVIDER QUALIFICATIONS

Respite service provider must be a general residential operation licensed with the Department of Family and Protective Services, in accordance with 40 TAC, Chapter 748, available at:

http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=40&pt=19&ch=748

WRAPAROUND PLAN

The Wraparound Plan must describe the type, scope, and duration of the service.

PROGRESS NOTES

Progress notes are required for the provision of respite service provided at a general residential operation and must include:

1. Participant name;
2. Date of contact with the participant;
3. Start and stop time of contact with the participant;
4. Service name and description;
5. Service location;
6. Summary of activities, meals, and behaviors during the service; and
7. Direct service provider's signature and credentials.

PROVISION OF SERVICE

The provider must document the provision of respite service by maintaining up-to-date progress notes, which will be reviewed by the Department of State Health Services.

PROGRAM TRAINING

Prior to providing respite services, a residential child care respite provider must receive program training in accordance with PROGRAM TRAINING REQUIREMENTS, policy 2200.2 or 2300.2 of this manual, as applicable.

BILLING

Information regarding unit designation, payment rate, and required documentation for submitting a claim for residential child care respite is detailed in BILLING, RESPITE, OUT-OF-HOME: RESIDENTIAL CHILD CARE, policy 2600.19 of this manual.

SERVICES
SPECIALIZED THERAPIES
ANIMAL-ASSISTED THERAPY 2400.19

SERVICE DESCRIPTION

Animals are utilized in goal-directed treatment sessions as a modality to facilitate optimal physical, cognitive, social, and emotional outcomes of a participant, such as increasing self-esteem, increasing motivation, and reducing stress.

PROVIDER QUALIFICATIONS

An animal-assisted therapy provider must utilize animals that meet guidelines established by the American Veterinary Medical Association and either:

1. Be a licensed professional with documented training and experience relative to the specialized therapy being provided. This may include a: clinical social worker; professional counselor; marriage and family therapist; registered nurse; vocational nurse; physical therapist; occupational therapist; or dietitian; or
2. Obtain certification specific to the type of program and animal(s) involved.

ANIMAL CERTIFICATION PROGRAMS

YES Waiver-endorsed certification programs are:

1. Pet Partners;
2. Equine Assisted Growth and Learning Association (EAGALA); and
3. Professional Association of Therapeutic Horsemanship (PATH) International.

Other certification programs are subject to approval by the Department of State Health Services, upon request by the local mental health authority or comprehensive waiver provider.

WRAPAROUND PLAN

The Wraparound Plan must describe:

1. The skills training that will be provided to participant, as they relate to achieving the participant's identified goal(s);
2. The strategies and/or action steps that will be used to assist the participant in achieving the identified goal(s); and
3. The type, scope, and duration of the service.

PROGRESS NOTES

Progress notes are required for the provision of animal-assisted therapy and must include:

1. Participant name;
2. Date of contact with the participant;
3. Start and stop time of contact with the participant;

4. Service name and description;
5. Service location;
6. Wraparound plan objective(s) that was the focus of the service;
7. Participant response to animal-assisted therapy being provided;
8. Progress or lack of progress in achieving Wraparound Plan goals; and
9. Direct service provider's signature and credentials.

PROVISION OF SERVICE DOCUMENTATION

The provider must document the provision of animal-assisted therapy services by maintaining up-to-date progress notes, which will be reviewed by the Department of State Health Services.

PROGRAM TRAINING

Prior to providing Waiver services and/or participating on a Child and Family Team, an animal-assisted therapy provider must receive program training in accordance with PROGRAM TRAINING REQUIREMENTS, policy 2200.2 or 2300.2 of this manual, as applicable.

BILLING

Information regarding unit designation, payment rate, and required documentation for submitting a claim for animal-assisted services is detailed in BILLING, SPECIALIZED THERAPIES, policy 2600.20 of this manual.

SERVICES
SPECIALIZED THERAPIES
ART THERAPY 2400.20

SERVICE DESCRIPTION

Through the use of art media, the creative process, and the resulting artwork, art therapy assists the participant in exploring feelings, reconciling emotional conflicts, fostering self-awareness, managing behavior, developing social skills, improving reality orientation, reducing anxiety, and increasing self-esteem.

PROVIDER QUALIFICATIONS

An art therapy provider must be:

1. A licensed professional with documented training and experience relative to the specialized therapy being provided. This may include a: clinical social worker; professional counselor; marriage and family therapist; registered nurse; vocational nurse; physical therapist; occupational therapist; or dietitian; or
2. Certified by the Art Therapy Credentials Board (AT-BC).

WRAPAROUND PLAN

The Wraparound Plan must describe:

1. The skills training that will be provided to participant, as they relate to achieving the participant's identified goal(s);
2. The strategies and/or action steps that will be used to assist the participant in achieving the identified goal(s); and
3. The type, scope, and duration of the service.

PROGRESS NOTES

Progress notes are required for the provision of art therapy and must include:

1. Participant name;
2. Date of contact with the participant;
3. Start and stop time of contact with the participant;
4. Service name and description;
5. Service location;
6. Wraparound plan objective(s) that was the focus of the service;
7. Participant response to art therapy being provided;
8. Progress or lack of progress in achieving Wraparound Plan goals; and
9. Direct service provider's signature and credentials.

PROVISION OF SERVICE DOCUMENTATION	The provider must document the provision of art therapy services by maintaining up-to-date progress notes, which will be reviewed by the Department of State Health Services.
PROGRAM TRAINING	Prior to providing Waiver services and/or participating on a Child and Family Team, an art therapy provider must receive program training in accordance with PROGRAM TRAINING REQUIREMENTS, policy 2200.2 or 2300.2 of this manual, as applicable.
BILLING	Information regarding unit designation, payment rate, and required documentation for submitting a claim for art therapy is detailed in BILLING, SPECIALIZED THERAPIES, policy 2600.20 of this manual.

SERVICES
SPECIALIZED THERAPIES
MUSIC THERAPY 2400.21

SERVICE DESCRIPTION

Musical or rhythmic interventions are utilized to assist the participant in accomplishing the restoration, maintenance, or improvement of social or emotional functioning, mental processing, or physical health. Music therapy provides a participant the opportunity to move from isolation into active participation through an increase in verbal and nonverbal communication, social expression, behavioral and social functioning, and self-awareness.

PROVIDER QUALIFICATIONS

A music therapy provider must be:

1. A licensed professional with documented training and experience relative to the specialized therapy being provided. This may include a: clinical social worker; professional counselor; marriage and family therapist; registered nurse; vocational nurse; physical therapist; occupational therapist; or dietitian; or
2. Certified by the Certification Board for Music Therapists (MT-BC).

WRAPAROUND PLAN

The Wraparound Plan must describe:

1. The skills training that will be provided to participant, as they relate to achieving the participant's identified goal(s);
2. The strategies and/or action steps that will be used to assist the participant in achieving the identified goal(s); and
3. The type, scope, and duration of the service.

PROGRESS NOTES

Progress notes are required for the provision of music therapy and must include:

1. Participant name;
2. Date of contact with the participant;
3. Start and stop time of contact with the participant;
4. Service name and description;
5. Service location;
6. Wraparound plan objective(s) that was the focus of the service;
7. Participant response to nutritional counseling being provided;
8. Progress or lack of progress in achieving Wraparound Plan goals; and
9. Direct service provider's signature and credentials.

PROVISION OF SERVICE DOCUMENTATION	The provider must document the provision of music therapy by maintaining up-to-date progress notes, which will be reviewed by the Department of State Health Services.
PROGRAM TRAINING	Prior to providing Waiver services and/or participating on a Child and Family Team, a music therapy provider must receive program training in accordance with PROGRAM TRAINING REQUIREMENTS, policy 2200.2 or 2300.2 of this manual, as applicable.
BILLING	Information regarding unit designation, payment rate, and required documentation for submitting a claim for music therapy is detailed in BILLING, SPECIALIZED THERAPIES, policy 2600.20 of this manual.

SERVICES
SPECIALIZED THERAPIES
NUTRITIONAL COUNSELING 2400.22

SERVICE DESCRIPTION

Nutritional counseling assists the participant in meeting basic and/or special therapeutic nutritional needs, including, but not limited to, counseling in nutrition principles, dietary plans, and food selection and economics.

PROVIDER QUALIFICATIONS

Nutritional counseling must be provided by a person who is a registered, licensed, or provisionally licensed dietitian by the Texas Board of Examiners.

Licensed professionals, with documented training and experience relative to the specific service, may include a: clinical social worker; professional counselor; marriage and family therapist; registered nurse; vocational nurse; physical therapist; occupational therapist; or dietitian.

WRAPAROUND PLAN

The Wraparound Plan must describe:

1. The skills training that will be provided to participant, as they relate to achieving the participant's identified goal(s);
2. The strategies and/or action steps that will be used to assist the participant in achieving the identified goal(s); and
3. The type, scope, and duration of the service.

PROGRESS NOTES

Progress notes are required for the provision of art therapy services and must include:

1. Participant name;
2. Date of contact with the participant;
3. Start and stop time of contact with the participant;
4. Service name and description;
5. Service location;
6. Wraparound plan objective(s) that was the focus of the service;
7. Participant response to nutritional counseling being provided;
8. Progress or lack of progress in achieving Wraparound Plan goals; and
9. Direct service provider's signature and credentials.

PROVISION OF SERVICE DOCUMENTATION

The provider must document the provision of nutritional counseling by maintaining up-to-date progress notes, which will be reviewed by the Department of State Health Services.

PROGRAM TRAINING

Prior to providing Waiver services and/or participating on a Child and Family Team, a nutritional counselor must receive program training in accordance with PROGRAM TRAINING REQUIREMENTS, policy 2200.2 or 2300.2 of this manual, as applicable.

BILLING

Information regarding unit designation, payment rate, and required documentation for submitting a claim for nutritional counseling is detailed in BILLING, SPECIALIZED THERAPIES, policy 2600.20 of this manual.

SERVICES
SPECIALIZED THERAPIES
RECREATIONAL THERAPY 2400.23

SERVICE DESCRIPTION

The prescribed use of recreational and other activities as a treatment intervention is designed to restore, remediate, or habilitate improvement in a participant's functioning and independence, while reducing or eliminating the effects of the participant's serious emotional disturbance.

PROVIDER QUALIFICATIONS

A recreational therapy provider must be:

1. A licensed professional with documented training and experience relative to the specialized therapy being provided. This may include a: clinical social worker; professional counselor; marriage and family therapist; registered nurse; vocational nurse; physical therapist; occupational therapist; or dietitian; or
2. Certified by the National Council of Therapeutic Recreation Certification (CTRS); or
3. Certified as a Texas Certified Therapeutic Recreation Specialist (TRS/TXC).

WRAPAROUND PLAN

The Wraparound Plan must describe:

1. The skills training that will be provided to participant, as they relate to achieving the participant's identified goal(s);
2. The strategies and/or action steps that will be used to assist the participant in achieving the identified goal(s); and
3. The type, scope, and duration of the service.

PROGRESS NOTES

Progress notes are required for the provision of recreational therapy and must include:

1. Participant name;
2. Date of contact with the participant;
3. Start and stop time of contact with the participant;
4. Service name and description;
5. Service location;
6. Wraparound plan objective(s) that was the focus of the service;
7. Participant response to nutritional counseling being provided;
8. Progress or lack of progress in achieving Wraparound Plan goals; and
9. Direct service provider's signature and credentials.

PROVISION OF SERVICE DOCUMENTATION	The provider must document the provision of recreational therapy by maintaining up-to-date progress notes, which will be reviewed by the Department of State Health Services.
PROGRAM TRAINING	Prior to providing Waiver services and/or participating on a Child and Family Team, a recreational therapy provider must receive program training in accordance with PROGRAM TRAINING REQUIREMENTS, policy 2200.2 or 2300.2 of this manual, as applicable.
BILLING	Information regarding unit designation, payment rate, and required documentation for submitting a claim for recreational therapy is detailed in BILLING, SPECIALIZED THERAPIES, policy 2600.20 of this manual.

SERVICE DESCRIPTION

Assistance provided in order to sustain competitive and integrated employment, to a participant who, because of a disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting in which individuals without disabilities are employed. A participant receiving supported employment earn at least minimum wage, if not self-employed.

Supported employment includes:

1. Employment adaptations;
2. Supervision; and
3. Training related to a participant's assessed needs.

LIMITATIONS

Supported employment cannot be provided at the same time as:

1. Community living supports;
2. Employment assistance;
3. Non-medical transportation;
4. Paraprofessional services; or
5. Respite.

TRANSPORTATION

Transporting a participant to support his or her self-employment, working from home, or performing in a work setting is a billable activity within this service.

PERSONAL ASSISTANCE

If a participant requires personal assistance with activities of daily living that are necessary to sustain him or her in the work environment and are incidental to the provision of supported employment, the supported employment provider is permitted to deliver personal assistance.

INCENTIVES, SUBSIDIES, AND CERTAIN EXPENSES

This service does not include sheltered work or other types of vocational services in specialized facilities, or for incentive payments, subsidies, or unrelated vocational training expenses such as:

1. Incentive payments made to an employer to encourage hiring the participant;
2. Payments that are passed through to the participant;
3. Payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business; or
4. Payments used to defray the expenses associated with starting up or operating a business.

PROVIDER QUALIFICATIONS

A provider of supported employment must:

1. Be at least 18 years of age;
2. Maintain a current driver's license, and insurance if transporting the participant;
3. Have a criminal history and background check. [See CRIMINAL HISTORY AND BACKGROUND CHECK, policy 2300.1 of this manual]; and
4. Have one of the following:
   a. A bachelor's degree in rehabilitation, business, marketing, or a related human services field and six months of paid or unpaid experience providing services to people with disabilities;
   b. An associate's degree in rehabilitation, business, marketing, or a related human services field and one year of paid or unpaid experience providing services to people with disabilities; or
   c. A high school diploma or certificate of high school equivalency (GED credentials) and two years of paid or unpaid experience providing services to people with disabilities.

WRAPAROUND PLAN

The Wraparound Plan must describe the type, scope, and duration of the service.

PROGRESS NOTES

The provider must document the provision of supported employment by maintaining progress notes detailing the activity the participant engaged in with the service provider, which will be reviewed by the Department of State Health Services (DSHS).

PROVISION OF SERVICE DOCUMENTATION

Documentation of supported employment must include:

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

PROGRAM TRAINING

Prior to providing Waiver services and/or participating on a Child and Family Team, a supported employment provider must receive program training in accordance with PROGRAM TRAINING REQUIREMENTS, policy 2200.2 or 2300.2 of this manual, as applicable.

BILLING

Information regarding unit designation, payment rate, and required documentation for submitting a claim for employment assistance is detailed in BILLING, SUPPORTED EMPLOYMENT, policy 2600.21 of this manual.

SERVICE DESCRIPTION

To provide therapeutic support to a participant and to model appropriate behaviors for the participant's family, the participant temporarily resides in a home other than the home of his or her legally authorized representative (LAR). The objective is to enable the participant to successfully return home to live in the community with his or her family. Services may include:

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

LIMITATIONS

PRE-AUTHORIZATION

Supported family-based alternatives (SFA) must be pre-authorized by the Department of State Health Services (DSHS) and can be authorized for up to 90 consecutive or cumulative days, per service authorization year.

COSTS NOT COVERED

Costs that are not included in the payment of SFA are:

1. Room and board, as the participant is responsible for costs associated with room and board; and
2. Transportation, which is included in the provider rate.

OTHER SERVICES

The participant cannot receive respite or community living support services while receiving SFA. In addition, a participant who is eligible for, or receiving, Title IV-E services cannot receive SFA.

SUPPORT FAMILY REQUIREMENTS

The support family must:

1. Include at least one adult residing in the home who:
   a. Is at least 18 years of age;

b. Is not the parent, spouse, legal guardian, or LAR of the participant;

c. Has a current Texas driver's license;

d. Has insurance appropriate to the vehicle used to provide transportation;

e. Must be CPR and first aid trained; and

f. Must have a criminal history and background check. [See CRIMINAL HISTORY AND BACKGROUND CHECK, policy 2300.1 of this manual];

2. Not have more than four non-related individuals residing in the home;

3. Have legal responsibility for the residence and either own or lease the residence;

4. Reside in a home located in a typical residence in the community;

5. Provide an environment that assures the community integration, health, safety, and welfare of the participant; and

6. Provide services in accordance with the participant's service authorization.

PROVIDER QUALIFICATIONS

SFA services may be provided through one of the following:

FOSTER FAMILY

A foster family verified with the Department of Family and Protective Services, in accordance with 40 TAC, Chapter 749, available at:

http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=40&pt=19&ch=749

CHILD PLACING AGENCY

A child placing agency licensed with the Department of Family and Protective Services, in accordance with 40 TAC, Chapter 749, available at:

http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=40&pt=19&ch=749

The child placing agency must recruit, train, and certify the support family and coordinate with the support family.

WRAPAROUND PLAN

The Wraparound Plan must describe:

1. The skills training that will be provided to participant, as they relate to achieving the participant's identified goal(s);

2. The strategies and/or action steps that will be used to assist the participant in achieving the identified goal(s); and
3. The type, scope, and duration of the service.

PROGRESS NOTES

Progress notes are required for the provision of SFA services and must include:

1. Participant name;
2. Date of contact with the participant;
3. Start and stop time of contact with the participant;
4. Service name and description;
5. Service location;
6. Use of adaptive aids and supports, if applicable;
7. Transportation services, if applicable;
8. Participant response to SFA service being provided;
9. Participant progress or lack of progress;
10. Summary of activities, meals, and behaviors during the service; and
11. Direct service provider's signature and credentials.

PROVISION OF SERVICE DOCUMENTATION

The provider must document the provision of SFA services by maintaining up-to-date progress notes, which will be reviewed by DSHS.

PROGRAM TRAINING

Prior to providing Waiver services and/or participating on a Child and Family Team, a SFA provider must receive program training in accordance with PROGRAM TRAINING REQUIREMENTS, policy 2200.2 or 2300.2 of this manual, as applicable.

BILLING

Information regarding unit designation, payment rate, and required documentation for submitting a claim for SFA is detailed in BILLING, SUPPORTIVE FAMILY-BASED ALTERNATIVES, policy 2600.22 of this manual.

SERVICE DESCRIPTION

Transitional services are a one-time, non-recurring allowable expense provided when a participant transitions from an institution, provider-operated setting, or family home to his or her own private community residence. Assistance may include:

1. Utility and security deposits for the home or apartment;
2. Needed household items such as linens and cooking utensils;
3. Essential furnishings;
4. Moving expenses; or
5. Services necessary to ensure health and safety in the home or apartment (e.g. pest eradication, allergen control, or one-time cleaning).

LIMITATIONS

Transitional services cannot be used to pay for:

1. Furnishing living arrangements that are owned or leased by a Waiver provider where the provision of those items and services are inherent to the service already being provided;
2. Monthly rental or mortgage expense;
3. Food;
4. Regular utility charges; or
5. Household appliances or items intended for purely diversional or recreational purposes.

PROVIDER QUALIFICATIONS

Transitional services are provided either directly through the LMHA or CWP staff or an outside vendor subcontracted with the LMHA or CWP (e.g. furniture store, grocery store, or moving company). The LMHA or CWP must demonstrate to the Department of State Health Services that services provided meet the requirements of the participant's service authorization.

TRANSITION PLAN

The Child and Family Team must develop a transition plan which includes:

1. A summary of the mental health community services and treatment the youth received as a Waiver participant;
2. The assistance that will be provided to the participant as part of the transition plan;
3. Strategies for the transition;
4. The participant's current status (e.g., diagnosis, medications, level of functioning) and unmet needs;

5. Information from the participant and the legally authorized representative (LAR) regarding the participant's strengths, preferences for mental health community services, and responsiveness to past interventions;

6. A service plan that indicates the mental health and other community services the participant will receive as an adult; and

7. Adequate time for both current and future providers to transition the participant into adult services without a disruption in services.

[See TRANSITION PLAN–AGING OUT, policy 2200.9 of this manual.]

PROVISION OF SERVICE DOCUMENTATION

The provider must retain invoices for purchases related to transitional services, per the transition plan, in the participant's case record, which will be reviewed by the Department of State Health Services. [See RECORD KEEPING, policy 2500.3 of this manual.]

BILLING

Information regarding unit designation, payment rate, and required documentation for submitting a claim for transitional services is detailed in BILLING, TRANSITIONAL SERVICES, policy 2600.23 of this manual.

QUALITY MANAGEMENT
OVERVIEW 2500

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

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

OVERSIGHT

The Department of State Health Services (DSHS) will develop, implement, and monitor compliance activities of local mental health authorities (LMHA) and comprehensive Waiver providers (CWP), through policies, procedures, and other guidance governing the YES Waiver (Waiver).

ACTIVITIES

To ensure compliance with the Waiver, DSHS will:

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

PROVIDER REVIEW

DSHS will compare a sample of service claims and/or encounter data to the participant's service authorization to ensure the services being provided are consistent with the participant's service authorization in scope, frequency, and duration.

DSHS will review provider employee and training records to verify staff member credentials, current criminal history and background checks, and completion of Waiver training requirements. [See PROGRAM TRAINING REQUIREMENTS, policy 2200.2 or 2300.2 of this manual, as applicable.]

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

PLAN OF CORRECTION

When the DSHS official report identifies areas needing improvement or noncompliance issues, the LMHA or CWP must submit a Plan of Correction to DSHS no later than 30 business days after the date of the DSHS official report. The Plan of Correction must be implemented at all sites or locations where the LMHA or CWP provides Waiver services.

The Plan of Correction must:

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

APPROVAL

Upon approval of the Plan of Correction by DSHS, the LMHA or CWP must submit any requested documentation to DSHS to demonstrate progress of corrective action(s).

PROTECTED HEALTH INFORMATION

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

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

SHARING OR EXCHANGING CONFIDENTIAL INFORMATION

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

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

INFORMATION MANAGEMENT SYSTEM

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

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

6. All service-related information.

RELEASE OF CONFIDENTIAL INFORMATION RELATED TO THE WAIVER

The Wraparound Facilitator (Facilitator) must inform the participant and legally authorized representative (LAR) of the participant's confidentiality rights and the reasons associated with the Waiver requiring release of confidential information.

The Facilitator must obtain permission, through a signed release, from the participant and LAR in order to release personal or program information for administrative purposes.

RELEASE FORM

The release form must grant permission to the entity to release participant information, billing and claims information, information needed for quality assurance and Waiver claims monitoring, and audits.

The release form must:

1. Be signed by the participant and the participant's LAR, if the participant is under the age of 18;
2. Be signed by the participant if the participant is legally emancipated or is 18 years of age;
3. Include the date of signature;
4. Include a specific termination date, which shall be no longer than one year from the date of signature; and
5. Be renewed as necessary.

RELEASE OF CONFIDENTIAL INFORMATION NOT RELATED TO THE WAIVER

In the event an entity must disclose confidential information for purposes other than those related to Waiver administration, the entity or direct service provider must obtain separate permission from the participant and LAR prior to the release of any information.

A release granting permission to disclose information for a non-Waiver related purpose is not a blanket release of information. The entity must obtain a release of information for each separate non-Waiver related purpose.

CONFIDENTIALITY IN SERVICE DELIVERY

Staff must consider the participant's privacy and confidentiality rights and preferences to the greatest extent possible when determining locations for services.

To accommodate service delivery in various environments such as homes, schools, homeless shelters, or street locations, the entity must have policies and procedures addressing confidentiality considerations when services are provided in a community based setting.

OFFICIAL AGENCIES

Acting in their official capacity, staff of DSHS, the Health and Human Services Commission (HHSC), and/or the Centers for Medicare and Medicaid Services (CMS) are permitted to access information or records related to participants, in accordance with applicable law, rule, or regulation.

Staff of official agencies is required to follow all applicable confidentiality laws, rules, and regulations regarding the transmission, sharing, or exchange of confidential information.

TRANSFER OF RECORDS

DSHS has the authority to require an entity to transfer original and/or copies of participant records to another entity without consent from the participant and LAR:

1. Upon termination of the contract between the entity and DSHS; or
2. When the care and treatment of the participant is transferred to another entity.

FEES

An entity cannot charge fees to any official agency requesting information or records.

RETENTION OF WAIVER INFORMATION

Records retention practices must be in compliance with current federal or state law, rule, or regulation.

SERVICE DATA

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

PENDING LITIGATION OR AUDIT

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

REQUIRED BY CONTRACT

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

1. The contract with DSHS;
2. Internal monitoring records of the quality and appropriateness of Medicaid program participation and compliance;
3. All plans required by the contract;
4. All accounting and other financial records;
5. Real and personal property leases;
6. Policies, manuals, and standard operating procedures;
7. Provider credentialing records;
8. Records relating to insurance policies;
9. Employee records;
10. Licenses and certifications;
11. Subcontracts;
12. Audit records and working papers;
13. Claim payments; and
14. Any records required by DSHS.

SECURITY OF PARTICIPANT RECORDS

An entity must ensure the security of participant records in retention and destruction, in accordance with all applicable federal and state laws, rules, and regulations by establishing an effective and efficient record keeping system. All active records must be maintained in an organized system located in a secure, locked area.

An effective and efficient record keeping system must:

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

TYPES OF PARTICIPANT RECORDS

All clinical and case records must be current and meaningful, and maintained in an organized, concise, and complete manner. Participant records must be retained for a minimum of six years following either the date of the participant's termination from the Waiver, or the termination of the entity's contract with DSHS, whichever is later.

PARTICIPANT CLINICAL RECORD

A local mental health authority (LMHA) must maintain a clinical record for each participant. A participant's clinical record must:

1. Include participant name and contact information;
2. Identify an emergency contact with contact information;
3. Include participant diagnosis;
4. Include detail regarding any medication(s) used by participant;
5. Include information regarding previously received services, if applicable;
6. Identify whether the participant has allergies, and if so, the specific allergies;
7. Demonstrate medical necessity of the service(s); and
8. Include financial and insurance information.

PARTICIPANT CASE RECORD

The LMHA and comprehensive Waiver provider (CWP) must each maintain a case record for each participant which documents services provided both directly and through businesses subcontracted with the LMHA or CWP, as applicable, in accordance with the following:

LMHA

The participant case record maintained by the LMHA must include:

1. The Clinical Eligibility Determination Form;
2. The Enrollment Packet:

a. Freedom of Choice Form;

b. Notice of Participant Rights Form;

c. Provider Selection Form;

d. Enrollment Form and Participant Agreement; and

e. Authorization of Services;

3. All service authorizations;

4. All Wraparound Plans/IPC;

5. Summaries of all meetings regarding the participant;

6. Critical Incident Reports, if applicable;

7. Denial of Eligibility Letter, if applicable;

8. Letter of Withdrawal, if applicable; and

9. Other Waiver documentation.

COMPREHENSIVE WAIVER PROVIDER

The participant case record maintained by the CWP must include:

1. The Enrollment Packet:

a. Freedom of Choice Form;

b. Notice of Participant Rights Form;

c. Provider Selection Form; and

d. Enrollment Form and Participant Agreement.

2. Documentation identifying whether the participant has allergies, and if so, the specific allergies;

3. All service authorizations;

4. All receipts, invoices, or other proofs of purchase associated with, as applicable:

a. Adaptive Aids and Supports;

b. Minor home modifications; or

c. Transitional services;

5. Critical Incident Reports, if applicable;

6. A transportation log, if applicable;

7. Progress Notes for all Waiver services provided to participant;

8. Summaries of all meetings regarding the participant; and

9. Other Waiver documentation.

PARTICIPANT ASSESSMENTS

Participant assessments and reassessments of level of care must be maintained by the LMHA and DSHS.

AUDITS OF CLAIMS

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

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

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

DISASTER RECOVERY PLAN

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

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

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

ENROLLMENT PROCESS

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

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

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

BILLING
LOCAL MENTAL HEALTH AUTHORITY 2600.1

A local mental health authority serving as the comprehensive waiver provider will bill for YES Waiver services in accordance with BILLING, COMPREHENSIVE WAIVER PROVIDER, policy 2600.2 of this manual.

A comprehensive Waiver provider (CWP) must enter service notes into CMBHS to bill for YES Waiver (Waiver) services. The CWP must maintain documentation of service provision for each invoiced amount in the participant's case record.

REIMBURSEMENT RATE

In accordance with the CWP agreement with DSHS, the current Waiver service reimbursement rate(s), or any amendment to the rate(s), is payment in full for the provision of Waiver services.

ADDITIONAL CHARGES PROHIBITED

The CWP is prohibited from assessing additional charges to a participant, any member of a participant's family, or any other party, including a third-party payer, except as permitted by federal and/or state law, rule, regulation, or the Medicaid State Plan.

NON–REIMBURSED SERVICES

Services that are not reimbursed include those:

1. Not previously approved on the participant's service authorization;
2. Exceeding the limits authorized by DSHS;
3. Provided on a date in which a current service authorization was not in place; or
4. Provided outside of the participant's Waiver eligibility.

STATE PLAN SERVICES

Medicaid providers of State Plan Services must submit claims for payment to Texas Medicaid Healthcare Partnership (TMHP), the appropriate Managed Care Organization, or private insurance, as applicable. DSHS does not pay claims for State Plan Services or for other non–Waiver services.

PAYER OF LAST RESORT

Medicaid is the payer of last resort. Any claims that may be covered by a private insurance benefit must be submitted for payment to the private insurance provider prior to submitting the claim to Medicaid; i.e. TMHP or a Managed Care Organization.

BILLABLE AIDS AND SUPPORTS

A provider can submit a claim for reimbursement for the following types of adaptive aids and supports (AA&S):

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

NONBILLABLE AIDS AND SUPPORTS

A provider cannot bill Medicaid for items or services that are included in a participant's Individualized Education Plan (IEP) through his or her school.

FEES

FOR LEGALLY AUTHORIZED REPRESENTATIVE

A provider can submit a claim for reimbursement for entry, registration, or other applicable fee(s) to pay for a legally authorized representative (LAR) to facilitate a Waiver service on behalf of the participant.

FOR PROVIDER

A provider cannot bill Medicaid for entry, registration, or other applicable fee(s) to pay for a provider to facilitate a Waiver service for the participant, as these fees are included in the provider's pay rate.

PAYMENT RATE

The payment rate for an AA&S is dependent upon the direct and associated costs for the type of aid or support chosen: consumable goods; durable goods; lessons, classes, and seasonal activities; memberships; or camps.

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

ANNUAL LIMIT

There is a combined limit of $5,000 for minor home modifications and AA&S, per 365-day service authorization period.

The availability of annual AA&S varies, depending upon the recommendations of the Child and Family Team and the Wraparound Plan, in consideration of the annual cost limit.

BIDS

DSHS requires a comprehensive Waiver provider (CWP) to obtain three bids for any AA&S costing more than $500.

REQUIRED DOCUMENTATION

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

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

REQUISITION FEE

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

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

REIMBURSEMENT OF SERVICE RATE

DSHS directly reimburses the CWP for the total cost, per identified support. If the AA&S was subcontracted, the CWP must reimburse the subcontractor the total cost.

UNIT DESIGNATION AND PAYMENT RATE

The unit designation for community living supports (CLS) is 15-minutes. One 15-minute increment is billed as one unit. In order to bill for a unit, the entire unit must be provided to the participant, face-to-face.

Bachelor's degree and Master's degree level CLS clinicians are paid at the rate of $25.02 per unit.

AVAILABILITY OF ANNUAL UNITS

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

GROUP SETTING SERVICE(S)

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

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

REQUIRED DOCUMENTATION

In order to properly bill for the provision of CLS service(s), a provider must document:

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

REIMBURSEMENT AND NEGOTIATION OF SERVICE RATE

The Department of State Health Services directly reimburses the comprehensive Waiver provider (CWP) for the entire, per unit, rate.

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

UNIT DESIGNATION AND PAYMENT RATE

The unit designation for employment assistance is hourly. One hour is billed as one unit. In order to bill for a unit, the entire unit must be provided to the participant, face-to-face.

Employment assistance services are paid at the rate of $26.07 per unit.

AVAILABILITY OF ANNUAL UNITS

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

REQUIRED DOCUMENTATION

In order to properly bill for the provision of employment assistance services, a provider must document:

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

REIMBURSEMENT AND NEGOTIATION OF SERVICE RATE

The Department of State Health Services directly reimburses the comprehensive Waiver provider (CWP) for the entire, per unit, rate.

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

UNIT DESIGNATION AND PAYMENT RATE

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

Family support services are paid at the rate of $6.25 per unit.

AVAILABILITY OF ANNUAL UNITS

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

GROUP SETTING SERVICE(S)

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

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

REQUIRED DOCUMENTATION

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

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

REIMBURSEMENT AND NEGOTIATION OF SERVICE RATE

The Department of State Health Services directly reimburses the comprehensive Waiver provider (CWP) for the entire, per unit, rate.

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

PAYMENT RATE

The payment rate for minor home modifications is dependent upon the direct and associated costs for the type of modification chosen.

ANNUAL LIMIT

There is a combined limit of $5,000 for minor home modifications and AA&S, per 365-day service authorization period.

AVAILABILITY OF ANNUAL UNITS

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

NONBILLABLE MODIFICATIONS

A provider cannot bill Medicaid for room and board, normal household expenses, or items not related to the amelioration of the participant's disability.

BIDS

DSHS requires a comprehensive Waiver provider (CWP) to obtain three bids for any modification costing more than $500.

REQUIRED DOCUMENTATION

In order to properly bill for minor home modifications, a provider must provide:

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

REQUISITION FEE

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

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

REIMBURSEMENT OF SERVICE RATE	DSHS directly reimburses the CWP for the total cost, per identified modification. If the modification was subcontracted, the CWP must reimburse the subcontractor the total cost.

UNIT DESIGNATION AND PAYMENT RATE

The unit designation for non-medical transportation is one mile. One mile is billed as one unit. In order to bill for a unit, it must be provided to the participant, face-to-face.

Mileage incurred prior to picking the participant up or after dropping the participant off to access Waiver services are not units and cannot be billed.

Non-medical transportation is paid at the rate of $0.55 per unit.

LIMITATIONS

Payment for non-medical transportation is limited to the costs of transporting a participant to Waiver services included in the service authorization, or to access other activities and/or resources identified in the service authorization.

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

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

AVAILABILITY OF ANNUAL UNITS

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

REQUIRED DOCUMENTATION

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

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

ROUNDING MILEAGE

Mileage is rounded to the nearest whole mile, in accordance with the following:

Mileage	Round
.01–.49	Down
.50–.99	Up

REIMBURSEMENT AND NEGOTIATION OF SERVICE RATE

The Department of State Health Services directly reimburses the comprehensive Waiver provider (CWP) for the entire, per unit rate.

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

UNIT DESIGNATION AND PAYMENT RATE

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

Paraprofessional services are paid at the rate of $6.15 per unit.

AVAILABILITY OF ANNUAL UNITS

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

GROUP SETTING SERVICE(S)

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

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

REQUIRED DOCUMENTATION

In order to properly bill for the provision of paraprofessional services, a provider must document:

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

REIMBURSEMENT AND NEGOTIATION OF SERVICE RATE

The Department of State Health Services directly reimburses the comprehensive Waiver provider (CWP) for the entire, per unit rate.

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

UNIT DESIGNATION AND PAYMENT RATE	The unit designation for pre-engagement services is hourly. One hour is billed as one unit. The maximum number of hours permitted to be billed for pre-engagement services is 16. Pre-engagement services are paid at the rate of $15.85 per unit.
NON–BILLABLE HOURS AND ACTIVITIES	Billing for pre-engagement services is not permitted when the individual was receiving Medicaid benefits prior to seeking Waiver eligibility.

UNIT DESIGNATION AND PAYMENT RATE

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

In-home respite services are paid at the rate of $20.88 per unit.

UNIT LIMITATION

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

REQUIRED DOCUMENTATION

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

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

REIMBURSEMENT AND NEGOTIATION OF SERVICE RATE

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

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

UNIT DESIGNATION AND PAYMENT RATE

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

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

INCREMENTAL BILLING

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

Incremental billing is in accordance with the following:

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

UNIT LIMITATION

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

REQUIRED DOCUMENTATION

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

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

REIMBURSEMENT AND NEGOTIATION OF SERVICE RATE

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

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

BILLING
RESPITE
OUT-OF-HOME: LICENSED CHILD CARE CENTER 2600.13

UNIT DESIGNATION AND PAYMENT RATE

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

PRESCHOOL AGE

LCCC respite services for preschool youth, ages three to five years old, are paid at the rate of $5.32 per unit.

SCHOOL AGE

LCCC respite services for school age youth, ages six to 18 years old, are paid at the rate of $5.17 per unit.

INCREMENTAL BILLING

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

Incremental billing is in accordance with the following:

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

UNIT LIMITATION

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

REQUIRED DOCUMENTATION

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

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

REIMBURSEMENT AND NEGOTIATION OF SERVICE RATE

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

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

UNIT DESIGNATION AND PAYMENT RATE

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

PRESCHOOL AGE

TRS Provider respite services for preschool youth, ages three to five years old, are paid at the rate of $5.61 per unit.

SCHOOL AGE

TRS Provider respite services for school age youth, ages six to 18 years old, are paid at the rate of $5.54 per unit.

INCREMENTAL BILLING

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

Incremental billing is in accordance with the following:

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

UNIT LIMITATION

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

REQUIRED DOCUMENTATION

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

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

REIMBURSEMENT AND NEGOTIATION OF SERVICE RATE

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

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

UNIT DESIGNATION AND PAYMENT RATE

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

PRESCHOOL AGE

LCCH respite services for preschool youth, ages three to five years old, are paid at the rate of $4.90 per unit.

SCHOOL AGE

LCCC respite services for school age youth, ages six to 18 years old, are paid at the rate of $4.86 per unit.

INCREMENTAL BILLING

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

Incremental billing is in accordance with the following:

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

UNIT LIMITATION

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

REQUIRED DOCUMENTATION

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

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

REIMBURSEMENT AND NEGOTIATION OF SERVICE RATE

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

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

UNIT DESIGNATION AND PAYMENT RATE

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

PRESCHOOL AGE

TRS Provider respite services for preschool youth, ages three to five years old, are paid at the rate of $5.17 per unit.

SCHOOL AGE

TRS Provider respite services for school age youth, ages six to 18 years old, are paid at the rate of $5.62 per unit.

INCREMENTAL BILLING

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

Incremental billing is in accordance with the following:

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

UNIT LIMITATION

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

REQUIRED DOCUMENTATION

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

1. Date of Contact;
2. Start and Stop Time;
3. Progress towards goals set forth in the service authorization;
4. A summary of activities, meals, and behaviors; and
5. Information about the service provider, including:
6. Printed name;
7. Signature (electronic signature is acceptable); and
8. Credentials.

REIMBURSEMENT AND NEGOTIATION OF SERVICE RATE

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

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

UNIT DESIGNATION AND PAYMENT RATE

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

PRESCHOOL AGE

RCCH respite services for preschool youth, ages three to five years old, are paid at the rate of $4.75 per unit.

SCHOOL AGE

RCCH respite services for school age youth, ages six to 18 years old, are paid at the rate of $3.83 per unit.

INCREMENTAL BILLING

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

Incremental billing is in accordance with the following:

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

UNIT LIMITATION

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

REQUIRED DOCUMENTATION

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

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

REIMBURSEMENT AND NEGOTIATION OF SERVICE RATE

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

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

UNIT DESIGNATION AND PAYMENT RATE

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

PRESCHOOL AGE

TRS Provider respite services for preschool youth, ages three to five years old, are paid at the rate of $4.99 per unit.

SCHOOL AGE

TRS Provider respite services for school age youth, ages six to 18 years old, are paid at the rate of $4.08 per unit.

INCREMENTAL BILLING

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

Incremental billing is in accordance with the following:

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

UNIT LIMITATION

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

REQUIRED DOCUMENTATION

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

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

REIMBURSEMENT AND NEGOTIATION OF SERVICE RATE

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

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

UNIT DESIGNATION AND PAYMENT RATE	The unit designation for out-of-home, residential child care, Department of Family and Protective Services (DFPS) respite services is daily. Any portion of a 24-hour period is permitted to be billed as one unit.
FOSTER FAMILY	DFPS residential child care respite services provided by a foster family are paid at the rate of $88.62 per unit, the mandated maximum.
CHILD PLACING AGENCY	DFPS residential child care respite services provided by a child placing agency are paid at the rate of $67.98 per unit.
GENERAL RESIDENTIAL OPERATION (GRO)	DFPS residential child care respite services provided by a general residential operation (GRO), which provides emergency care services, are paid at the rate of $115.44 per unit.

TYPES OF SPECIALIZED THERAPIES

There are five types of specialized therapies:

1. Animal-Assisted Therapy;
2. Art Therapy;
3. Licensed Nutritional Counseling;
4. Music Therapy; and
5. Recreational Therapy.

UNIT DESIGNATION

The unit designation for each specialized therapy is 15-minutes. One 15-minute increment is billed as one unit.

PROVISION OF SERVICE

In order to bill for a unit of providing a specialized therapy service, the entire unit must be provided to the participant, face-to-face.

CHILD AND FAMILY TEAM MEETING

IN-PERSON PARTICIPATION

In-person participation of a therapist in Child and Family Team meetings is strongly encouraged. A therapist who participates in a Child and Family Team meeting in-person is permitted to bill for a maximum of one hour, for each Child and Family Team meeting attended.

PHONE PARTICIPATION

50 MILES AND OVER

A therapist who must travel 50 miles or more to attend a Child and Family Team meeting is permitted to call in to participate in the meeting. The therapist is permitted to bill for a maximum of one hour, for each Child and Family Team meeting attended.

UNDER 50 MILES

A therapist who must travel 49 miles or less to attend a Child and Family Team meeting is permitted to call in to participate in the meeting. The therapist is permitted to bill for a maximum of one unit, or one 15-minute increment, for each Child and Family Team meeting attended.

PAYMENT RATE

The payment rate for each specialized therapy is in accordance with the following:

Service	Payment Rate
Animal-Assisted Therapy	$19.36
Art Therapy	$19.36
Music Therapy	$19.36
Nutritional Counseling	$13.82
Recreational Therapy	$19.36

AVAILABILITY OF ANNUAL UNITS

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

GROUP SETTING SERVICE(S)

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

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

REQUIRED DOCUMENTATION

In order to properly bill for the provision of specialized therapy, a provider must document:

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

REQUISITION FEE

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

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

EXCEPTION	Nutritional counseling does not have an associated requisition fee.
REIMBURSEMENT AND NEGOTIATION OF SERVICE RATE	DSHS directly reimburses the comprehensive Waiver provider (CWP) for the actual direct service cost, up to the per unit maximum. The amount billed will reflect the payment amount to employees or subcontractors. The CWP is permitted to negotiate payment to its employees or subcontractors, only for services that do not have an associated requisition fee. The CWP must pass the full payment rate to the direct service provider for services that have an associated requisition fee.

UNIT DESIGNATION AND PAYMENT RATE

The unit designation for supported employment is hourly. One hour is billed as one unit. In order to bill for a unit, the entire unit must be provided to the participant, face-to-face.

Supported employment services are paid at the rate of $26.07 per unit.

AVAILABILITY OF ANNUAL UNITS

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

REQUIRED DOCUMENTATION

In order to properly bill for the provision of supported employment services, a provider must document:

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

REIMBURSEMENT AND NEGOTIATION OF SERVICE RATE

The Department of State Health Services directly reimburses the comprehensive Waiver provider (CWP) for the entire, per unit, rate.

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

UNIT DESIGNATION AND PAYMENT RATE

The unit designation for supportive family-based alternatives (SFA) is daily. Any portion of a 24-hour period is permitted to be billed as one unit.

SUPPORT FAMILY

SFA services provided by a support family are paid at the rate of $69.25 per unit, the mandated maximum.

CHILD PLACING AGENCY

SFA services provided by a child placing agency are paid at the rate of $67.98 per unit.

UNIT LIMITATION

Up to 90 consecutive or cumulative days of SFA are permitted to be provided, per participant, per service authorization year.

REQUIRED DOCUMENTATION

In order to properly bill for the provision of SFA service(s), a provider must document:

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

REIMBURSEMENT AND NEGOTIATION OF SERVICE RATE

The Department of State Health Services directly reimburses the comprehensive Waiver provider (CWP) for the entire, per unit rate.

The CWP is permitted to negotiate payment to its employees or subcontractors for services provided by a child placing agency; however, a support family must be paid the entire mandated maximum rate.

PAYMENT	Transitional services are paid as a one-time, non-recurring expense, to a maximum of $2,500, per participant. Failure to use the full $2,500 at one time will result in a loss of the remainder amount.
REQUIRED DOCUMENTATION	In order to properly bill for transitional services, a provider must retain receipt(s) of purchase in the participant's case record. [See RECORD KEEPING, policy 2700.3 of this manual.]
REQUISITION FEE	The Department of State Health Services (DSHS) reimburses the comprehensive Waiver provider (CWP) for transitional services coordination in the amount of $158.28.
REIMBURSEMENT OF SERVICE RATE	In addition to the requisition fee, DSHS directly reimburses CWP for the total amount of assistance, to the allowed maximum. If transitional services were subcontracted, the CWP must reimburse the subcontractor for the total amount of assistance; however, the CWP retains the requisition fee.

To receive payment, or to appeal the denial of a claim, from the Texas Medicaid Healthcare Partnership for intensive case management provided to participants ages 18 years to 18 years, 11-months old, the local mental health authority (LMHA) must, in addition to the standard process for the PAYMENT OF CLAIMS, policy 2600.22 of this manual, submit documentation verifying that the participant is eligible for YES Waiver services. Acceptable verification includes, but is not limited to:

1. An approved clinical eligibility determination (CED); or
2. A letter from the LMHA indicating the participant is a Waiver participant.

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

ENTERING A SERVICE NOTE

To enter a service note:

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

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

DELETING A SERVICE NOTE

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

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

A 'Canceled Claim' must be created in CMBHS, and once the claim is canceled, the service units from the canceled claim will be re-added to the service authorization.

To submit a pending claim in Clinical Management for Behavioral Health Services (CMBHS), a comprehensive Waiver provider must:

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

A claim for Waiver services is paid by the Texas Medicaid Healthcare Partnership (TMHP). In order to receive payment for performing the service(s), a comprehensive Waiver provider (CWP) must enter and manage claims through Clinical Management for Behavioral Health Services (CMBHS) as a service note. [See SERVICE NOTES, policy 2600.23 of this manual.]

Initial claims must be submitted to TMHP within 95 days of the date of the provision of the Waiver service. To ensure accuracy during claim processing, TMHP verifies that all required information is included in the claim.

PAYMENT

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

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

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

APPEAL OF DENIED PAYMENT

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

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

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

APPENDIX

DEFINITIONS

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

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

Billable Time – The billable units, per participant.

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

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

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

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

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

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

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

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

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

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

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

Enrolled – A designation given to an interested individual once his or her clinical eligibility is authorized by the Department of State Health Services.

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

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

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

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

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

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

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

Legally Authorized Representative (LAR)– A person authorized by law to act on behalf of a child or youth, including, but not limited to, a parent, guardian, or managing conservator, in accordance with Texas Administrative Code §414.403, Subchapter I, available at:
http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=414&rl=403

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

Local Mental Health Authority – An entity established, as a community mental health center or community mental health and mental retardation center, in accordance with the Texas Health and Safety Code, § 531.002, available at:

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http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.531.htm

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

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

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

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

Protected Health Information (PHI) – Individually identifiable health information transmitted by electronic media or maintained in any medium, in accordance with 4 TAC §1.501, Subchapter W, available at:
http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=1&rl=501
PHI excludes education records or information protected by the Family Educational Rights and Privacy Act (FERPA), employment records, and records of a person deceased for more than 50 years.

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

- Has a Bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major, as determined by the local mental health authority (LMHA) or Managed Care Organization (MCO), in accordance with 25 TAC §412.316(d), Subchapter G, available at: http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=412&rl=316. Major course work must be in one of the following: psychology; social work; medicine; nursing; rehabilitation; counseling; sociology; human growth and development; physician assistant; gerontology; special education; educational psychology; early childhood education; or early childhood intervention;
- Is a registered nurse (RN); or
- Completes an alternative credentialing process approved by the Department of State Health Services.

Sensitive Personal Information (SPI) – An individual's non-encrypted first name or first initial and last name, in combination with any one of the following: Social

Security number; driver's license or government-issued identification number; or account number or credit or debit card number in combination with any required security or access code or password that would permit access to the individual's financial account(s). Any information that identifies an individual and relates to his or her: physical or mental health or other condition; provision of any health care service(s); or payment for the provision of any health care service(s).

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

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

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

State Plan Services – Services offered under the Medicaid State Plan service array, which can be provided by a local mental health authority (LMHA) or any other credentialed Medicaid State Plan service provider.

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

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

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

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

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

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

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

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

Waiver Service Area – The geographical area covered by YES Waiver participating entities.

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

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

Wraparound Plan – Also referred to as the Individual Plan of Care (IPC). Developed using the Wraparound Planning Process, is the comprehensive plan of all services the participant is receiving. Ideally, the plan is comprehensive to the degree that it can be used/meet the needs of all plans (across all child serving systems) developed to address the needs of the individual youth.