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State/Territory Name: Texas

State Plan Amendment (SPA) #: 14-26

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
3) Superseding Page Listing
4) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, Texas 75202

DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI

April 2, 2015

Our Reference: SPA TX 14-026

Ms. Kay Ghahremani
State Medicaid/CHIP Director
Health and Human Services Commission
Post Office Box 13247
Mail Code H100
Austin, Texas 78711

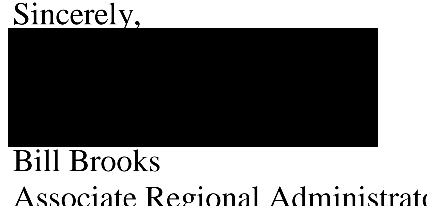
Dear Ms. Ghahremani:

We have reviewed the State's proposed amendment to the Texas State Plan submitted under Transmittal Number 14-026, dated October 10, 2014. This state plan amendment implements the Community First Choice (CFC) program under section 1915(k) of the Social Security Act. CFC services would be provided to individuals who meet categorical coverage requirements for Medicaid or meet financial eligibility for home and community-based services and who meet an institutional level of care.

Based on the information submitted, we have approved the amendment for incorporation into the official Texas State Plan with an effective date change of June 1, 2015. A copy of the CMS-179 and approved plan pages are enclosed with this letter.

If you have questions, please contact Cheryl Rupley at (214) 767-6278.

Sincerely,



Bill Brooks
Associate Regional Administrator

cc: Becky Brownlee, Policy Development Support

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **14-026**

2. STATE: **TEXAS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **June 1, 2015**

5. TYPE OF PLAN MATERIAL *(Circle One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1915(k) of the Social Security Act; 42 CFR 441.500-590

7. FEDERAL BUDGET IMPACT: **SEE ATTACHMENT**
a. **FFY 2015** **$ 84,500,737**
b. **FFY 2016** **$257,016,922**
c. **FFY 2017** **$276,631,866**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
SEE ATTACHMENT TO BLOCKS 8 & 9

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
SEE ATTACHMENT TO BLOCKS 8 & 9

10. SUBJECT OF AMENDMENT:

The proposed amendment implements the Community First Choice (CFC) program under section 1915(k) of the Social Security Act.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Kay Ghahremani

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
October 10, 2014

16. RETURN TO:

Kay Ghahremani
State Medicaid Director
Post Office Box 13247, MC: H-100
Austin, Texas 78711

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 10 October, 2014

18. DATE APPROVED: 2 April, 2015

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 June, 2015

20. SIGNATU[redacted]ICIAL:

21. TYPED NAME: Bill Brooks

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

FORM CMS – 179 (07-92)

Attachment to Blocks 8 & 9 of CMS Form 179

Transmittal Number 14-026

Number of the Plan Section or Attachment	**Number of the Superseded Plan Section or Attachment**
Attachment 3.1-K	Attachment 3.1-K
Page 1	N/A – new page
Page 2	N/A – new page
Page 3	N/A – new page
Page 4	N/A – new page
Page 5	N/A – new page
Page 6	N/A – new page
Page 7	N/A – new page
Page 8	N/A – new page
Page 9	N/A – new page
Page 10	N/A – new page
Page 11	N/A – new page
Page 12	N/A – new page
Page 13	N/A – new page
Page 14	N/A – new page
Page 15	N/A – new page
Page 16	N/A – new page
Page 17	N/A – new page
Page 18	N/A – new page
Page 19	N/A – new page
Page 20	N/A – new page
Page 21	N/A – new page
Page 22	N/A – new page
Page 23	N/A – new page
Page 24	N/A – new page
Page 25	N/A – new page
Page 26	N/A – new page
Page 27	N/A – new page
Page 28	N/A – new page
Page 29	N/A – new page
Page 30	N/A – new page
Page 31	N/A – new page
Page 32	N/A – new page
Supplement 4 to Attachment 4.19-B	Supplement 4 to Attachment 4.19-B
Page 1	N/A – new page
Page 2	N/A – new page
Page 3	N/A – new page
Page 4	N/A – new page

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State: Texas
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Community First Choice State Plan Option

1. Eligibility

   (a) The State determines eligibility for Community First Choice (CFC) services in the manner prescribed under 42 CFR §441.510. To receive CFC services and supports in Texas, an individual must meet the following requirements:

      (1) Be eligible for medical assistance under the state plan;

      (2) As determined annually, be in an eligibility group under the state plan that includes nursing facility services; and

      (3) Receive a determination, at least annually, that in the absence of the home and community-based personal assistance services and supports, the individual would otherwise require the level of care furnished in a hospital, a nursing facility, an intermediate care facility for individuals with an intellectual disability or a related condition, an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over, if the cost could be reimbursed under the state plan.

   (b) Individuals who qualify for medical assistance under the special home and community- based waiver eligibility group defined at section 1902(a)(10)(A)(ii)(VI) of the Social Security Act must meet all section 1915(c) requirements and receive at least one home and community-based service per month.

   (c) Individuals receiving services through CFC are not precluded from receiving other home and community-based long-term services and supports (LTSS) through other Medicaid state plan, waiver, grant, or demonstration authorities.

2. Statewideness

   CFC is available to all eligible individuals in Texas, regardless of their location within the State, in a manner that provides the services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of CFC services and supports the individual requires to lead an independent life.

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Community First Choice State Plan Option (continued)

3. Included Services

(a) **CFC personal assistance services**: assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), as defined in 42 CFR §441.505, through hands-on assistance, supervision, and/or cueing. Such assistance is provided to an individual in performing ADLs and IADLs based on a person-centered service plan. CFC personal assistance services include:

(1) Non-skilled assistance with the performance of ADLs and IADLs;
(2) Household chores necessary to maintain the home in a clean, sanitary, and safe environment;
(3) Escort services, which consist of accompanying, but not transporting, and assisting an individual to access services or activities in the community; and
(4) Assistance with health-related tasks as defined in 42 CFR §441.505. Health-related tasks, in accordance with state law, include tasks delegated by a registered nurse, health maintenance activities, and extension of therapy. An extension of therapy is an activity that a speech therapist, physical therapist or occupational therapist, instructs the individual to do as follow-up to therapy sessions. If appropriate, the individual's attendant can assist the individual in accomplishing such activities with supervision, cueing and hands-on assistance.

In the consumer-directed services model, the individual or legally-authorized representative determines health-related tasks without a nurse assessment, in accordance with state law.

(b) **CFC habilitation**: acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks as defined in 42 CFR §441.505. This service is provided to allow an individual to reside successfully in a community setting by assisting the individual to acquire, retain, and improve self-help, socialization, and daily living skills or assisting with and training the individual on ADLs and IADLs. Personal assistance may be a component of CFC habilitation for some individuals. CFC habilitation services include training, which is interacting face-to-face with an individual to train the individual in activities such as:

(1) self-care;
(2) personal hygiene;
(3) household tasks;

Community First Choice State Plan Option (continued)

(4) mobility;
(5) money management;
(6) community integration, including how to get around in the community;
(7) use of adaptive equipment;

(8) personal decision-making;
(9) reduction of challenging behaviors to allow individuals to accomplish ADLs, IADLs, and health-related tasks; and
(10) self-administration of medication.

(c) **CFC emergency response services**: backup systems and supports, as defined in 42 CFR §441.505, to ensure continuity of services and supports. Reimbursement for backup systems and supports is limited to electronic devices to ensure continuity of services and supports and are available for individuals who live alone, who are alone for significant parts of the day, or have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

(d) **CFC support management**: voluntary training on how to select, manage, and dismiss attendants.

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Community First Choice State Plan Option (continued)

4. Home and Community-Based Setting

All CFC services are provided in a home or community-based setting, which does not include a nursing facility, hospital providing long-term care services, institution for mental disease, intermediate care facility for individuals with an intellectual disability or related condition, or setting with the characteristics of an institution. All CFC settings comply with 42 CFR §441.530. The state has process and procedures to ensure ongoing compliance with the setting requirements outlined in 42 CFR §441.530. Settings include individual homes, apartment buildings, and non-residential settings that meet the settings criteria outlined in 42 CFR §441.530. Settings do not include provider-owned or controlled residential settings. The State will amend the state plan if it determines that other settings meet the settings criteria outlined in 42 CFR §441.530.

5. Assessment of Institutional Level of Care and Functional Need

Individuals receive an assessment of institutional level of care (LOC) and functional need by a qualified provider initially and on an annual basis.

(a) LOC Assessment:

(1) To determine nursing facility and hospital LOC, Texas uses the Medical Necessity/Level of Care (MN/LOC) assessment. MN is the determination that an individual requires the services (supervision, assessment, planning, and intervention) of licensed nurses in an institutional setting to carry out a physician's planned regimen for total care.

(1) To determine ICF/IID LOC, Texas uses the Intellectual Disability/Related Condition assessment (ID/RC). The ID/RC assessment includes all factors needed to determine an LOC: diagnostic information that includes age of onset of the qualifying conditions, names of qualifying conditions, the appropriate International Classification of Diseases codes, results of standardized intelligence testing, and the adaptive behavior level as determined by an approved adaptive behavior assessment tool.

(2) To determine psychiatric inpatient LOC for individuals under age 21, and institution for mental disease LOC for individuals age 65 and over, the Child and Adolescent Needs and Strengths assessment (CANS) or Adult Needs and Strengths assessment (ANSA) is completed and entered into a State

Community First Choice State Plan Option (continued)

system which has an automated clinical and diagnostic tool that helps determine an individual's LOC. The system uses CANS or ANSA data to determine whether an individual meets Medicaid inpatient psychiatric admission criteria.

(b) Functional Needs Assessment: Assessments for CFC services are conducted by assessors who are determined to be qualified by the State. Such assessments are performed as an administrative function. The functional needs assessment and service plan development process comply with the requirements set forth in 42 CFR §§441.535-441.540.

(1) CFC functional need assessments are conducted initially and at least annually, unless a change in condition, health status, or support needs requires reassessment at an earlier date, or the individual requests a reassessment. The assessments are conducted face-to-face and include an assessment of an individual's functional needs, strengths, preferences, and goals for the services and supports provided under CFC.

(2) Individuals are assessed for functional need at a time and location convenient for the individual. The assessment is conducted as part of a person-centered planning process with the individual and anyone else chosen by the individual. Initially and at least annually, in partnership, the assessor, individual, and a service planning team comprised of members chosen by the individual develop a recommended service plan for review and consideration by the State or its designee.

(3) Qualified assessors of functional need include local intellectual and developmental disability and mental health authorities, MCO service coordinators or service managers, Department of State Health Services (DSHS) case workers, direct service agencies, and case managers.

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6. Person-Centered Service Plan

The person centered service planning process will be provided in accordance with 42 CFR 441.540.

Responsible parties and qualifications:

A. The person-centered service plan is created simultaneously and in conjunction with the functional needs assessment by qualified assessors which include local intellectual and developmental disability and mental health authorities, MCO service coordinators or service managers, DSHS case workers, direct service agencies, and case managers.
B. Texas partners with the Institute for Person-Centered Practices (the Institute) for development of a person-centered thinking and person-centered plan facilitation training, which is tailored to teach facilitators to meet the person-centered planning requirements contained in the CFC and the HCBS settings federal requirements.
C. Every person-centered plan facilitator will complete the Institute for Person-Centered Practices training or an HHSC-approved training developed and delivered within two years of the implementation of CFC. The parties required to complete the training include those that conduct the functional assessment for CFC in the Deaf Blind with Multiple Disabilities (DBMD) and Community Living Assistance and Support Services (CLASS) programs; local intellectual and developmental disability authorities in the Home and Community-based Services (HCS), Texas Home Living (TxHmL), and STAR+PLUS programs; managed care organizations in STAR+PLUS and STAR Health programs; and DSHS case workers.

Development of the person-centered service plan:

A. The person-centered plan facilitator contacts the individual to schedule a time to complete the person-centered service plan, which is conducted face-to-face and occurs at a time and location convenient to the individual.
B. As the individual's functional need is assessed simultaneously, the person-centered plan facilitator works with the individual to identify the individual's goals, needs, and preferences through use of a series of discovery skills: rituals and routines, good day/bad day communication chart, relationship map, and other tools. The individual or legally authorized representative may choose who is included in the person-centered plan development process. The individual and people who know and care about the individual are considered the content experts that provide the information to the person-centered plan facilitator.

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C. The person-centered plan facilitators have previous experience with the creation of service plans for individuals with disabilities and incorporate cultural considerations of the individual.
D. Person-centered plan facilitators use a variety of skills to resolve conflict or disagreement while developing the plan. The “Four Plus One” skill and the “What’s Working/What’s Not Working” skill are used in these instances .The “Four Plus One” is a skill used to collect, evaluate, and learn from everyday situations. “What’s Working/What’s Not Working” is a problem-solving negotiation skill that analyzes issues across multiple perspectives.
E. The person-centered service plan is reviewed and revised at least annually, upon reassessment of functional need, when the individual's circumstances or needs change significantly, and at the request of the individual or legally authorized representative through contact with the individual's person-centered plan facilitator. The person-centered service plan is reviewed by the service planning team, which consists of the individual, the individuals LAR, the person-centered plan facilitator, and any other individuals designated by the individual or the individual’s legally authorized representative. The provider may be a participant on the service planning team.
F. Throughout development of the person-centered plan, the facilitator ensures consideration of information from the individual or legally authorized representative to determine any risks that might exist to health and welfare of the individual as a result of living in the community. The discovery process utilized by the person-centered facilitator is designed to address all areas of an individual’s life: social inclusion/relationships, health and safety, work/school, self-determination, financial security, living environment, physical/emotional/behavioral, rights/legal status, and daily living skills. Following the discovery process, the facilitator identifies and documents in the person-centered plan those services that are critical to the health and welfare of the individual for which a backup plan must be developed.
G. The person-centered plan includes documentation on whether the individual has chosen the agency model or the self-directed model of service delivery.
H. The person-centered plan is finalized and agreed to in writing by the individual and signed by all individuals and providers responsible for its implementation.
I. The person-centered service plan will reflect that the setting meets the criteria outlined in 42 CFR 441.530 and is chosen by the individual.

Community First Choice State Plan Option (continued)

7. Service Delivery Model

_X_ Agency-Provider Model – The agency-provider model is based on the person-centered assessment of need. The agency-provider model is a delivery method in which the services and supports are provided by entities under a contract with the Health and Human Services Commission (HHSC) or its designee.

Individuals may also elect to use the Service Responsibility Option (SRO) model. In the SRO model, a provider agency is the attendant's employer of record and handles the business details. The member is responsible for the day-to-day management of the attendant's activities, beginning with interviewing and selecting the person who will be the attendant.

__ Self-Directed Model with service budget – This model is one in which the individual has both a person-centered service plan and service budget based on the assessment of need. The service plan conveys authority to perform the functions pursuant to 42 CFR §441.550. The service budget meets the requirements set forth in 42 CFR §441.560.

____ Direct Cash

____ Vouchers

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_X_ Other Service Delivery Model as described below:

Consumer-Directed Services Model

_X_ – In this model, the individual or the legally authorized representative is the common-law employer of service providers and has decision-making authority and budget authority over the services he or she is directing. The employer assumes and retains responsibility to recruit, determine the competence of, hire, train, manage, and fire their employees.

The financial management services include, but are not limited to, the following activities: collect and process timesheets of the individual's attendant care providers; process payroll, withholding, filing, and payment of applicable federal, state, and local employment related taxes and insurance; separately track budget funds and expenditures for each individual; track and report disbursements and

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balances of each individual's funds; process and pay invoices for services in the person-centered service plan; and provide individual periodic reports of expenditures and the status of the approved service budget to the individual and to the State.

The consumer directed budget, developed by the CDS employer (the individual or Legally Authorized Representative), with assistance from the FMSA is based on the cost of the self-directed services in the approved service plan. The cost of self-directed services is defined as the number of hours authorized for the service multiplied by adopted consumer directed services reimbursement rate for the service. The CDS employer allocates the wages and benefits, if any, to be paid to the employee and any employer supports. Employer supports are permissible services and supports that are linked to an assessed need or goal in the individual's person-centered service plan that increase an individual's independence or substitute for human assistance. Employer supports are defined as services and items the employer needs to perform employer and employment responsibilities. Employer supports include recruiting expenses, required employee specific training (if not available through the State), fax machine, mailing costs, envelopes, file folders, and support consultation provided by certified support advisors. The FMSA must approve the budget by ensuring that projected expenditures are within the authorized budget for each service, are allowable and reasonable, and are projected over the effective period of the plan to ensure that sufficient funds will be available to the end date of the service plan. A revision to the budget for a particular service or a request to shift funds from one service to another requires a service plan change and must be justified by the service planning team and authorized by the State. Information described above concerning budget methodology for the consumer directed services budget is available to the public in Title 40 of the Texas Administrative Code, Part 1, Chapter 41, Subchapter E.

Support consultation provides a level of training, assistance, and support that does not duplicate or replace the services delivered through FMS, case management services, or other available program or non-program service or resource; practical skills training and assistance to successfully manage service providers for authorized program services delivered through the CDS option; and skills training and assistance for employer responsibilities including recruitment and hiring, maintaining employment documentation, communication and problem solving, decision making, coaching and one-on-one assistance, and conflict resolution related to being an employer.

Community First Choice State Plan Option (continued)

8. Support System

(a) Texas provides, or arranges for the provision of, a support system that meets all of the required conditions as described in 42 CFR §441.555. Components of the support system include the local intellectual and developmental disability authorities; MCOs, including the MCO service coordinators and service managers; case management agencies; financial management services agencies; support advisors; Personal Care Services case managers; comprehensive mental health providers including local mental health authorities; and provider agencies. The support system ensures:

(1) Appropriate assessment and counseling for an individual before receiving services;
(2) Provision of appropriate information, counseling, training, and assistance to ensure an individual is able to manage the services;
(3) Establishment of conflict of interest standards for the assessments of functional need and the person-centered service plan development process that apply to all individuals and entities, public or private; and
(4) Identification of the responsibilities for assessment of functional need and person-centered service plan development.

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9. Provider Qualifications

CFC services are provided by LTSS and state plan service providers determined to be qualified by the State in a program already approved by CMS. Texas ensures all current qualification standards are maintained. Providers delivering CFC services include licensed home and community support services agencies (HCSSAs), certified HCS and TxHmL providers, licensed personal emergency response services agencies, qualified financial management services agencies, and providers hired by individuals using the CDS option who meet qualifications. In accordance with Section 1902(a)(23) of the Act, the state assures that individuals will have free choice of provider, unless a limitation is authorized through a Section 1915(b)(4) waiver authority.

Service	Personal Assistance Services and Habilitation (PAS/HAB)

Service Provider Qualifications	• is at least 18 years of age; and
	• has a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma ; or
	• documentation of a proficiency evaluation of experience and competence to perform the job tasks that includes:
	  o a written competency-based assessment; and
	  o at least three written personal references from persons not related by blood that indicate the ability to provide a safe, healthy environment for the individuals being served.
	• is not the parent of an individual who is under 18 years of age or the individual's spouse; and
	• meets any other qualifications requested by the individual or legally authorized representative (LAR) based on the individual's needs and preferences.
	• if requested by an individual the provider must allow the individual to train a CFC PAS/HAB service provider in the specific assistance needed by the individual and to have the service provider perform CFC PAS/HAB in a manner that comports with the individual's personal, cultural, or religious preferences; and
	• ensure that an individual has the right to access other training provided by or through the State so that the service provider can meet any additional qualifications required or desired by the individual

Community First Choice State Plan Option (continued)

Service Provider Qualifications (continued)	**Consumer Directed Services** • is at least 18 years of age; and • has a high school diploma; or a certificate recognized by a state as the equivalent of a high school diploma ; or documentation of a proficiency evaluation of experience and competence to perform the job tasks that includes: (1) a written competency-based assessment; and (2) at least three written personal references from persons not related by blood that indicate the ability to provide a safe, healthy environment for the individuals being served. • is not the individual's legally authorized representative (LAR), LAR's spouse, designated representative, or designated representative's spouse; and • meets any other qualifications requested by the individual or LAR based on the individual's needs and preferences.
Provider Entity Qualifications	• Licensed home and community support services agencies (HCSSAs). The agency must be licensed as a home and community support service agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97. • Certified HCS and TxHmL providers.
Service	**Emergency Response Services**
Service Provider Qualifications	See provider entity qualifications
Provider Entity Qualifications	• be licensed as a personal emergency response system provider in accordance with 25 TAC Chapter 140, Subchapter B (relating to Personal Emergency Response System Providers); or • contract with a personal emergency response system provider licensed in accordance with 25 TAC Chapter 140, Subchapter B

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Service	Support Management
Service Provider Qualifications	• is at least 18 years of age; and • has a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma.
Provider Entity Qualifications	• Licensed home and community support services agencies (HCSSAs). The agency must be licensed as a home and community support service agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97 • Certified HCS and TxHmL providers • Financial Management Services Agencies (FMSAs)
Service	**Financial Management Services Providers**
Service Provider Qualifications	See provider entity qualifications
Provider Entity Qualifications	Financial Management Services Agencies (FMSAs) Prior to contracting with DADS or an MCO, FMSAs must • attend a mandatory three-day training conducted by DADS; and • demonstrate knowledge of training material including the definition and responsibilities of a vendor fiscal employer agent in accordance with IRS Revenue Procedure and an explanation of fiscal employer agent based on Section 3504 of the IRS code and state tax (unemployment) requirements as a Vendor Fiscal/Employer Agent. Individual service provider must not be the individual's legal guardian; the spouse of the individual's legal guardian; the individual's designated representative; or the spouse of the individual’s designated representative

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Community First Choice State Plan Option (continued)

10. State Assurances

Necessary safeguards are in place to protect the health and welfare of individuals provided services under this state plan option, and to prevent payment for items or services furnished by service providers or entities excluded from participating in the Medicaid program, in accordance with §1903(i) of the Act.

With respect to expenditures during the first full 12 month period in which the state plan amendment is implemented, the State will maintain or exceed the level of state expenditures for home and community-based attendant services and supports provided under section 1905(a), section 1915, section 1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding 12 month period.

CFC services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and all applicable provisions of Federal and State laws regarding withholding and payment of Federal and State income and payroll taxes, the provision of unemployment and workers compensation insurance, maintenance of general liability insurance, occupational health and safety, and any other employment or tax related requirements.

The State intends to include the Community First Choice (Section 1915(k)) payments in the MCO capitation rate.

- The State provides an assurance that at least annually, it will submit to the regional office as part of its capitated rate actuarial certification a separate Community First Choice section which outlines the following:
  - Any program changes based on the inclusion of Community First Choice services in the array of benefits delivered by the MCOs
  - Estimates of, or actual (base) costs to provide Community First Choice services (including detailed description of the data used for the cost estimates)
  - Assumptions on the expected utilization of Community First Choice services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)
  - Any risk adjustments made by plan that may be different than overall risk adjustments
  - How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM

Community First Choice State Plan Option (continued)

11. Development and Implementation Council

HHSC identifies the Promoting Independence Advisory Committee (PIAC) to serve in the role of the Development and Implementation Council. The PIAC was established in 2001 in response to several key laws, decisions, and State actions related to supporting the choice of individuals with disabilities to receive LTSS in the most integrated setting. The PIAC helps to ensure Texas Medicaid home and community-based programs and benefits effectively foster independence and productivity and provide opportunities for people with disabilities to live in the most appropriate care setting. Members of the PIAC include individuals with disabilities, advocates of individuals with disabilities, representatives of long-term care service providers who serve individuals with disabilities (including individuals who are older) and representatives of Texas health and human services agencies.

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12. Quality Assurance System

Texas proposes to provide CFC services through the state plan, leveraging existing program infrastructure. Cited below are the various activities engaged in by the State to meet the standards outlined in 42 CFR §441.585 (Quality assurance system). The State uses these policies and processes to the greatest extent possible, and is actively identifying areas where new policies will need to be developed.

a) Quality Improvement Strategy (§441.585(a)(1))

The state must ensure the quality assurance system will employ methods that maximizes individual independence and control, and provides information about the provisions of quality improvement and assurance to each individual receiving such services and supports. §441.585(b))

1) CFC services provided through managed care

The Texas Healthcare Transformation and Quality Improvement Program Quality Improvement Strategy is posted at http://www.hhsc.state.tx.us/medicaid/about/transformation-waiver.shtml. The State posts any revisions to the Strategy on the website and requests public comment when changes are necessary. The State is in the process of developing a comprehensive Texas Medicaid managed care quality improvement strategy. All Texas Medicaid managed care programs will be included in this Strategy. A summary of the existing strategy follows.

The Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, known as the 1115 Transformation Waiver, is a five-year demonstration waiver running through September 2016 that allows the state to expand Medicaid managed care while preserving federal hospital funding historically received as Upper Payment Limit payments. The 1115 Transformation Waiver includes multiple Texas Medicaid managed care programs, including STAR+PLUS, a program through which CFC services will be provided.

HHSC's mission is to create a customer-centered, innovative, and adaptable managed care system that provides the highest quality of care to individuals served by the agency while ensuring access to services. To this end, the 1115 Transformation Waiver goals and objectives include improving outcomes and transitioning to quality-based payment systems across managed care and hospitals. The 1115 Quality Improvement Strategy outlines the internal and

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external resources, mechanisms, and initiatives that together will achieve these goals. The Code of Federal Regulations includes requirements outlining the components of a state quality strategy. CMS has approved the 1115 Managed Care Strategy, demonstrating that it meets all federal requirements.

The 1115 Quality Improvement Strategy encompasses multiple programs and divisions within HHSC as well as advisory committees, and the external quality review organization. Each of these areas is responsible for complex, unique activities and serves a specific purpose in the overall Texas Medicaid quality system. Their distinct roles interact with each other to fluctuating degrees, largely dictated by specific projects and needs of the agency and stakeholders.

EVIDENCE-BASED CARE AND QUALITY MEASUREMENT

Measurement

Texas relies on a combination of established and state-developed measures that are validated by the external quality review organization, including:

- National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (HEDIS®)
- Agency for Healthcare Research and Quality Pediatric Quality Indicators/Prevention Quality Indicators
- 3M Software for Potentially Preventable Events
- Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Surveys

Encounter Data Requirements

Managed care organizations (MCOs) are required to submit complete and accurate encounter data for all covered services, including value-added services, to a data warehouse for reporting purposes at least monthly. HHSC contracts with the external quality review organization to certify the accuracy and completeness of this organization encounter data. Encounter data that does not meet quality standards must be corrected and returned within a time period specified by HHSC.

Data certification reports support rate-setting activities and provide information relating to the quality, completeness, and accuracy of the MCO encounter data.

MCO-generated data and reports

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Quality Assessment and Performance Improvement
Each MCO must develop, maintain, and operate a Quality Assessment and Performance Improvement Program that meets state and federal requirements.

Performance Improvement Projects
Each MCO must develop and implement performance improvement projects as required by CMS and the State. When conducting performance improvement projects, MCOs are required to follow the ten-step CMS protocol published in the CMS External Quality Review Organization Protocols.

External quality review organization processes and reports

The EQRO conducts multiple activities and develops reports to assist the State in ensuring high quality delivery of Medicaid managed care services and to meet federal requirements. These activities and reports include:

- MCO Administrative Interviews
- Data Certification Reports
- Encounter Data Validation Report
- Quarterly Topic Reports
- Summary of Activities Report
- Member Surveys and Reports
- Quality of Care Reports
- FREW-related activities and reports

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TEXAS QUALITY INITIATIVES

Pay-for-Quality Program
To comply with legislative direction and to best identify quality of care measures that reflect the needs of the population served and areas needing improvement, HHSC implemented the Pay-for-Quality Program, which uses an incremental improvement approach that provides financial incentives and disincentives to MCOs based on year-to-year incremental improvement on pre-specified quality goals. The State also operates a similar dental pay-for-quality program.

Performance Indicator Dashboards
The Performance Indicator Dashboard includes a series of measures that identify key aspects of performance and support MCO accountability. The Performance

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Indicator Dashboard is not an all-inclusive set of performance measures, but it does include those measures that assess many of the most important dimensions of MCO performance and that incentivize excellence.

MCO Report Cards
HHSC develops annual MCO report cards for each program service area to allow members to easily compare the MCOs on specific quality measures. MCO report cards are posted on the HHSC website and included in Medicaid enrollment packets sent by the enrollment broker to potential members.

Innovation
Texas is engaging in multiple activities to develop new strategies to measure and encourage quality service delivery in Medicaid managed care. Examples of these activities include 1115 Waiver Regional Healthcare Partnership Projects, legislatively mandated activities such as reduction of potentially preventable events, and participation in the Texas Dual Eligible Integrated Care Project.

Data on utilization of managed care long-term services and supports is shared at regularly-scheduled STAR+PLUS stakeholder meetings. Additionally, reports developed by the State's external quality review organization are posted for public viewing on the Health and Human Services Commission website.

2) CFC services provided through fee-for-service

For most individuals receiving fee-for-service CFC services, the quality improvement strategy is referred to as the Quality Oversight Plan (the Plan). Central to the Plan is the Quality Review Team (the Team), which consists of representatives from several agencies within the Texas health and human services enterprise. In addition to establishing quality-related priorities and directing improvement activities, the Team oversees implementation of the Plan and related processes. The Plan uses numerous quality indicators that are tracked and reported on a quarterly basis using data compiled from multiple automated systems. The areas covered by the reports include: demographics; service utilization; enrollment; level of care; service planning; consumer direction; critical incidents; provider compliance and oversight; transfers; and discharges. Activities are underway to include the remaining fee-for-service population not covered in this plan.

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The State has multiple mechanisms through which to communicate with external stakeholders, including:

- Advisory committees made up of interested professionals, such as the Medical Care Advisory Committee, the Department of Aging and Disability Services Advisory Council, and the Health and Human Services Commission Advisory Council.
- Advisory committees made up of other interested community members, such as the Intellectual and Developmental Disability System Redesign Advisory Committee, the STAR+PLUS Quality Council, and the Promoting Independence Advisory Committee.

b) Methods to continuously monitor the health and welfare of each individual who receives home and community-based attendant services and supports, including a process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of such services and supports.(42 CFR §441.585(a)(2))

(1) CFC services provided through managed care

The State Medicaid Agency or its designee monitors licensed or certified provider compliance with state requirements.

Licensed or certified CFC providers are required to report instances of abuse, neglect, or exploitation of an individual to the State Medicaid Agency or its designee immediately upon suspicion of such activities. This includes suspicion of abuse, neglect, or exploitation of a child by an employee of the HCSSA.

Abuse, neglect, and exploitation requirements for licensed CFC providers require the provider to adopt and enforce a written policy relating to the agency's procedures for reporting alleged acts of abuse, neglect, and exploitation of a client by an employee of the agency. At the time an individual begins receiving services from a licensed CFC provider, the provider must give the individual a written statement informing him that complaints against the agency may be directed to the State Medicaid Agency or its designee.

Certified CFC providers must ensure that employees, subcontractors, and volunteers are knowledgeable of the acts that constitute abuse, neglect, and exploitation; the requirement to report suspicion of such acts to the State

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Medicaid Agency or its designee; how to report allegations; and methods to prevent the occurrence of abuse, neglect, or exploitation. Individuals must be informed of how to report abuse, neglect or exploitation before the individual begins receiving services from the provider.

MCOs monitor contract performance on a biannual basis. Critical events or incidents are defined in the applicable managed care contract and include:

- abuse, neglect, or exploitation;
- the unauthorized use of restraint, seclusion, or restrictive interventions;
- serious injuries that require medical intervention or result in hospitalization;
- criminal victimization;
- unexplained death;
- medication errors; and
- other incidents or events that involve harm or risk of harm to a member.

MCOs, their subcontractors, and providers must report any suspicion or allegation of abuse or neglect of a child in accordance with Texas Family Code § 261.101. The MCO, its subcontractors, and providers must report any suspicion or allegation of abuse, neglect or exploitation of an individual who is aged or who has a disability in accordance with Texas Human Resources Code § 48.051. The MCO must establish ongoing provider training regarding the providers' obligation to identify and report to the State a critical event or incident such as abuse, neglect, or exploitation related to LTSS delivered in the STAR+PLUS program. MCO member service hotline representatives must be knowledgeable about how to identify and report to the State a critical event or incident such as abuse, neglect, or exploitation related to LTSS delivered in the STAR+PLUS program. At a minimum, the STAR Health MCO's member service representatives must be knowledgeable and trained in issues related to child abuse and how to assist members and medical consenters seeking care and services. The MCO must include information in its provider manuals and training materials regarding recognition of abuse and neglect, and the mandatory reporting requirements under the Texas Family Code. MCO service coordinators must complete service coordination training every two years. MCOs must administer the training, which must include how to identify and report critical events or incidents such as abuse, neglect, or exploitation and educating Members regarding protections. At the time a STAR+PLUS or STAR Health member is approved for long-term services and supports, the MCO must ensure that the member is informed orally and through the member handbook of the processes for reporting allegations of

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abuse, neglect, or exploitation. The MCO must ensure that members are provided the toll-free numbers for the State Medicaid Agency or its designee.

Qualified providers

Before contracting with a long-term services and supports provider not licensed or certified by a Texas health and human services agency, the MCOs must ensure that the provider:

1. has not been convicted of a crime listed in Texas Health and Safety Code §250.006;
2. is not listed as "unemployable" in the Employee Misconduct Registry or the Nurse Aide Registry maintained by the State Medicaid Agency or its designee by searching or ensuring a search of such registries is conducted, before contracting with the provider and annually thereafter;
3. is knowledgeable of acts that constitute abuse, neglect, or exploitation of a member;
4. is instructed on and understands how to report suspected abuse, neglect, or exploitation;
5. adheres to applicable state laws governing transportation if providing transportation; and
6. is not the spouse of, legally responsible person for, or employment supervisor of the member who receives the service.

The MCO must also ensure the non-licensed, non-certified provider is not listed on either the State or federal Office of Inspector General lists as excluded from participation in any federal or state health care program by searching or ensuring a search of those websites is conducted before contracting and at least monthly thereafter.

As part of their licensure requirements, licensed CFC providers are required to check the Employee Misconduct Registry prior to offering employment to anyone that will have duties that include face-to face contact with a member.

Through their credentialing process, the MCOs ensure the licensed agencies they contract with have met all licensure requirements.

Complaints

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MCOs must develop, implement, and maintain a member complaint and appeal system that complies with the requirements in applicable federal and state laws and regulations, including 42 Code of Federal Regulations §431.200, 42 Code of Federal Regulations Part 438, Subpart F, "Grievance System," and the provisions of 1 Texas Administrative Code Chapter 357 relating to Medicaid MCOs. The complaint and appeal system must include a complaint process, an appeal process, and access to the Health and Human Services Commission's fair hearing system. The procedures must be the same for all members and must be reviewed and approved in writing by the Health and Human Services Commission or its designee. Modifications and amendments to the member complaint and appeal system must be submitted for the Health and Human Services Commission's approval at least 30 days prior to the implementation.

The STAR Health appeal process includes a process for pre-appeals, standard appeals, and expedited appeals. The MCO is required by contract to inform all members that they have the right to request a fair hearing at any point during the appeal process, and the MCO must continue the member's benefits if certain criteria are met.

(2) CFC services provided through fee-for-service

The State Medicaid Agency or its designee monitors licensed or certified provider compliance with state requirements.

Licensed and certified CFC providers are required to report instances of abuse, neglect, or exploitation of an individual to the State Medicaid Agency or its designee immediately upon suspicion of such activities. This includes suspicion of abuse, neglect, or exploitation of a child by an employee of the HCSSA.

Abuse, neglect, and exploitation requirements for licensed CFC providers require the provider to adopt and enforce a written policy relating to the agency's procedures for reporting alleged acts of abuse, neglect, and exploitation of a client by an employee of the agency. At the time an individual begins receiving services from licensed CFC provider, the provider must give the individual a written statement informing him that complaints against the agency may be directed to the State Medicaid Agency or its designee.

Certified CFC providers must ensure that employees, subcontractors, and volunteers are knowledgeable of the acts that constitute abuse, neglect, and

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exploitation; the requirement to report suspicion of such acts to the State Medicaid Agency or its designee; how to report allegations; and methods to prevent the occurrence of abuse, neglect, or exploitation. Individuals must be informed of how to report abuse, neglect or exploitation before the individual begins receiving services from the provider.

Qualified providers

Licensed and certified CFC providers, financial management services agencies, and individuals/employers employing providers of CFC services through the consumer-directed services option must comply with Texas Health and Safety Code, Chapter 250 and 253, including taking the following actions regarding applicants, contractors, and employees:

1) Prior to employment, obtain Texas criminal history record information from the Texas Department of Public Safety that relates to an unlicensed applicant, volunteer, contractor, or employee whose duties would or do involve direct contact with an individual; and
2) Refrain from employing or contracting with, or immediately discharge, a person who has been convicted of an offense that bars employment under Texas Health and Safety Code, Chapter 250, or an offense that the provider or participant employer determines is a contraindication to the person's employment or contract to provide services to the individual.
3) Prior to employment, search the Nurse Aide Registry maintained by the State Medicaid Agency or its designee and refrain from employing or contracting with, or immediately discharge, a person who is designated in the registry as having abused, neglected, or mistreated an individual of a facility or has misappropriated an individual’s property; and
4) Prior to employment, search the Employee Misconduct Registry maintained by the State Medicaid Agency or its designee and refrain from employing or contracting with or immediately discharge, a person whose duties would or do involve direct contact with an individual, and who is designated in the registry as having abused, neglected, or exploited an individual or has misappropriated an individual's property.

All licensed and certified CFC providers and consumer directed services individual/employers are required to maintain documentation of the criminal history checks performed. All licensed and certified CFC providers, financial management services agencies, and individual/employers must screen all

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employees and contractors for exclusion prior to hiring or contracting, and on an ongoing monthly basis, by searching both the State and federal Office of Inspector General lists of excluded individuals and entities. As part of on-site provider reviews, the State Medicaid Agency or its designee monitors if criminal history checks are conducted as required.

Complaints

Complaints that pertain to licensed or certified CFC providers are reported directly to the State Medicaid Agency or its designee. This includes complaints from individuals, members of the public, case managers, licensed home and community support services agency staff, and certified Home and Community-based Services and Texas Home Living providers delivering CFC services. As necessary, complaints are referred to the appropriate state agency unit (e.g. Community Services Contracts, Regulatory Services, etc.) or to another agency, if appropriate (e.g., HHS Ombudsman, Office of Inspector General) for follow-up and resolution.

c) Measures of individual outcomes associated with the receipt of home and community-based attendant services and supports as set forth in the person centered service plan, particularly for the health and welfare of individuals receiving such services and supports. (§441.585(a)(3))

(1) CFC services provided through managed care

Texas is participating in a national initiative to obtain feedback from individuals receiving long-term services and supports on their experience receiving those services through the NCI-AD survey. Data for the project is gathered through yearly in-person member surveys of a sample that includes managed care members receiving CFC services.

(2) CFC services provided through fee-for-service

Performance measures that assess for level of care, service planning, and health and safety are used to measure CFC outcomes for most individuals receiving fee-for-service CFC services. These measures address the following assurances:

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- An evaluation for level of care is provided to all individuals for whom there is a reasonable indication that services may be needed in the future.
- The process and instruments described in the state plan are applied appropriately and according to the approved description to determine level of care.
- Service plans address individual's assessed needs and personal goals.
- Services are delivered in accordance with the service plan.
- The State demonstrates on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect, and exploitation.

Activities are underway to include the remaining fee-for-service population not covered in this plan.

d) Standards for all service delivery models for training, appeals for denials, and reconsideration procedures for an individual's person-centered service plan. (42 CFR §441.585(a)(4))

(1) CFC services provided through managed care- provider requirements

Provider requirements are described in Attachment 3.1-K, Section 9: Provider Qualifications.

(2) CFC services provided through managed care- appeals

Individuals receiving CFC are entitled to appeal the following actions:

1. an action to reduce, suspend, terminate, or deny benefits or eligibility;
2. a failure to act with reasonable promptness on a client's claim for benefits or services;
3. the denial of a prior authorization request; and
4. the failure to reach a service authorization decision within the time period specified by federal law.

In accordance with 42 C.F.R. §438.410, the MCO must establish and maintain an expedited review process for appeals.

In accordance with 42 C.F.R.§ 438.406, the MCO's policies and procedures must require that individuals who make decisions on appeals are not involved in any previous level of review or decision-making, and are health care

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professionals who have the appropriate clinical expertise in treating the member's condition or disease. In accordance with 42 C.F.R. §438.420, the MCO must continue the member's benefits currently being received by the member, including the benefit that is the subject of the appeal, if all criteria are met.

During the appeal process, the MCO must provide the member a reasonable opportunity to present evidence and any allegations of fact or law in person as well as in writing. The MCO must provide the member and his or her representative opportunity, before and during the appeal process, to examine the member's case file, including medical records and any other documents considered during the appeal process.

In accordance with 42 C.F.R. §438.420(d), if the final resolution of the appeal upholds the MCO's action, then to the extent that the services were furnished to comply with the managed care contract, the MCO may recover such costs from the member. STAR Health MCOs agree to waive this right. If the MCO or state fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires. If the MCO or state fair hearing officer reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending, the MCO is responsible for the payment of services. In accordance with 42 C.F.R.§ 438.408, the MCO must provide written notice of resolution of appeals, including expedited appeals, as expeditiously as the member's health condition requires, but the notice must not exceed the timeframes for standard appeals or expedited appeals. The written resolution notice must include the results and date of the appeal resolution.

Access to Fair Hearings
The MCO must inform members that they have the right to access the fair hearing process at any time during the appeal system provided by the MCO, with the following exception. If a member requests a fair hearing, the MCO will submit the request to the fair hearings office. The MCO will prepare an evidence packet for submission to the HHSC fair hearings staff and send a copy of the packet to the member.

Appeals for IDD Eligibility Purposes

Community First Choice State Plan Option (continued)

For STAR+PLUS or STAR Health members with an intellectual disability or related condition, the local authority completes the level of care assessment instrument and submits the information to the State Medicaid Agency or its designee. The State Medicaid Agency or its designee determines whether the member meets the criteria for an institutional level of care for an intermediate care facility for individuals with an intellectual disability or related conditions. If the level of care is approved, the local authority and MCO are notified to continue the eligibility process. If a member does not demonstrate a need for services but has an approved level of care, the MCO sends a denial notice and the member has the opportunity to appeal through the MCO's established procedures. If the State Medicaid Agency or its designee denies the level of care, a denial notice is sent to the member, who can then appeal that decision through state agency appeal processes.

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(3) CFC services provided through fee-for-service- provider requirements

Provider requirements are described in Attachment 3.1-K, Section 9: Provider Qualifications.

(4) CFC services provided through fee-for-service- appeals

All Medicaid programs are subject to the Uniform Fair Hearing Rules adopted by HHSC. Medicaid recipients may appeal the following actions:

- an action to reduce, suspend, terminate, or deny benefits or eligibility;
- a failure to act with reasonable promptness on a client's claim for benefits or services;
- the denial of a prior authorization request; and
- the failure to reach a service authorization decision within the time period specified by federal law.

HHSC is required to follow the notice requirements set forth in the appropriate state or federal law or regulation for the affected program. In addition, HHSC must give clients timely and adequate notice of the right to a fair hearing; explain the right of appeal; explain the procedures for requesting an appeal; explain the right to be represented by others, including legal counsel; provide information about legal services available in the community; and continue benefits if required to do so by state or federal law or regulations of the affected program; and

Except as specifically provided in federal regulations, written notice to an individual of the individual's right to a hearing must contain an explanation of the circumstances under which Medicaid is continued if a hearing is requested; and must be mailed before the date the individual's Medicaid eligibility or service is scheduled to be terminated, suspended, or reduced, except as provided by federal rules.

The individual is permitted to examine the content of his or her case file as well as all documents and records to be used by the agency at the hearing. The individual may review the appeal procedures outlined in agency policy and may request a copy of the official recording at no charge after the decision is issued.

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An individual or his or her authorized representative or legal counsel may send written questions or request a pre-hearing conference to obtain additional information. The individual may also:

- present the case personally or with the aid of others, including but not limited to the individual's representative or legal counsel;
- bring witnesses;
- present information about all pertinent facts and circumstances;
- present arguments or address anything about the case without undue interference;
- confront and cross-examine adverse witnesses; and
- submit documentary evidence to the hearings officer before, during, or after the hearing as allowed by the hearings officer. Evidence submitted after the hearing, if accepted, must be entered into the record and shared with all parties.

The HHSC hearings officer issues a decision based exclusively on testimony and evidence introduced at the hearing. The HHSC hearings officer must provide the individual with a copy of the decision.

The appeals processes for individuals receiving CFC services while enrolled in a 1915(c) waiver are summarized below. These processes are summarized below.

If services are reduced, denied, suspended, or terminated, the case manager or the State Medicaid Agency or its designee informs the individual of the change and that the individual is entitled to a fair hearing. In cases where services are being reduced or terminated, the notice includes the date by which the individual or legally authorized representative must request the hearing in order to maintain the individual's current level of services, pending the hearing decision.

If an individual requests a fair hearing, the State Medicaid Agency or its designee notifies the hearing officer of the request. The State Medicaid Agency or its designee sends copies of all relevant documentation to the individual and, depending on the program, to all known parties and required witnesses.

The State Medicaid Agency or its designee must implement the decision of the hearing officer and must send to the Health and Human Services Commission hearing office documentation that the decision has been implemented.

Community First Choice State Plan Option (continued)

(f) The State must elicit and incorporate feedback from individuals and their representatives, disability organizations, providers, families of disabled or elderly individuals, members of the community, and others to improve the quality of the community-based attendant services and supports benefit. (42 CFR §441.585(c))

The primary mechanism for obtaining stakeholder feedback on the CFC implementation is the Promoting Independence Advisory Committee, which holds quarterly public meetings. In addition, CFC-specific information has been solicited through a dedicated website and email inbox. Multiple public meetings and trainings held at least in part for the purposes of sharing CFC information and obtaining stakeholder feedback have been held and are continuing.

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13. Data Collection
As required under 42 CFR §441.580, the State will annually provide CMS with the following data on the provision of CFC services:

(a) Number of individuals estimated to receive state plan Community First Choice services and supports;

(b) Number of individuals who received the state plan CFC services and supports during the preceding federal fiscal year;

(c) Number of individuals who received state plan CFC services during the preceding federal fiscal year, reported by:

(1) disability;
(2) age;
(3) gender;
(4) education level; and
(5) employment status;

(d) Number of individuals who have been previously served under sections 1115, 1915(c) and (i) of the Social Security Act, or the personal care State plan option;

(e) Number of individuals receiving services through non-CFC LTSS services;

(f) Total dollars spent on CFC and other LTSS;

(g) Number of individuals offered the choice between community and institutional care during the service planning process and number of individuals receiving CFC who continue to remain in a community setting; and

(h) Data regarding the impact of CFC services and supports on the physical and emotional health of individuals.

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Community First Choice (CFC) Reimbursement Methodology

(a) Except as otherwise noted in the plan, State-developed fee schedule rates are the same for both government and private providers of services provided under the CFC option. The agency's fee schedule is effective for services provided on or after June 1, 2015. All rates are published at: http://www.hhsc.state.tx.us/rad/long-term-svcs/index.shtml.

(b) State Plan CFC Services: Rates are established using pre-existing rates from other programs.

1. CFC State Plan Rate – Attendant and Habilitation: Rates will be equal to a weighted average of rates established for Community Living Assistance and Support Services (CLASS) habilitation services according to the reimbursement methodology for the CLASS waiver program and proxy rates for attendant services used in the calculation of the STAR+PLUS managed care capitation rates for the Home and Community-based Services (HCBS) risk group. The weighted average will include applicable attendant compensation rate enhancements.

    A. Proxy rates are equal to rates established for attendant services under the Community Based Alternatives (CBA) waiver prior to its termination, updated for changes in allowable reported expenses and units of service.

    B. Weighting factors assume that 30 percent of personal attendant services historically provided to existing recipients in the STAR+PLUS HCBS risk group and 100 percent of personal attendant services provided to newly eligible recipients under CFC will be for habilitation.

    C. CLASS waiver habilitation rates and proxy rates for CBA waiver attendant services are current as of June 1, 2015.

2. CLASS – Attendant and Habilitation CFC: Rates will be equal to rates established for CLASS habilitation services, including applicable attendant compensation rate enhancements, according to the reimbursement methodology for the CLASS waiver program. CLASS waiver habilitation rates are current as of June 1, 2015.

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Community First Choice (CFC) Reimbursement Methodology (continued)

3. Deaf-Blind with Multiple Disabilities (DBMD) – Attendant and Habilitation CFC: Rates will be equal to rates established for DBMD habilitation services, including applicable attendant compensation rate enhancements, according to the reimbursement methodology for the DBMD waiver program. DBMD waiver habilitation rates are current as of June 1, 2015.

4. Home and Community-Based Services (HCS) – Supported Home Living (SHL) CFC: Rates will be equal to rates established for HCS SHL services, including applicable attendant compensation rate enhancements, according to the reimbursement methodology for the HCS waiver program. HCS waiver rates are current as of June 1, 2015.

6. Texas Home Living (TxHmL) – Community Support Services (CSS) CFC: Rates will be equal to rates established for TxHmL CSS, including applicable attendant compensation rate enhancements, according to the reimbursement methodology for the TxHmL waiver program. TxHmL waiver rates are current as of June 1, 2015.

7. Personal Care Services (PCS) – Attendant CFC: Rates will be equal to rates established for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) PCS attendant services according to Item 32 of Attachment 4.19-B of this State plan. PCS attendant services rates are current as of June 1, 2015.

8. PCS – Habilitation CFC: Rates will be equal to rates established for EPSDT PCS services for recipients with a behavioral health condition according to Item 32 of Attachment 4.19-B of this State plan. PCS behavioral services rates are current as of June 1, 2015.

9. Consumer Directed Services (CDS) - CFC: The rates for CDS that provide the funds available to the consumers participating in CDS are modeled and are based on the payment rates paid to contracted agencies for providing services to consumers who do not participate in CDS, and then removing from those rates amounts needed to fund Financial Management Services Agencies' responsibilities. CDS rates are current as of June 1, 2015.

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10. Support Consultation Services – CFC: Rates are determined by modeling the cost of providing this service using staff costs and other statistics from the most recently audited cost reports from providers for staff whose required qualifications are similar to the qualifications required for individuals delivering this service. CDS rates are current as of June 1, 2015.

11. CFC State Plan rate for Financial Management Services Agencies (FMSA) (only authorized for individuals receiving all of their CDS services under CFC): The monthly payment to the FMSA is determined by modeling the estimated cost to carry out the responsibilities of the FMSA. FMSA rates are current as of June 1, 2015.

12. Emergency Response Services (ERS) – CFC: The Health and Human Services Commission (HHSC) determines the payment rate through the analysis of financial and statistical data submitted by provider agencies on cost reports and, as deemed appropriate, a market survey analysis of emergency response equipment suppliers.

    A. Allowable expenses are projected from the provider agency's reporting period to the rate period using the Personal Consumption Expenditures (PCE) chain-type price index. Depreciation and mortgage interest are not adjusted for inflationary increases.

    B. Allowable reported expenses are combined into three cost areas: responder, program operations, and facility. To determine the projected cost per unit of service, a contracted provider's projected expenses in each cost area are divided by its total units of service for the reporting period.

    C. The contracted providers' projected costs per unit of service are ranked from low to high in each cost area, with corresponding units of service.

    D. The 80th percentile cost, weighted by units of service, is determined for each cost area. The payment rate is the sum of the 80th percentile costs of the three cost areas.

    E. ERS rates are current as of June 1, 2015.

Community First Choice (CFC) Reimbursement Methodology (continued)

(c) Changes to Reimbursement Methodologies: Whenever a change is made to any of the reimbursement methodologies described in subsections (1) through (12) above which is anticipated to cause a change in the rate payable to a provider, a state plan amendment will be submitted.

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