

*Revisions to Subchapter Governing*

# **ICF/IID Programs — Contracting**

## **Chapter 9, Subchapter E**

EFFECTIVE DATE: April 17, 2016

**DADS maintains the formatted version of ICF/IID Programs rules on its website to enhance public access to information concerning the programs. The *Texas Register* and the Texas Administrative Code remain the official sources for all DADS rules.**

Please replace your file copy of Chapter 9, Subchapter E (effective November 4, 2013) with the attached version of the subchapter.

### **What has changed?**

New §9.218 sets forth the requirements that a program provider in the Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Condition (ICF/IID) program must comply with to voluntarily close a facility and, at the program provider's option, to request suspension of a closing facility's certified capacity for up to one year after the facility closes. For DADS to approve the suspension of certified capacity, the closing facility must meet certain requirements, including having a certified capacity of eight or less. To activate the suspended capacity, the program provider must submit an application for enrollment in the ICF/IID Program before the suspension period ends.

### **Process**

The new section and amendments were proposed for public comment in the January 8, 2016, issue of the Texas Register. The adoption was published in the April 8, 2016, issue of the Texas Register.

### **Questions**

Please send questions concerning this subchapter to:

[ICFIID.Questions@dads.state.tx.us](mailto:ICFIID.Questions@dads.state.tx.us)

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DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS)  
 40 TAC, CHAPTER 9, SUBCHAPTER E  
 ICF/IID PROGRAMS – CONTRACTING

TABLE OF CONTENTS

<u>Section</u>	<u>Title</u>	<u>Page</u>
<b>DIVISION 1 – GENERAL REQUIREMENTS</b>		
§9.201.	Purpose.....	2
§9.202.	Application.....	2
§9.203.	Definitions.....	2
§§9.204.-9.205. (Reserved.)		
<b>DIVISION 2 – PROVIDER ENROLLMENT</b>		
§9.206.	Application Process.....	8
§9.207.	Certification and Licensure.....	9
§9.208.	Provider Agreement.....	9
§§9.209.-9.210. (Reserved.)		
<b>DIVISION 3. – PROVIDER ADMINISTRATIVE REQUIREMENTS</b>		
§9.211.	Compliance with State and Federal Laws.....	9
§9.212.	Non-licensed Providers Meeting Licensure Standards.....	10
§9.213.	Records.....	10
§9.214.	Certified Capacity of a Facility.....	10
§9.215.	Relocation of Facility.....	11
§9.216. (Reserved)		
§9.217.	Assignment of Provider Agreement.....	11
§9.218.	Voluntary Facility Closure and Suspension Of Certified Capacity.....	13
§9.219.	Provider Reimbursement.....	14
§9.220. (Reserved.)		
<b>DIVISION 4 – PROVIDER SERVICE REQUIREMENTS</b>		
§9.221.	Durable Medical Equipment.....	15
§9.222.	Permanency Planning and LAR Participation for Individuals Under 22 Years of Age.....	15
§9.223.	Review of Living Options.....	18
§9.224.	Capacity Assessment.....	18
§9.225.	Reporting Incidents to DADS.....	19
§9.226.	Leaves.....	19
§9.227.	Discharge From a Facility.....	20
§9.228.	Augmentative Communication Device System.....	21
§9.229.	Critical Incident Reporting.....	22
§§9.230-9.235. (Reserved.)		
<b>DIVISION 5. – ELIGIBILITY, ENROLLMENTS AND REVIEW</b>		
§9.236.	Eligibility Criteria.....	23
§9.237.	Level of Care.....	24
§9.238.	ICF/MR Level of Care I Criteria.....	24
§9.239.	ICF/MR Level of Care VIII Criteria.....	24
§9.240.	Level of Need.....	24
§9.241.	Level of Need Criteria.....	25
§9.242.	Supporting Documentation for Level of Need.....	26
§9.243.	Reconsideration of Level of Need.....	27
§9.244.	Applicant Enrollment in the ICF/MR Program.....	27
§9.245.	Renewal of Level of Care.....	30
§9.246.	Renewal and Revision of Level of Need.....	30
§9.247.	Re-administration of the ICAP.....	31
§9.248.	Lapsed Level of Care.....	31
§9.249.	Fair Hearing.....	31
§9.250.	Permanency Planning Reviews.....	31

<b>DIVISION 6 – PERSONAL FUNDS</b>		
§9.251.	Protecting Individuals’ Personal Funds.....	32
§9.252.	Notice Regarding Personal Funds.....	32
§9.253.	Determining Management of Personal Funds.....	33
§9.254.	Items and Services Provided by the Program Provider.....	33
§9.255.	Items and Services Purchased with Personal Funds..	34
§9.256.	Program Provider-Managed Personal Funds.....	35
§9.257.	Request for Personal Funds from Trust Fund Accounts.....	37
§9.258.	Closing Trust Fund Accounts.....	37
§9.259.	Refunds.....	38
§9.260.	Applied Income.....	38
§9.261.	Contributions.....	38
§9.262.	Trust Fund Monitoring and Audits.....	38
§9.263.	Informal Review and Administrative Hearing.....	39
§§9.264.-9.265. (Reserved.)		
<b>DIVISION 7 – PROVIDER AGREEMENT SANCTIONS</b>		
§9.266.	DADS Review of Inspection or Survey Findings.....	40
§9.267.	Directed Plan of Correction and Vendor Hold Based on State Survey Agency Findings.....	41
§9.268.	Termination of Provider Agreement.....	41
§9.269.	Audits.....	43
§9.270.	Suspension of Payments.....	44
§9.271.-9.272. (Reserved.)		
<b>DIVISION 8 – ADMINISTRATIVE HEARINGS</b>		
§9.273.	Administrative Hearings.....	44
<b>DIVISION 9. HOSPICE SERVICES</b>		
§9.274.	Hospice Services.....	45
<b>DIVISION 10 – SURROGATE DECISION-MAKING</b>		
§9.281.	Purpose.....	45
§9.282.	Application.....	46
§9.283.	Informed Decision Assessment.....	46
§9.284.	Making Informed Decisions.....	46
§9.285.	IDT Decisions.....	47
§9.286.	Surrogate Decision-Maker.....	47
§9.287.	Provider Responsibilities Regarding Surrogate Decision-Maker.....	48
§9.288.	Surrogate Consent Committee Decisions.....	48
§9.289.	Submission of Application Packet for Surrogate Consent Committee.....	48
§9.290.	Appointment and Qualifications of a Surrogate Consent Committee.....	49
§9.291.	Notice of Hearing and Documents Provided to Surrogate Consent Committee.....	50
§9.292.	Review and Consultation Prior to Hearing.....	50
§9.293.	Surrogate Consent Committee Hearing.....	51
§9.294.	Notice of Guardianship Proceeding.....	52
§9.295.	Liability for Treatment Decision.....	52

## DIVISION 1. GENERAL REQUIREMENTS

### §9.201. Purpose.

*Effective: January 1, 2001*

The purpose of this subchapter is to describe:

- (1) policies and procedures for the Intermediate Care Facilities for the Mentally Retarded (ICF/MR) Program in Texas;
- (2) responsibilities of program providers in the ICF/MR Program;
- (3) rights and protections for persons applying for and receiving ICF/MR Program services; and
- (4) responsibilities of mental retardation authorities (MRAs).

### §9.202. Application.

*Effective: January 1, 2001*

This subchapter applies to provider applicants, program providers, and MRAs.

### §9.203. Definitions.

*Effective: November 4, 2013*

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

(1) **Active treatment** -- Continuous, aggressive, consistent implementation of a program of habilitation, specialized and generic training, treatment, health services, and related services. Active treatment does not include services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous active treatment program. The program must be directed toward:

(A) the acquisition or maintenance of the behaviors necessary for the individual to function with as much self-determination and independence as possible; and

(B) the prevention or deceleration of regression or loss of current optimal functional status.

(2) **Actively involved** -- Significant, ongoing, and supportive involvement with an individual by a person, as determined by the individual's IDT, based on the person's:

(A) interactions with the individual;

(B) availability to the individual for assistance or support when needed; and

(C) knowledge of, sensitivity to, and advocacy for the individual's needs, preferences, values, and beliefs.

(3) **Adult** -- A person who is 18 years of age or older.

(4) **Affiliate** -- An employee or independent contractor of a provider applicant or a person with a significant financial interest in a provider applicant, including the following:

(A) if the provider applicant is a corporation, then each officer, director, stockholder with an ownership of at least 5 percent, subsidiary, and parent company;

(B) if the provider applicant is a limited liability company, then each officer, member, subsidiary, and parent company;

(C) if the provider applicant is an individual, then the individual's spouse, each partnership and each partner thereof of which the individual is a partner and each corporation in which the individual is an officer, director, or stockholder with an ownership of at least 5 percent;

(D) if the provider applicant is a partnership, then each partner and parent company; or

(E) if the provider applicant is a group of co-owners under any other business arrangement, then each owner, officer, director, or the equivalent thereof under the specific business arrangement, and each parent company.

(5) **Applicant** -- A person seeking enrollment in the ICF/IID Program or seeking admission to a facility.

(6) **Applied income** -- The portion of an individual's cost of care that the individual is responsible for paying. The amount of an individual's applied income is determined by the policies and procedures authorized by the Health and Human Services Commission and depends on the individual's earned and unearned income.

(7) **Assignment** -- The transfer of rights, interests, and obligations of the program provider agreement from the program provider to another person.

(8) **Aversive stimulus** -- A stimulus that is

DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS)  
40 TAC, CHAPTER 9, SUBCHAPTER E  
ICF/IID PROGRAMS – CONTRACTING

unpleasant, noxious, startling, or painful; is applied after an inappropriate behavior; and is intended to suppress the inappropriate behavior.

(9) **Behavior intervention plan** -- A written plan prescribing the systematic application of behavioral techniques regarding an individual that, at a minimum, contains:

(A) reliable and representative baseline data regarding the targeted behavior;

(B) a specific objective to decrease or eliminate the targeted behavior;

(C) a functional analysis of the events which contribute to or maintain the targeted behavior;

(D) detailed procedures for implementing the plan;

(E) ongoing, written quantitative data of the targeted behavior;

(F) written descriptions of incidents of the targeted behavior including the individual's actions and staff interventions;

(G) methods for evaluating plan effectiveness;

(H) procedures for making necessary plan revisions at least annually; and

(I) a fading process for one-to-one supervision, if the individual is assigned an LON 9.

(10) **Budgeted amount** -- The amount of cash that may be disbursed to an individual at regular intervals; for example, weekly, monthly, for discretionary spending without obtaining a sales receipt for the expenditure.

(11) **Campus-based facility** -- A facility that is located on the grounds of a state supported living center or the ICF/IID Program component of Rio Grande State Center.

(12) **CARE** -- DADS Client Assignment and Registration System, a database with demographic and other data about an individual who is receiving services and supports or on whose behalf services and supports have been requested.

(13) **Certified capacity** -- The maximum number of individuals who may reside in a facility, as set forth in the facility's provider agreement.

(14) **CFR (Code of Federal**

**Regulations)** -- The compilation of federal agency regulations.

(15) **Community Center** -- A community center established under the THSC, Chapter 534, Subchapter A.

(16) **Community program provider** -- A program provider acting on behalf of a facility that is not a campus-based facility.

(17) **CRCG (Community Resource Coordination Group)** -- A local interagency group composed of public and private agencies that develops service plans for individuals whose needs can be met only through interagency coordination and cooperation. The group's role and responsibilities are described in the Memorandum of Understanding on Coordinated Services to Persons Needing Services from More Than One Agency, available on the Health and Human Services Commission website at [www.hhsc.state.tx.us/crcg/crcg.htm](http://www.hhsc.state.tx.us/crcg/crcg.htm).

(18) **DADS** -- The Department of Aging and Disability Services.

(19) **Day** -- Calendar day, unless otherwise specified.

(20) **Department** -- Department of Aging and Disability Services.

(21) **Discharge** -- The absence, for a full day or more, of an individual from the facility in which the individual resides, if such absence is not during a therapeutic, extended, or special leave, as described in §9.226 of this subchapter (relating to Leaves).

(22) **DPoC (directed plan of correction)** -- A plan developed by DADS sanction team that requires a program provider to take specified actions within specified time frames to correct the program provider's failure to meet one or more federal standards of participation (SoPs) or conditions of participation (CoPs) or lack of compliance with one or more state rules.

(23) **Effortful task** -- A task directed by staff that requires physical effort by an individual performed after an inappropriate behavior, including required exercise, negative practice, and restitutive overcorrection.

(24) **Emergency situation** -- An unexpected situation involving an individual's health, safety, or welfare, of which a person of

ordinary prudence would determine that the LAR should be informed, such as:

(A) an individual needing emergency medical care;

(B) an individual being removed from his residence by law enforcement;

(C) an individual leaving his residence without notifying staff and not being located; and

(D) an individual being moved from his residence to protect the individual (for example, because of a hurricane, fire, or flood).

(25) **Excluded** -- Temporarily or permanently prohibited by a state or federal authority from participating as a provider in a federal health care program, as defined in 42 USC §1302a-7b(f).

(26) **Exclusionary time-out** -- A procedure by which an individual is, after an inappropriate behavior, placed alone in an enclosed area in which positive reinforcement is not available and from which egress is physically prevented by staff until appropriate behavior is exhibited.

(27) **Facility** -- An intermediate care facility for individuals with an intellectual disability or related conditions.

(28) **Family-based alternative** -- A family setting in which the family provider or providers are specially trained to provide support and in-home care for children with disabilities or children who are medically fragile.

(29) **Full day** -- A 24-hour period extending from midnight to midnight.

(30) **Highly restrictive procedure** -- The application of an aversive stimulus, exclusionary time-out, physical restraint, a requirement to engage in an effortful task, or other technique with a similar degree of restriction or intrusion to manage an individual's inappropriate behavior.

(31) **Hospice** -- An entity that is primarily engaged in providing care to terminally ill individuals and is approved by DADS to participate in the Medicaid Hospice Program in accordance with §30.30 of this title (relating to General Contracting Requirements).

(32) **ICAP (Inventory for Client and Agency Planning)** -- A validated, standardized

assessment that measures the level of supervision an individual requires and, thus, the amount and intensity of services and supports an individual needs.

(33) **ICF/IID Program** -- The Intermediate Care Facilities for Individuals with an Intellectual Disability Program, which provides Medicaid-funded residential services to individuals with an intellectual disability or related conditions.

(34) **ICF/MR Program** -- ICF/IID Program.

(35) **ID/RC Assessment Form** -- A form used by DADS for LOC determination and LON assignment.

(36) **IDT (interdisciplinary team)** -- A group of people assembled by the program provider who possess the knowledge, skills, and expertise to assess an individual's needs and make recommendations for the individual's IPP. The group includes the individual, LAR, intellectual disability professionals and paraprofessionals and, with approval from the individual or LAR, other concerned persons.

(37) **Individual** -- A person enrolled in the ICF/IID Program.

(38) **Intellectual disability** -- Significant sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

(39) **IPP (individual program plan)** -- A plan developed by an individual's IDT that identifies the individual's training, treatment, and habilitation needs and describes services to meet those needs.

(40) **IQ (intelligence quotient)** -- A score reflecting the level of an individual's intelligence as determined by the administration of a standardized intelligence test.

(41) **LAR (legally authorized representative)** -- A person authorized by law to act on behalf of an individual with regard to a matter described in this subchapter, and may include a parent, guardian, managing conservator of a minor individual, a guardian of an adult individual, or legal representative of a deceased individual.

(42) **LOC (level of care)** -- A determination given by DADS to an individual as part of the eligibility process based on data submitted on the ID/RC Assessment Form.

(43) **Local authority** -- An entity to which the Health and Human Services Commission's authority and responsibility described in TSHC §531.002(11) has been delegated.

(44) **LON (level of need)** -- An assignment given by DADS to an individual upon which reimbursement for ICF/IID Program services is based. The LON assignment is derived from the service level score obtained from the administration of the ICAP to the individual and from selected items on the ID/RC Assessment Form.

(45) **Long Term Care Plan** -- The plan required by THSC, §533.062, which is developed by DADS and specifies, in part, the capacity of the ICF/IID Program in Texas.

(46) **Major dental treatment** -- A dental treatment, intervention, or diagnostic procedure that:

- (A) has a significant recovery period;
- (B) presents a significant risk;
- (C) employs a general anesthetic; or

(D) in the opinion of the individual's physician, involves a significant invasion of bodily integrity that requires an incision or the extraction of bodily fluids that produces substantial pain, discomfort, or debilitation.

(47) **Major medical treatment** -- A medical, surgical, or diagnostic procedure or intervention that:

- (A) has a significant recovery period;
- (B) presents a significant risk;
- (C) employs a general anesthetic; or

(D) in the opinion of the individual's physician, involves a significant invasion of bodily integrity that requires an incision or the extraction of bodily fluids that produces substantial pain, discomfort, or debilitation.

(48) **Medical necessity** -- The need for a treatment decision that is essential to avoid adversely affecting an individual's mental or physical health or the quality of care rendered.

(49) **Mental retardation** -- Intellectual

disability.

(50) **MRA (mental retardation authority)** -- A local authority.

(51) **MR/RC** -- ID/RC Assessment Form.

(52) **Natural support network** -- Those persons, including family members, church members, neighbors, and friends, who assist and sustain an individual with supports that occur naturally within the individual's environment and that are not reimbursed or purposely developed by a person or system.

(53) **Negative practice** -- A procedure in which an individual is required, after an inappropriate behavior, to repeatedly engage in an activity that is similar to the inappropriate behavior.

(54) **Non-state operated facility** -- A facility for which the program provider is an entity other than DADS, such as a community center or private organization.

(55) **Occupational therapist (OT)** -- A person licensed by the Texas Board of Occupational Therapy Examiners to practice occupational therapy, as defined in Texas Occupations Code §454.002(4).

(56) **PDP (person-directed plan)** -- A plan of services and supports developed under the direction of an individual or LAR with the support of a local authority or program provider staff and other people chosen by the individual or LAR.

(57) **Permanency planning** -- A philosophy and planning process that focuses on the outcome of family support for an individual under 22 years of age by facilitating a permanent living arrangement in which the primary feature is an enduring and nurturing parental relationship.

(58) **Permanency Planning Review Screen** -- A screen in CARE that, when completed by a local authority, identifies community supports needed to achieve an individual's permanency planning outcomes and provides information necessary for approval of the individual's initial and continued residence in a facility.

(59) **Personal funds** -- The funds that belong to an individual, including earned income, social security benefits, gifts, and inheritances.

(60) **Personal hold** --

(A) A manual method, except for physical guidance or prompting of brief duration, used to restrict:

(i) free movement or normal functioning of all or a portion of an individual's body; or

(ii) normal access by an individual to a portion of the individual's body.

(B) Physical guidance or prompting of brief duration becomes a physical restraint if the individual resists the guidance or prompting.

(61) **Petty cash fund** -- Personal funds managed by a program provider that are maintained for individuals' cash expenditures.

(62) **Physical restraint** -- A manual method, or a physical or mechanical device, material, or equipment attached or adjacent to an individual's body that the individual cannot remove easily, that restricts freedom of movement or normal access to an individual's body. This term includes a personal hold.

(63) **Physical therapist (PT)** -- A person licensed by the Texas Board of Physical Therapy Examiners to practice physical therapy, as defined in Texas Occupations Code §453.001(4).

(64) **Pooled account** -- A trust fund account containing the personal funds of more than one individual.

(65) **Professional** -- A person who is licensed or certified by the State of Texas in a health or human services occupation or who meets DADS criteria to be a case manager, service coordinator, qualified intellectual disability professional, or certified psychologist as described in §5.161 of this title (relating to TDMHMR-Certified Psychologist).

(66) **Program provider** -- An entity with whom DADS has a provider agreement.

(67) **Provider agreement** -- A written agreement between DADS and a program provider that obligates the program provider to deliver ICF/IID Program services.

(68) **Provider applicant** -- An entity seeking to participate as a program provider.

(69) **Psychoactive medication** -- Any medication prescribed for the treatment of symptoms of psychosis or other severe mental or

emotional disorders and that is used to exercise an effect upon the central nervous system for the purposes of influencing and modifying behavior, cognition, or affective state.

(70) **Qualified intellectual disability professional (QIDP)** -- A person with at least a bachelor's degree who has at least one year of experience working with persons with an intellectual disability or related conditions.

(71) **Qualified rehabilitation professional (QRP)** -- A person who holds one or more of the following certifications in good standing:

(A) certification as an assistive technology professional or a rehabilitation engineering technologist issued by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA);

(B) certification as a seating and mobility specialist issued by RESNA; or

(C) certification as a rehabilitation technology supplier issued by the National Registry of Rehabilitation Technology Suppliers.

(72) **Related condition** -- Consistent with 42 CFR §435.1010, a severe and chronic disability that:

(A) is attributed to:

(i) cerebral palsy or epilepsy; or

(ii) any other condition, other than mental illness, found to be closely related to intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with intellectual disability, and requires treatment or services similar to those required for individuals with intellectual disability;

(B) is manifested before the individual reaches 22 years of age;

(C) is likely to continue indefinitely;

and

(D) results in substantial functional limitation in at least three of the following areas of major life activity:

(i) self-care;

(ii) understanding and use of language;

(iii) learning;

(iv) mobility;

(v) self-direction; and  
(vi) capacity for independent living.

(73) **Required exercise** -- A procedure in which an individual, after an inappropriate behavior, performs or is guided by staff to perform a series of physical movements that are incompatible with the inappropriate behavior.

(74) **Restitutional overcorrection** -- A procedure in which an individual is required to correct the consequences of an inappropriate behavior by performing a task that improves the individual's environment.

(75) **Sales receipt** -- A written statement issued by the seller that includes:

- (A) the date it was created; and
- (B) the cost of the item or service.

(76) **Separate account** -- A trust fund account containing the personal funds of only one individual.

(77) **Specially constituted committee** -  
- A committee designated by the program provider in accordance with 42 CFR §483.440(f)(3) that consists of staff, LARs, individuals (as appropriate), qualified persons who have experience or training in contemporary practices to change an individual's inappropriate behavior, and persons with no ownership or controlling interest in the facility. The committee is responsible, in part, for reviewing, approving, and monitoring individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to individuals' safety and rights.

(78) **SSI** -- Supplemental Security Income.

(79) **State-operated facility** -- A facility for which DADS is the program provider.

(80) **TAC (Texas Administrative Code)** -- A compilation of state agency rules published by the Texas Secretary of State in accordance with Texas Government Code, Chapter 2002, Subchapter C.

(81) **TDHS** -- Formerly, this term referred to the Texas Department of Human Services; it now refers to DADS, except in the context of Medicaid eligibility it refers to the Health and Human Services Commission.

(82) **THSC (Texas Health and Safety Code)** -- Texas statutes relating to health and safety.

(83) **Third Party** -- An individual, entity, or program other than DADS or the program provider, that is or may be liable to pay all or part of the expenditures for ICF/IID Program services, including:

(A) a commercial insurance company offering health or casualty insurance to individuals or groups (including both experience-rated insurance contracts and indemnity contracts);

(B) a profit or nonprofit prepaid plan offering either medical services or full or partial payment for services; and

(C) an organization administering health or casualty insurance plans for professional associations, unions, fraternal groups, employer-employee benefit plans, and any similar organization offering these payments or services, including self-insured and self-funded plans.

(84) **Trust fund account** -- An account at a financial institution in the program provider's control that contains personal funds.

(85) **Unclaimed personal funds** -- Personal funds managed by the program provider that have not been transferred to the individual or LAR within 30 days after the individual's discharge.

(86) **Unidentified personal funds** -- Personal funds managed by the program provider for which the program provider cannot identify ownership.

(87) **USC (United States Code)** -- A compilation of statutes enacted by the United States Congress.

(88) **Vendor hold** -- Temporary suspension of ICF/IID payments from DADS to a program provider.

(89) **Wheeled mobility system** -- An item of durable medical equipment that is a customized, powered, or manual mobility device or a feature or component of the device, including the following:

- (A) seated positioning components;
- (B) powered or manual seating options;
- (C) specialty driving controls;
- (D) multiple adjustment frame;

(E) nonstandard performance options;  
and

(F) other complex or specialized components.

(90) **Working day** -- Any day except a Saturday, a Sunday, or a national or state holiday listed in Texas Government Code §662.003(a) or (b).

§§9.204-9.205. (*Reserved*).

## DIVISION 2. PROVIDER ENROLLMENT

### §9.206. Application Process.

*Effective: January 1, 2001*

(a) The department will accept an application for enrollment:

(1) from a provider applicant, if the department determines that new or existing ICF/MR Program beds authorized in the *Long Term Care Plan for People with Mental Retardation and Related Conditions* are available for allocation to a program provider for a new facility not to exceed a capacity of six;

(2) from an assignee, if the department receives notice that a provider agreement is being assigned; or

(3) from a provider applicant, if the provider applicant provides residential services funded with general revenue that have been authorized by the department to be refinanced as ICF/MR Program services.

(b) The department will publish a notice in the *Texas Register*, an official publication of the Texas Office of the Secretary of State (<http://www.sos.state.tx.us/texreg/index.html>), if it is accepting applications for enrollment in accordance with subsection (a)(1) of this section.

(c) A provider applicant must request an application for enrollment in accordance with the published notice and must submit the application according to the notice and the department's application instructions.

(d) A provider applicant must complete all portions of the application for enrollment and provide information according to the department's application instructions, including but not limited

to:

(1) providing an operational or organizational plan that describes in detail how the provider applicant will ensure sufficient staff resources are available to provide all services required by the ICF/MR Program; and

(2) providing the resume or curriculum vita of the provider applicant's employee or contractor who will manage and oversee the provision of ICF/MR Program services, which:

(A) demonstrates that the employee or contractor has a minimum of three years verifiable work experience in planning and providing direct services to people with mental retardation or other developmental disabilities; and

(B) is accompanied by letter(s) of reference verifying the work experience in subparagraph (A) of this paragraph.

(e) The department may reject an application for enrollment for good cause, including but not limited to:

(1) the application is incomplete in any aspect;

(2) the application is not submitted in accordance with the department's application instructions or published notice;

(3) the application was submitted under the circumstances described in subsection (a)(1) of this section and requests a capacity exceeding six;

(4) the application contains false information;

(5) the application does not contain original signatures and dates;

(6) the department has terminated a contract with the provider applicant or its affiliate during the three years prior to the application date;

(7) the provider applicant or its affiliate has been excluded or debarred;

(8) another state or federal agency has terminated a contract, licensure, or certification of the provider applicant or its affiliate during the three years prior to the application date;

(9) the provider applicant or its affiliate has an outstanding Medicaid program audit exception or other unresolved financial liability owed to the State of Texas;

(10) the provider applicant or its affiliate is ineligible to enroll as a Medicaid

provider for reasons relating to criminal history records as set forth in department rules; or

(11) the provider applicant or its affiliate terminated a provider agreement in a federal health care program, as defined in 42 USC, §1302a-7b(f), while an adverse action or sanction was in effect.

(f) The department will review an application for enrollment received by the department and provide written notice to the provider applicant stating whether the application was approved or rejected.

(g) The department will not enter into a provider agreement with a provider applicant whose application for enrollment is rejected.

(h) If a provider applicant's application for enrollment is approved:

(1) the department will notify the state survey agency of the application approval; and

(2) the provider applicant must contact the state survey agency to initiate licensure and certification action.

### **§9.207. Certification and Licensure.**

*Effective: November 4, 2013*

(a) To obtain a provider agreement under §9.208 of this division (relating to Provider Agreement), a provider applicant whose application for enrollment is approved must receive licensure under THSC, Chapter 252, if applicable, and certification as an ICF/IID by DADS within 270 days from the date DADS approves the application, except as provided in subsection (b) of this section.

(b) DADS may, for good cause, grant an extension of the 270 day period described in subsection (a) of this section for a period of time to be determined by DADS if a provider applicant submits to DADS a written request for an extension, including supporting documentation, prior to the expiration of the 270 day period. For purposes of this subsection, good cause includes, but is not limited to:

(1) construction of the facility is delayed for causes beyond the provider applicant's control, such as a natural disaster;

(2) DADS is unable to make an on-site visit to the facility within the 270 day period,

through no fault of the provider applicant; or

(3) construction of the facility is delayed because of litigation regarding the construction or operation of the facility.

(c) DADS does not enter into a provider agreement with a provider applicant who does not obtain licensure and certification in accordance with this section.

### **§9.208. Provider Agreement.**

*Effective: November 4, 2013*

(a) DADS enters into a provider agreement only with a provider applicant that has received licensure under THSC, Chapter 252, if applicable, and certification by DADS in accordance with §9.207 of this division (relating to Certification and Licensure).

(b) The effective date of a provider agreement is the effective date of certification by DADS.

(c) A provider agreement remains in effect until it is terminated.

### **§§9.209-9.210. (Reserved.)**

## **DIVISION 3. PROVIDER ADMINISTRATIVE REQUIREMENTS**

### **§9.211. Compliance with State and Federal Laws.**

*Effective: September 1, 2001*

A program provider must comply with:

(1) applicable state laws and rules, including but not limited to:

(A) this subchapter;

(B) Chapter 409, Subchapter A of this title (relating to General Reimbursement Methodology for all Medical Assistance Programs);

(C) Chapter 409, Subchapter B of this title (relating to Adverse Actions);

(D) Chapter 409, Subchapter C of this title (relating to Fraud and Abuse and Recovery of Benefits);

(E) Chapter 419, Subchapter G of this title (relating to Medicaid Fair Hearings);

(F) 1 TAC Chapter 355, Subchapter D (relating to Reimbursement Methodology); and

(G) 1 TAC §§355.701-355.709; and  
(2) applicable federal laws and regulations, including but not limited to:

(A) 42 CFR Parts 440, 441, 442, 455, 456, and 483; and

(B) 45 CFR Parts 46, 80, 84, 90, and 91.

**§9.212. Non-licensed Providers Meeting Licensure Standards.**

*Effective: July 26, 2001*

Program providers that, in accordance with the THSC, §252.003, are exempt from the license required by THSC, §252.031, must comply with the following subchapters of 40 TAC Chapter 90 (relating to Intermediate Care Facilities for Persons with Mental Retardation or Related Conditions):

(1) Subchapter C (relating to Standards for Licensure);

(2) Subchapter D (relating to General Requirements for Facility Construction); and

(3) Subchapter F (relating to Inspections, Surveys, and Visits).

**§9.213. Records.**

*Effective: September 1, 2001*

(a) A program provider must maintain a copy of the following records for each individual:

(1) the birth certificate;

(2) relevant legal documents including documents relating to guardianship, marital status, custody of a minor, or immigration status, if any;

(3) the Social Security card;

(4) a current photograph;

(5) immunization records;

(6) height and weight records;

(7) seizure records, if any;

(8) the most recent physician's orders, including treatment and diet orders;

(9) the most recent nursing care plan, if any;

(10) the most recent laboratory test results, if any;

(11) any significant medical reports, including reports regarding the most recent chest X-ray, electrocardiogram (EKG), and electroencephalogram (EEG), if any;

(12) the most recent medical examination results and a summary of the medical history, including all major surgeries, significant acute illnesses, and injuries requiring hospitalization or a long recovery period;

(13) a summary of the medication history for the last five years or from the time services were initiated, whichever is most recent, including start and stop dates, dose ranges, effectiveness and reactions of all long-term medications and antibiotics;

(14) the most recent dental examination results and a summary of the dental history, including all oral surgeries, extractions, restorations, appliances, and types of anesthesia required for dental work;

(15) the social history and the most recent psychological examination results;

(16) Medicaid and, if applicable, Medicare or third-party insurance cards;

(17) records necessary to disclose the nature and extent of services provided to the individual; and

(18) any other records required by this subchapter or the provider agreement.

(b) A program provider must retain the records described in subsection (a) of this section until the latest of the following occurs:

(1) five years elapse from the date the records were created;

(2) any audit exception or litigation involving the records is resolved; or

(3) the individual becomes 21 years of age.

(c) A program provider must, upon request, make available to the department or its designee the records described in subsection (a) of this section.

**§9.214. Certified Capacity of a Facility.**

*Effective: September 1, 2001*

(a) The certified capacity of a facility will be established by the department.

(b) A program provider may request that the department decrease the certified capacity of its facility.

(1) The class of a non-state operated facility that has its certified capacity decreased will be determined according to 1 TAC

§355.456(b) (relating to Rate Setting Methodology) for reimbursement purposes.

(2) The department will amend the *Long Term Care Plan for People with Mental Retardation and Related Conditions* to reflect the decrease in certified capacity of a facility or will determine that beds authorized by the *Long Term Care Plan for People with Mental Retardation and Related Conditions* are available for allocation.

(c) To ensure appropriate utilization of state schools and state centers, the department may increase the certified capacity of a state school and state center, if the total capacity of all state schools and state centers does not exceed the authorized bed capacity for “campus facilities” in the *Long Term Care Plan for People with Mental Retardation and Related Conditions*.

(d) If the department determines that redistributing the certified capacity of one or more existing facilities, other than state schools or state centers, into two or more new, smaller facilities may improve utilization of ICF/MR resources, the department may publish notice in the *Texas Register* that it is accepting requests from program providers to redistribute the certified capacity of their facilities. A program provider may submit a request to redistribute capacity. Such a request must be submitted according to the published notice and the department’s instructions. After reviewing the submitted requests, the department may negotiate a plan and enter into an agreement with a program provider to redistribute the program provider’s certified capacity.

**§9.215. Relocation of Facility.**

*Effective: September 1, 2001*

(a) Prior to relocating its facility, a program provider must receive department approval of a facility relocation application obtained from the department, if certification of the facility at a new physical address will be sought.

(b) To request the approval required by subsection (a) of this section, a program provider must, prior to the facility relocation, complete and submit to the department’s Office of Medicaid Administration, a facility relocation application.

(c) After reviewing an application, the department will provide written notice to the

program provider of its approval or denial. An incomplete application will not be approved.

(d) If the department approves the application for facility relocation, the department will notify the state survey agency of the facility relocation and request that the state survey agency initiate licensure and certification action of the relocated facility.

(e) Prior to the relocation, the program provider must notify each individual residing in the facility and LAR in writing of the date of facility relocation and the address of the relocated facility or explain to the individual or LAR why shorter notification was necessary.

(f) At the time of relocation, the program provider must notify the MRA in whose local service area the facility has relocated of the name and address of the relocated facility in writing.

(g) If the relocated facility is licensed in accordance with state law and determined by the state survey agency to meet certification requirements, the department will initiate an amendment to the provider agreement to reflect the address of the relocated facility. The program provider must execute and submit the amendment to the department.

**§9.216. (Reserved)**

**§9.217. Assignment of Provider Agreement.**

*Effective: September 1, 2001*

(a) A program provider must notify the department’s Office of Medicaid Administration in writing at least 30 days prior to the date of a proposed assignment. The notice must include:

- (1) the legal name and federal tax identification number of the proposed assignee;
- (2) the proposed date of the assignment, which must be on the first day of a month;
- (3) the provider vendor number of the assignor;
- (4) an application for enrollment obtained from the department and completed by the assignee as required for provider applicants by §419.206(d) of this title (relating to Application Process); and
- (5) a copy of the assignment agreement, which must include a statement that the assignee:

DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS)  
40 TAC, CHAPTER 9, SUBCHAPTER E  
ICF/IID PROGRAMS – CONTRACTING

(A) must keep, perform, and fulfill all of the terms, conditions, and obligations that must be performed by the assignor under the provider agreement;

(B) is subject to all pending conditions that exist against the assignor including, but not limited to, any plan of correction, audit exception, vendor hold, or proposed contract termination; and

(C) is liable to the department for any liabilities or obligations that arise from any act, event, or condition that occurred or existed prior to the effective date of the assignment and that is identified in any survey, review, or audit conducted by the department.

(b) The department may establish the date of assignment if:

(1) notice of a proposed assignment is not provided to the department at least 30 days prior to the proposed date of assignment; or

(2) the proposed date of assignment is not on the first day of a month.

(c) Upon receipt of notice provided in accordance with subsection (a) of this section, the department will:

(1) impose a vendor hold on payments due to the assignor under the provider agreement until an audit conducted in accordance with §419.269 of this title (relating to Audits) is complete; and

(2) review the application for enrollment.

(d) After the department reviews the application for enrollment, the department will provide written notice to the assignee and assignor stating whether the application is approved or rejected.

(e) The department may reject an application for enrollment for the same reasons a provider applicant's application for enrollment may be rejected as set forth in §419.206(e) of this title (relating to Application Process). If the department rejects the application for enrollment, the assignor may withdraw the proposed assignment. If the assignment is not withdrawn, the department may terminate the assigned provider agreement.

(f) If the department approves the proposed assignee's application for enrollment, the department will notify the state survey agency of the assignment and request that the state survey agency initiate licensure and certification action.

(g) The assignor must, prior to the effective date of the assignment, give written notice to each individual residing in the facility or LAR of the proposed assignment and the proposed effective date of the assignment.

(h) If the facility is licensed in accordance with state law and determined by the state survey agency to meet certification requirements on or before the 90th day after the effective date of the assignment, the department will pay the assignee for services provided on and after the effective date of the assignment, except the department will not pay the assignee for any period of time during the 90-day period that the facility was determined by the state survey agency to not meet certification requirements.

(i) If the facility is not licensed in accordance with state law and determined by the state survey agency to meet certification requirements on or before the 90th day after the effective date of the assignment, the department will terminate the provider agreement effective on the 91st day. A survey completed more than 90 days after the effective date of the assignment will not be used to determine if the facility met the licensure and certification requirements within the 90-day period.

(j) During the 90-day period after the effective date of the assignment, the provider agreement is subject to sanctions, including termination, in accordance with Division 7 of this subchapter (relating to Provider Agreement Sanctions).

(k) Upon the effective date of the assignment, the assignee:

(1) must keep, perform, and fulfill all of the terms, conditions and obligations that must be performed by the assignor under the provider agreement;

(2) is subject to all pending conditions which exist against the assignor, including but not limited to, any plan of correction, audit exception, vendor hold, or proposed contract termination; and

(3) is liable to the department for any liabilities or obligations that arise from any act, event, or condition that occurred or existed prior to the effective date of the assignment and that is identified in any survey, review, or audit conducted by the department.

(l) The assignor must complete and submit billing claims to the department in accordance with §419.219 of this title (relating to Provider Reimbursement) for services that were provided prior to the effective date of the assignment.

**§9.218. Voluntary Facility Closure and Suspension of Certified Capacity**

*Effective: April 17, 2016*

(a) In this section, the terms "close" and "closure" refer to a facility ceasing to operate. The terms do not include temporarily relocating individuals who reside in a facility.

(b) Except as provided in subsection (c) of this section, if a program provider intends to voluntarily close a facility, the program provider must submit to DADS, at least 60 days before the facility closes, written notice of the program provider's intent to close the facility, which includes:

- (1) the anticipated date of closure; and
- (2) a description of how the facility will discharge and relocate an individual who resides in the closing facility to a new residence.

(c) If, for reasons beyond the program provider's control, the program provider cannot provide the notice required by subsection (b) of this section at least 60 days before the program provider anticipates closing the facility, the program provider must state in the notice the reason why a shorter time period is necessary.

(d) The program provider must comply with §9.227 of this subchapter (relating to Discharge from a Facility).

(e) If a facility is closing, DADS imposes a vendor hold on payments due to the program provider under the provider agreement until an audit conducted in accordance with §9.269 of this subchapter (relating to Audits) is complete.

(f) A program provider that closes a facility may request that DADS suspend some or all of the facility's certified capacity for up to one year after the facility closes.

(g) To request that a facility's certified capacity be suspended:

- (1) the facility's certified capacity must be eight or less;
- (2) the facility must not be the subject of

any proposed or pending enforcement action; and

(3) the program provider must:

(A) voluntarily close the facility; and

(B) submit a letter to DADS requesting suspension of the facility's certified capacity.

(h) A letter submitted in accordance with subsection (g)(3)(B) of this section must include:

- (1) the legal name and address of the program provider;
- (2) the closing facility's name and address;
- (3) the facility's identification number;
- (4) the facility's contract number;
- (5) the facility's license number and expiration date, if the facility is licensed;
- (6) the certified capacity of the facility;
- (7) the certified capacity for which the program provider is requesting the suspension;
- (8) the anticipated closure date of the facility;
- (9) justification for the suspension of certified capacity; and
- (10) a statement regarding the possible use of the certified capacity in the future.

(i) Within 30 days after DADS receives a program provider's letter, as described in subsection (g)(3)(B) of this section, DADS notifies the program provider in writing whether DADS has approved or denied the program provider's request to suspend capacity.

(j) If DADS approves a request to suspend capacity, the notification from DADS states:

- (1) the period of time the capacity is suspended, which must not exceed one year;
  - (2) the effective date of the suspension;
  - (3) the certified capacity being suspended;
- and
- (4) the capacity available, which must not exceed six per facility.

(k) After DADS approves a request to suspend capacity, DADS does not extend the period of time for which capacity is suspended.

(l) A program provider may not transfer a facility's suspended capacity to another entity.

(m) DADS may rescind its approval of a request to suspend certified capacity. If DADS rescinds its approval, the suspended capacity reverts to the control of DADS.

(n) A program provider does not receive an

administrative hearing to challenge DADS denial of a request to suspend capacity or DADS rescission of its approval to suspend capacity.

(o) To activate a facility's suspended certified capacity, the program provider must submit an application for enrollment in the ICF/IID Program in accordance with Division 2 of this subchapter (relating to Provider Enrollment) before the suspension period ends. If a program provider does not submit an application for enrollment in the ICF/IID Program before the suspension period ends, the suspended capacity is not available to the program provider and reverts to the control of DADS. If DADS rejects a program provider's application for enrollment in the ICF/IID Program, the suspended capacity is not available to the program provider and reverts to the control of DADS.

#### **§9.219. Provider Reimbursement.**

*Effective: July 12, 2012*

(a) The department will pay a program provider for ICF/ID Program services provided to individuals enrolled in the ICF/ID Program. Such services include:

- (1) room and board;
- (2) active treatment; and
- (3) medical services.

(b) The department will reimburse a program provider other than a state supported living center, El Paso State Center or the Rio Grande State Center for durable medical equipment in accordance with 1 TAC §355.455 (relating to Payments to Non-State Operated Facilities) and the department's written procedures for durable medical equipment reimbursement.

(c) A program provider must accept the current reimbursement rate or the rate as it may hereafter be amended, as payment in full for ICF/ID Program services provided to an individual enrolled in the ICF/ID Program, and make no additional charge to the individual, any member of the individual's family, or any other source for any item or service including a third party payor, except as allowed by federal or state laws, rules or regulations or the Medicaid State Plan.

(d) If DADS has established the probable existence of a third-party for ICF/ID Program

services provided by a non-state operated facility at the time a claim is filed, DADS rejects the claim and returns it to the program provider for a determination of the amount of liability. When the amount of liability is determined, DADS pays the claim to the extent that payment allowed under the HHSC rate payment schedule exceeds the amount of the third party's payment.

(e) If a claim is returned to a program provider for a determination of liability in accordance with subsection (d) of this section, the program provider must:

- (1) submit the claim to the identified third-party for a determination of the amount of liability;
- (2) keep all documentation of actions taken to determine the amount of liability by the third-party; and
- (3) certify to DADS the actions the program provider has taken to determine the liability of the third-party in accordance with instructions from DADS.

(f) To receive payment for ICF/ID Program services, a program provider must:

- (1) prepare and submit a clean claim, as defined in 42 CFR §447.45(b), for such services in accordance with this subchapter and the information available from the state Medicaid claims administrator; and
- (2) submit such a claim within 12 months after the date of service or the date the individual's eligibility is established, whichever is later.

(g) For the purposes of this section, "date of service" is defined as the last day of the month in which the service was provided.

(h) If a program provider submits a claim to a third-party, the requirement to submit the claim to the state Medicaid claims administrator in accordance with subsection (f) of this section is not affected. In addition, the program provider must allow 110 days to elapse after the date the claim was submitted to the third-party before submitting the claim to the state Medicaid claims administrator.

(i) The department will not pay a program provider or will recoup payments made for services provided to an individual:

- (1) if the individual does not meet the

eligibility criteria described in §9.236 of this chapter (relating to Eligibility Criteria);

(2) if enrollment of the individual is not complete, as described in §9.244(l) of this chapter (relating to Applicant Enrollment in the ICF/MR Program);

(3) if the individual does not have a valid LOC determination;

(4) if the program provider does not have a signed and dated ID/RC Assessment Form for the individual;

(5) if the ID/RC Assessment Form electronically transmitted to the department for the individual does not contain information identical to information on the signed ID/RC Assessment Form;

(6) if the individual is an inpatient of a hospital or nursing facility, is enrolled in a waiver program established under §1915(c) of the Social Security Act, or has elected to receive hospice care in accordance with §30.16 of this title (relating to Election of Hospice Care);

(7) during a discharge of an individual, including the effective date of discharge as described in §9.227(b) of this chapter (relating to Discharge From a Facility);

(8) except as provided in this subsection, if the program provider does not have a provider agreement with the department;

(9) if the program provider does not submit a clean claim for the service in accordance with subsection (f) of this section; or

(10) if DADS returns a claim to the program provider in accordance with subsection (d) of this section and the program provider:

(A) does not submit the claim to the identified third party; or

(B) does not submit the claim to the identified third party in time to be paid in accordance with subsection (h) of this section.

(j) The department may pay a program provider for ICF/ID services up to 30 days after its provider agreement has expired or been terminated if the services were provided to individuals admitted to the facility before the effective date of the expiration or termination and reasonable efforts are being made to move the individuals from the facility.

**§9.220. (Reserved.)**

#### **DIVISION 4. PROVIDER SERVICE REQUIREMENTS**

##### **§9.221. Durable Medical Equipment.**

*Effective: November 4, 2013*

A program provider who arranges for durable medical equipment for an individual residing in the facility must:

(1) ensure that the individual receives the equipment prescribed, the equipment fits properly, if applicable, and the individual's caregivers, as appropriate, receive instruction regarding the equipment's use; and

(2) document compliance with the requirements of paragraph (1) of this section in the individual's record.

##### **§9.222. Permanency Planning and LAR Participation for Individuals Under 22 Years of Age.**

*Effective: September 1, 2006*

(a) As required by Texas Government Code, §531.153, a program provider must incorporate permanency planning as an integral part of the IPP for each individual under 22 years of age residing in the facility. In order to accomplish the permanency planning goal in accordance with §9.244(f) of this subchapter (relating to Applicant Enrollment in the ICF/MR Program), the program provider must identify in the IPP, as appropriate to the individual's needs:

(1) for an individual under 18 years of age, the activities, supports, and services that, when provided or facilitated by the program provider or MRA, will enable the individual to live with a family; or

(2) for an individual age 18 to 22 years of age, the activities, supports, and services that, when provided or facilitated by the program provider or MRA, will result in the individual having a consistent and nurturing environment in the least restrictive setting, as defined by the individual and LAR.

(b) A program provider must take the following actions to assist an MRA in conducting

DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS)  
40 TAC, CHAPTER 9, SUBCHAPTER E  
ICF/IID PROGRAMS – CONTRACTING

permanency planning for an individual under 22 years of age:

(1) cooperate with the MRA responsible for conducting permanency planning by:

(A) allowing access to an individual's records or providing other information in a timely manner as requested by the MRA or the Health and Human Services Commission;

(B) participating in meetings to review the individual's permanency plan; and

(C) identifying, in coordination with the individual's MRA, activities, supports, and services that can be provided by the family, LAR, program provider, or the MRA to prepare the individual for an alternative living arrangement;

(2) encourage regular contact between the individual and LAR and, if desired by the individual and LAR, between the individual and advocates and friends in the community to continue supportive and nurturing relationships;

(3) encourage participation in IDT meetings by the LAR, and, if desired by the individual or LAR, by family members, advocates, and friends in the community;

(4) provide the IPP summary to the individual's MRA;

(5) keep a copy of the individual's current permanency plan in the individual's record; and

(6) refrain from providing the LAR with inaccurate or misleading information regarding the risks of moving the individual to another facility or community setting.

(c) Within three days after the admission of an individual under 22 years of age, a program provider must notify the following entities of such admission and provide information in accordance with subsection (d) of this section:

(1) the MRA in whose local service area the facility is located (see [www.dads.state.tx.us/contact/mra/index.cfm](http://www.dads.state.tx.us/contact/mra/index.cfm) for a listing of MRAs by county or city);

(2) the CRCG for the county in which the LAR lives (see [www.hhsc.state.tx.us/crcg/crcg.htm](http://www.hhsc.state.tx.us/crcg/crcg.htm) for a listing of CRCG chairpersons by county); and

(3) the local school district for the area in which the facility is located, if the individual is at least three years of age, or the early childhood

intervention (ECI) program for the county in which the facility is located, if the individual is less than three years of age (see [www.dars.state.tx.us/ecis/index.shtml](http://www.dars.state.tx.us/ecis/index.shtml) or call 1-800-250-2246 for a listing of ECI programs by county).

(d) The program provider's notification given by the program provider in accordance with subsection (c) of this section must include the following information about an individual:

(1) full name;

(2) gender;

(3) ethnicity;

(4) birth date;

(5) Social Security number;

(6) LAR's name, address and county of residence;

(7) date of admission to the facility;

(8) name and address of the facility;

(9) name and phone number of person submitting the notification;

(10) those services from the following listing that will facilitate the individual's permanency planning outcomes:

(A) personal and family support services provided in the individual's home;

(B) residential services provided outside the individual's family or own home;

(C) vocational services; and

(D) training services provided outside of the individual's family or own home, including specialized professional services.

(e) A program provider must:

(1) request from and encourage an LAR to provide the following information for an individual during the annual IPP meeting and, for an applicant, upon admission:

(A) the LAR's:

(i) name;

(ii) address;

(iii) telephone number;

(iv) driver license number and state of issuance or personal identification card number issued by the Department of Public Safety; and

(v) place of employment and the employer's address and telephone number;

(B) the name, address, and telephone number of a relative of the individual or other

DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS)  
40 TAC, CHAPTER 9, SUBCHAPTER E  
ICF/IID PROGRAMS – CONTRACTING

person whom DADS or the program provider may contact in an emergency situation, a statement indicating the relationship between that person and the individual, and at the LAR's option:

(i) that person's driver license number and state of issuance or personal identification card number issued by the Department of Public Safety; and

(ii) the name, address, and telephone number of that person's employer; and

(C) a signed acknowledgement of responsibility stating that the LAR agrees to:

(i) notify the program provider of any changes to the contact information submitted; and

(ii) make reasonable efforts to participate in the individual's life and in planning activities for the individual; and

(2) inform the LAR that if the information described in paragraph (1) of this subsection is not provided or is not accurate and the program provider and DADS are unable to locate the LAR as described in subsections (j) and (k) of this section, DADS refers the case to the Department of Family and Protective Services.

(f) For an individual under 22 years of age, a program provider must:

(1) make reasonable accommodations to promote the participation of the LAR in all planning and decision-making regarding the individual's care, including participating in:

(A) the initial development and annual review of the individual's IPP;

(B) decision-making regarding the individual's medical care;

(C) routine IDT meetings; and

(D) decision-making and other activities involving the individual's health and safety; and

(2) ensure that reasonable accommodations include:

(A) conducting a meeting in person or by telephone, as mutually agreed upon by the program provider and the LAR;

(B) conducting a meeting at a time and, if the meeting is in person, at a location that is mutually agreed upon by the program provider and the LAR;

(C) if the LAR has a disability, providing reasonable accommodations in accordance with the Americans with Disabilities Act, including providing an accessible meeting location or a sign language interpreter, if appropriate; and

(D) providing a language interpreter, if appropriate.

(g) For an individual under 22 years of age, a program provider must provide written notice to the LAR of a meeting to conduct an annual review of the individual's IPP no later than 21 days before the meeting date and request a response from the LAR.

(h) If an emergency situation occurs, a program provider must attempt to notify the LAR as soon as the emergency situation allows and request a response from the LAR.

(i) If an LAR does not respond to a notice of the individual's IPP review meeting, a request for the LAR's consent, or an emergency situation, the program provider must attempt to locate the LAR by contacting a person identified by the LAR in the contact information described in subsection (e) of this section.

(j) No later than 30 days after the date a program provider determines that it is unable to locate the LAR, the program provider must notify DADS of that determination and request that DADS initiate a search for the LAR.

(k) If, within one year of the date DADS receives the notification described in subsection (j) of this section, DADS is unable to locate the LAR, DADS refers the case to:

(1) the Child Protective Services Division of the Department of Family and Protective Services if the individual is under 18 years of age; or

(2) the Adult Protective Services Division of the Department of Family and Protective Services if the individual is 18-22 years of age.

(l) Before an individual who is under 18 years of age, or who is 18-22 years of age and for whom an LAR has been appointed, is transferred to another facility operated by the transferring program provider, the program provider must attempt to obtain consent for the transfer from the LAR unless the transfer is made because of a

serious risk to the health and safety of the individual or another person.

(m) A program provider must document compliance with the requirements of this section in the individual's record.

### **§9.223. Review of Living Options.**

*Effective: March 31, 2002*

(a) At a facility other than a state school or state center, the IDT must discuss living options with the individual and LAR at least annually or upon the request of the individual or LAR. The facility must use the Community ICF/MR Living Options instrument, copies of which are available on the department's website at [www.mhmr.state.tx.us/CentralOffice/Medicaid/i.html](http://www.mhmr.state.tx.us/CentralOffice/Medicaid/i.html) or by contacting Office of Medicaid Administration, Texas Department of Mental Health and Mental Retardation, P.O. Box 12668, Austin, Texas 78711. State schools and state centers must discuss living options with the individual and LAR in accordance with §412.274 of this title (relating to Consideration of Living Options for Individuals Residing in State MR Facilities).

(1) During the discussion, the IDT must use information obtained from the MRA in whose local service area the facility is located to inform the individual and LAR of the different types of alternative living arrangements, including:

(A) other ICF/MR Program providers – state schools and state centers and community-based ICF/MRs;

(B) waiver services under §1915(c) of the Social Security Act; and

(C) other community-based services and supports.

(2) The IDT must document the discussion in the IDT summary and file the summary in the individual's record.

(3) If the individual or LAR expresses interest in an alternative living arrangement, the program provider must send a copy of the IDT summary to the MRA in whose local service area the facility is located.

(b) If an MRA receives an IDT summary, the MRA must, within 30 days after receiving the IDT summary:

(1) contact the individual or LAR to discuss the alternative living arrangements in which the individual or LAR has expressed an interest; and

(2) determine if the individual or LAR is interested in seeking an alternative living arrangement in another MRA's local service area and, if so, notify the MRA for that local service area.

(c) The MRA for the local service area in which the individual or LAR is interested in seeking an alternative living arrangement must:

(1) enter on the Client Assignment and Registration (CARE) system the individual's name and the specific type of service requested, if that service will not be available within 30 days of the date of request; and

(2) assist the individual or LAR in accessing the service requested when it becomes available.

### **§9.224. Capacity Assessment.**

*Effective: September 1, 2001*

(a) As described in §411.61 of this title, (relating to Memorandum of Understanding Concerning Capacity Assessment for Self Care and Financial Management) a program provider must perform a capacity assessment for an individual receiving services from that program provider if the program provider:

(1) believes a guardian of the person or the estate for that individual may be appropriate and a referral to the appropriate court for guardianship is anticipated; or

(2) is directed to do so by a court.

(b) In conducting the capacity assessment, the program provider must use the Capacity Assessment for Self Care and Financial Management. Copies of this assessment may be obtained by contacting the Office of Policy Development, Texas Department of Mental Health and Mental Retardation, 909 West 45th Street, Austin, Texas, 78756, 512/206-4516, or from the Texas Department of Human Services Long Term Care Policy web site at [www.dhs.state.tx.us](http://www.dhs.state.tx.us).

(c) The capacity assessment must be performed by the professional designated by the IDT with assistance from other staff or consultants

as requested by the professional or directed by the IDT.

**§9.225. Reporting Incidents to DADS.**

*Effective: November 4, 2013*

(a) In this section, "serious physical injury" is defined as in Chapter 711 of this title (relating to Investigations in DADS and DSHS Facilities and Related Programs).

(b) A program provider that, in accordance with THSC §252.003, is exempt from licensure under THSC §252.031 must report the following incidents to DADS Consumer Rights and Services at 1-800-458-9858 within one hour after suspecting or learning of the incident:

(1) alleged (Class I) physical abuse of an individual, as defined in Chapter 711 of this title, that caused or may have caused serious physical injury;

(2) alleged (Class I) sexual abuse of an individual, as defined in Chapter 711 of this title;

(3) sexual activity between individuals resulting from coercion, physical force, or taking advantage of the disability of an individual;

(4) sexual activity involving an individual who is less than 18 years of age;

(5) the pregnancy of an individual;

(6) individual-to-individual aggression that results in serious physical injury;

(7) the death of an individual; and

(8) the inability to locate an individual if:

(A) the individual's health or safety is at risk; or

(B) the individual's location has been unknown for more than eight hours.

(c) Within five working days after making a report described in subsection (b) of this section, the program provider must:

(1) conduct a thorough investigation of the incident; and

(2) send a written investigation report on Form 3613A, Provider Investigation Report, to DADS Consumer Rights and Services.

**§9.226. Leaves.**

*Effective: September 1, 2001*

(a) An individual's absence from a facility must meet the requirements of this section to be

considered a therapeutic leave, an extended therapeutic leave, or a special leave.

(b) An individual is on a therapeutic leave if:

(1) the individual is absent from the facility one full day or more but less than four consecutive full days;

(2) the individual's IPP provides for therapeutic leave; and

(3) except as provided in subsection (e) of this section, the individual has stayed in the facility overnight since being on a prior therapeutic leave or extended therapeutic leave.

(c) An individual is on an extended therapeutic leave if:

(1) the individual is absent from the facility four consecutive full days or more;

(2) the number of days used by the individual for extended therapeutic leave does not exceed ten during the calendar year in which the leave is being taken;

(3) the individual's IPP provides for the extended therapeutic leave; and

(4) except as provided in subsection (e) of this section, the individual has stayed overnight in the facility since being on a prior extended therapeutic leave or therapeutic leave.

(d) An individual is on a special leave if:

(1) the individual is absent from the facility one full day or more;

(2) the individual's IPP provides for and describes the expected benefits of the special leave;

(3) during the absence, sufficient direct care staff of the program provider are with the individual to meet the requirements set forth in 42 CFR §483.430(d);

(4) during the absence, the program provider incurs the usual costs associated with providing services to the individual, including but not limited to costs necessary to provide meals, lodging, and staff; and

(5) during the absence, the program provider provides the active treatment specified in the individual's IPP.

(e) Once per calendar year, an individual may take a therapeutic leave immediately before or after an extended therapeutic leave without staying overnight in the facility between the two leaves.

(f) There is no limit on the number of therapeutic leaves or special leaves an individual may take.

(g) A program provider must maintain the following written documentation for each leave taken by an individual:

- (1) the name of the individual;
- (2) the type of leave taken (i.e., therapeutic, extended therapeutic, or special); and
- (3) the dates and times of the individual's departure from and return to the facility.

(h) Within three days after an individual's return from leave, a program provider must electronically submit a completed Client Movement form to the department.

### **§9.227. Discharge From a Facility.**

*Effective: September 1, 2001*

(a) When a discharge occurs, a program provider must comply with 42 CFR §483.440(b)(4) and (5) and this section.

(b) The effective date of a discharge is the first full day the individual is absent from the facility.

(c) Prior to the effective date of a discharge, a program provider must take the following action or document why such action is not feasible:

(1) notify the individual, LAR, and the individual's MRA of the proposed discharge in writing at least 30 days before the effective date of the proposed discharge;

(2) document the reason for the proposed discharge and, if the reason is that the facility can no longer meet the individual's needs, explain why;

(3) counsel the individual or LAR about the proposed discharge, including the potential outcomes of the proposed discharge; and

(4) develop a final summary and post-discharge plan in accordance with 42 CFR §483.440(b)(5) and provide a copy of both documents to the individual, LAR, and the individual's MRA.

(d) If any actions required by subsection (c) of this section are not feasible prior to the effective date of a discharge, a program provider must, within 7 days after the effective date of the discharge, complete the required actions.

(e) Within 3 days after the effective date of a

discharge, a program provider must:

(1) electronically submit a completed Client Movement Form to the department; and

(2) submit a paper copy of the completed Client Movement Form to the appropriate TDHS Medicaid eligibility worker.

(f) Except when an individual requires immediate admission to a psychiatric facility for inpatient services as provided in subsection (i) of this section, if a program provider proposes a discharge due to the individual's maladaptive behavior, the discharge must be approved in writing by the department prior to the effective date of the discharge. To request approval, the program provider must submit the following documentation to the department's Office of Medicaid Administration:

(1) a description of the maladaptive behavior(s);

(2) a summary of all behavioral interventions attempted, ranging from the most positive to the most restrictive, with the individual's response to these interventions, and reasons the interventions were ineffective in decreasing or eliminating the behavior(s);

(3) chronological psychoactive medication history, including start and stop dates of medications, dose changes to medications, and reasons for discontinuance or changes to dosages (e.g., adverse reactions, allergies, or increase in target symptoms);

(4) evidence of participation by a psychologist in the IDT meeting discussing the proposed discharge;

(5) evidence of approval of the proposed discharge by the facility's specially constituted committee;

(6) a description of the proposed living arrangement for the individual after the effective date of the discharge; and

(7) a written agreement from a representative of the proposed living arrangement to accept the individual on or after the effective date of the discharge.

(g) The department will review the documentation submitted in accordance with subsection (f) of this section and, within 14 days after receiving the documentation, provide written

notice to the program provider of its approval or denial of the discharge.

(h) If a proposed discharge is approved by the department in accordance with subsection (g) of this section, a psychologist must participate in the development of the post-discharge plan described in subsection (c)(4) of this section.

(i) If the reason for a discharge is that the individual requires immediate admission to a psychiatric facility for inpatient services, a program provider other than a state school or state center must, within three days after the effective date of the discharge, notify the Office of Medicaid Administration and the individual's MRA of:

(1) the individual's admission to the psychiatric facility; and

(2) whether the program provider intends to re-admit the individual to the facility and, if not, why the individual will not be re-admitted.

(j) During a discharge, a program provider may accept payment from the individual or other person to hold the individual's residential placement in the facility if a written contract, signed and dated by the program provider and the individual or the other person, is executed prior to each discharge that specifies:

(1) the amount, not to exceed the department's rate of reimbursement for the individual's LON on the effective date of discharge, that the individual or other person agrees to pay the program provider to hold the individual's residential placement;

(2) the period of time for which the individual's residential placement in the facility will be held by the program provider;

(3) that the program provider is not obligated to hold the individual's residential placement after the period of time described in paragraph (2) of this subsection; and

(4) agreement by the program provider that the individual or other person may terminate the contract immediately upon written notice to the program provider.

### **§9.228. Augmentative Communication Device System.**

*Effective: August 1, 2009*

(a) A specialized augmentative communication device system (ACD), also referred to as a speech-generating device system, is reimbursable if purchased by a program provider for a resident and all requirements of this section are met.

(b) A program provider must request and receive authorization from DADS before purchasing an ACD, referred to in this section as "prior authorization." The request for prior authorization must include:

(1) an evaluation and recommendation from a licensed speech therapist to purchase the ACD;

(2) a signed statement from the resident's attending physician that the ACD is medically necessary for the resident to maximize his functional communication; and

(3) a minimum of two bids for the ACD or a request for an exception to the two-bid minimum if the recommended ACD is available through only one vendor.

(c) The evaluation and recommendation from the licensed speech therapist must include:

(1) a description of how the ACD will specifically meet the needs of the resident;

(2) detailed instructions for training on the use of the ACD for the resident, program provider staff, and resident's family (if applicable);

(3) a diagnosis relevant to the need for the ACD; and

(4) the specific ACD being recommended.

(d) If an ACD costs more than \$10,000, DADS facilitates an independent speech language review, at DADS' expense, to determine necessity for the ACD.

(e) After receiving prior authorization from DADS, the program provider must purchase the ACD.

(f) To obtain reimbursement from DADS, a program provider must submit to DADS the receipt for payment for the ACD and a copy of the prior authorization from DADS.

(1) A program provider must fully investigate and use funding sources to pay for an ACD before submitting the request for

reimbursement to DADS. If another funding source will pay for part of the cost of the ACD, the program provider may request reimbursement from DADS for the balance of the cost if the requirements in subsections (b) and (c) of this section are met. If another funding source is available, DADS reimburses the program provider no more than the balance remaining after other sources are used fully.

(2) A program provider must submit the request for reimbursement to DADS within one year after the date of purchase.

(3) DADS reimburses the amount of the authorized bid or the balance remaining after all other sources are used fully.

(g) If DADS denies a request for reimbursement because the program provider did not receive prior authorization or did not submit the necessary documentation for the ACD, the program provider is responsible for the cost of the ACD.

(h) If DADS denies a prior authorization request, the resident may request a Medicaid fair hearing in accordance with 1 TAC Chapter 357, Subchapter A.

(i) Only the resident may use the ACD, and the program provider must identify the ACD as the personal property of the resident.

(1) Upon discharge from the facility, the resident must retain the ACD. If the resident dies, the ACD must be transferred to the resident's estate. If the ACD is donated or sold to the program provider by the resident or the resident's estate, the program provider must document the transaction.

(2) The program provider is responsible for repairing and maintaining the ACD while the resident resides in the facility.

### **§9.229. Critical Incident Reporting.**

*Effective: November 30, 2011*

(a) The following definitions apply to this section:

(1) Critical incident means:

(A) a medication error;

(B) a serious physical injury;

(C) a behavior intervention plan that authorizes restraint;

(D) an emergency personal restraint;

(E) an emergency mechanical restraint;

or

(F) an emergency psychoactive medication restraint.

(2) Emergency mechanical restraint means the use of a mechanical restraint on an individual not in accordance with a written behavior intervention plan approved by the individual's IDT.

(3) Emergency personal restraint means the use of a personal restraint on an individual not in accordance with a written behavior intervention plan approved by the individual's IDT.

(4) Emergency psychoactive restraint means the use of a psychoactive medication restraint on an individual not in accordance with a written behavior intervention plan approved by the individual's IDT.

(5) A behavior intervention plan that authorizes restraint means a behavior intervention plan approved by the individual's IDT that authorizes personal restraint, mechanical restraint, or psychoactive medication restraint.

(6) Mechanical restraint means the use of a device that restricts the free movement of part or all of an individual's body, including the use of an ankle, a wristlet, a camisole, a helmet with fasteners, a mitt with fasteners, a vest, a waist strap, a head strap, or a restraining sheet, but does not include the use of a device that provides support for functional body position or proper balance, such as a wheelchair belt, or that is used for medical treatment, such as a helmet to prevent injury during a seizure.

(7) Medication error means a difference between what is prescribed to an individual who self-administers medication under the supervision of the program provider or who has medication administered by the program provider and what the individual actually takes, but does not include an individual's refusal to take medication. The following are examples of medication errors:

(A) an individual takes medication that is not prescribed for the individual, including medication that has been discontinued for the individual or that was improperly labeled;

(B) an individual takes an amount of

medication different from the amount prescribed or the route prescribed for the individual;

(C) an individual does not take a prescribed dose of medication within one hour before or one hour after the prescribed time; and

(D) an individual does not take a medication as prescribed in relation to a meal.

(8) Personal restraint means the application of pressure, except physical guidance or prompting of brief duration that restricts the free movement of part or all of an individual's body.

(9) Psychoactive medication restraint means the use of a chemical, including a pharmaceutical, to control an individual's activity, if the chemical is not a standard treatment for the individual's medical or psychiatric condition.

(10) Serious physical injury is an injury determined serious by a physician, physician assistant, advance practice nurse, or a registered nurse, regardless of the cause or setting in which the injury occurred. A serious physical injury may include a fracture, a dislocation of any joint, an internal injury, a contusion larger than two and half inches in diameter, a concussion, a second or third degree burn, a laceration requiring sutures.

(b) A program provider must report to DADS the following information related to the critical incidents that occur in a calendar month:

(1) the number of medication errors;

(2) the number of individuals who have behavior intervention plans that authorize restraint;

(3) the number of times emergency personal restraint was used;

(4) the number of times emergency mechanical restraint was used;

(5) the number of times emergency psychoactive medication restraint was used;

(6) the number of times a serious physical injury was sustained;

(7) the number of times a serious physical injury was sustained due to personal restraint;

(8) the number of times a serious physical injury was sustained due to mechanical restraint;

(9) the number of times a serious physical injury was sustained due to psychoactive medication restraint;

(10) the number of individuals who

required restraint;

(11) the number of individuals who required emergency personal restraint;

(12) the number of individuals who required emergency mechanical restraint; and

(13) the number of individuals who required emergency psychoactive medication restraint.

(c) The program provider must make a report described in subsection (b) of this section within 30 days after the last day of the month in which the critical incidents occur. A program provider must make a separate report for each facility.

(d) A program provider must evaluate its use of restraint at least annually. The evaluation must, at a minimum, compare aggregate data provided by DADS at [www.dads.state.tx.us](http://www.dads.state.tx.us) for similarly sized facilities.

(e) Based on its evaluation, the program provider must develop and implement a plan to reduce the use of restraints.

§§9.230-9.235 (*Reserved.*)

## **DIVISION 5. ELIGIBILITY, ENROLLMENTS AND REVIEW**

### **§9.236. Eligibility Criteria.**

*Effective: September 1, 2001*

(a) To be eligible for the ICF/MR Program, a person must:

(1) meet the LOC I or LOC VIII criteria described in §419.238 of this title (relating to Level of Care I Criteria) and §419.239 of this title (relating to Level of Care VIII Criteria);

(2) be in need of and able to benefit from the active treatment provided in the 24-hour supervised residential setting of an ICF/MR; and

(3) be eligible for Supplemental Security Income (SSI) or be determined by TDHS to be financially eligible for Medicaid.

(b) Circumstances under which a person is not in need of and able to benefit from active treatment include when the person:

(1) has been diagnosed by a licensed physician as having "brain death";

(2) does not respond in any way to the

living environment;

(3) has a health condition that prevents participation in active treatment; or

(4) is generally able to function with little supervision or without a program of continuous active treatment.

### **§9.237. Level of Care.**

*Effective: September 1, 2001*

(a) An LOC for a person must be requested from the department by electronically transmitting a completed MR/RC Assessment, indicating the recommended LOC, to the department. The electronically transmitted MR/RC Assessment must contain information identical to the information on the signed MR/RC Assessment described in subsection (b) of this section.

(b) Information on the MR/RC Assessment must be supported by current data obtained from standardized evaluations and formal assessments that measure physical, emotional, social, and cognitive factors. A paper copy of the person's signed MR/RC Assessment and documentation supporting the recommended LOC must be maintained in the person's record.

(c) The department will make an LOC determination in accordance with §419.238 of this title (relating to ICF/MR LOC I Criteria) and §419.239 of this title (relating to ICF/MR LOC VIII) based on the department's review of information reported on the person's MR/RC Assessment.

(d) The department will notify the requestor electronically if the LOC is authorized. The department will send written notification to the requestor and the person or LAR if the LOC is denied.

(e) An initial LOC is valid for 180 days after its effective date.

(f) The effective date of a person's initial LOC is the date requested by the MRA, which may be no earlier than 30 days prior to the date the person's MR/RC Assessment is electronically transmitted to the department.

### **§9.238. ICF/MR Level of Care I Criteria.**

*Effective: November 30, 2011*

(a) To meet the LOC I criteria, a person must:

(1) meet the following criteria:

(A) have a full scale intelligence quotient (IQ) score of 69 or below, obtained by administering a standardized individual intelligence test; or

(B) have a full scale IQ score of 75 or below, obtained by administering a standardized individual intelligence test, and have a primary diagnosis by a licensed physician of a related condition that is included on the list of diagnostic codes for persons with related conditions that are approved by DADS and posted on its website at [www.dads.state.tx.us](http://www.dads.state.tx.us); and

(2) have an adaptive behavior level of I, II, III, or IV (i.e., mild to extreme deficits in adaptive behavior) obtained by administering a standardized assessment of adaptive behavior.

(b) If a person has a sensory or motor deficit for which a specially standardized intelligence test or a certain portion of a standardized intelligence test is appropriate, the appropriate test or portion thereof and the resultant score should be used.

(c) If a full scale IQ score cannot be obtained from a standardized intelligence test due to age, functioning level, or other severe limitations, an estimate of a person's intellectual functioning should be documented with clinical justification.

### **§9.239. ICF/MR Level of Care VIII Criteria.**

*Effective: November 30, 2011*

To meet the LOC VIII criteria, a person must:

(1) have a primary diagnosis by a licensed physician of a related condition that is included on the list of diagnostic codes for persons with related conditions that are approved by DADS and posted on its website at [www.dads.state.tx.us](http://www.dads.state.tx.us); and

(2) have an adaptive behavior level of II, III, or IV (i.e., moderate to extreme deficits in adaptive behavior) obtained by administering a standardized assessment of adaptive behavior.

### **§9.240. Level of Need.**

*Effective: September 1, 2001*

(a) An LON for a person must be requested from the department by electronically transmitting a completed MR/RC Assessment, indicating the recommended LON, and submitting any supporting documentation required by §419.242 of

this title (relating to Supporting Documentation for Level of Need). The electronically transmitted MR/RC Assessment must contain information identical to the information on the signed MR/RC Assessment described in subsection (c) of this section.

(b) Supporting documentation must be received by the department within seven days after the completed MR/RC Assessment is electronically transmitted to the department.

(c) A paper copy of the person's signed MR/RC Assessment and the supporting documentation must be maintained in the person's record.

(d) The department will assign an LON 1, LON 5, LON 6, LON 8, or LON 9, to a person in accordance with the criteria described in §419.241 of this title (relating to Level of Need Criteria).

(e) The department will assign an LON to a person based on the department's review of information reported on the person's MR/RC Assessment, including the ICAP service level score, and any supporting documentation required by §419.242 of this title (relating to Supporting Documentation for Level of Need).

(f) Within 21 days after receiving an MR/RC Assessment and any supporting documentation, the department will request additional documentation, electronically approve the recommended LON, or send written notification to the requestor that the recommended LON has been denied.

(g) If additional documentation is requested, the department will review any additional documentation submitted in accordance with its request and electronically approve the recommended LON or send written notification to the requestor that the recommended LON has been denied.

(h) The department may review a recommended or assigned LON at any time to determine if it is appropriate. If the department reviews a recommended or assigned LON, documentation supporting the LON must be submitted to the department in accordance with the department's request. The department may modify an LON and recoup or deny payment based on its review.

#### **§9.241. Level of Need Criteria.**

*Effective: September 1, 2001*

(a) The department will assign one of five LONs as follows:

(1) An intermittent LON (LON 1) will be assigned if the person's ICAP service level score equals 7, 8, or 9;

(2) A limited LON (LON 5) will be assigned if the person's ICAP service level score equals 4, 5, or 6, or an LON 1 is increased in accordance with subsection (b) or (d) of this section;

(3) An extensive LON (LON 8) will be assigned if the person's ICAP service level score equals 2 or 3, or an LON 5 is increased in accordance with subsection (b) or (d) of this section;

(4) A pervasive LON (LON 6) will be assigned if the person's ICAP service level score equals 1, or an LON 8 is increased in accordance with subsection (b) or (d) of this section; and

(5) Regardless of a person's ICAP service level score, a pervasive plus LON (LON 9) will be assigned if the person meets the criteria set forth in subsection (c) of this section.

(b) An LON 1, LON 5, or LON 8 will be increased to the next LON by the department, due to a person's dangerous behavior, if the supporting documentation described in §419.242 (1) (relating to Supporting Documentation for Level of Need) is submitted to the department proving that:

(1) the person exhibits dangerous behavior that could cause serious physical injury to the person or others;

(2) a written behavior intervention plan has been implemented for the person;

(3) more staff members are needed and available than would be needed if the person did not exhibit dangerous behavior;

(4) management of the individual's behavior requires that staff members are constantly prepared to physically prevent the dangerous behavior or intervene when the behavior occurs; and

(5) the person's MR/RC Assessment is correctly scored with a "1" in the "Behavior" section.

(c) An LON 9 will be assigned by the

department, due to the person's extremely dangerous behavior, if the supporting documentation described in §419.242(2) (relating to Supporting Documentation for Level of Need) is submitted to the department proving that:

(1) the person exhibits extremely dangerous behavior that is life threatening to the person or to others such that specified staff must be at arm's length during waking hours;

(2) a written behavior intervention plan has been implemented for the person;

(3) management of the person's behavior requires a staff member to exclusively and constantly supervise the person during the person's waking hours, which must be at least 16 hours per day;

(4) the staff member assigned to supervise the person has no other duties during such assignment; and

(5) the person's MR/RC Assessment is correctly scored with a "2" in the "Behavior" section.

(d) An LON 1, LON 5, or LON 8 will be increased to the next LON by the department, due to a person's extraordinary medical needs, if the supporting documentation described in §419.242(3) (relating to Supporting Documentation for Level of Need) is submitted to the department proving that:

(1) the person's extraordinary medical needs require direct nursing treatment in excess of 180 minutes per week;

(2) the provision of nursing treatment is documented by a nurse in the person's medical record to include the amount of time spent for treatment; and

(3) the person's MR/RC Assessment is correctly scored with a "6" in the "Nursing" section.

### **§9.242. Supporting Documentation for Level of Need.**

*Effective: September 1, 2001*

The following supporting documentation, at a minimum, must be submitted to the department when requesting an LON:

(1) if a request is made to increase an LON 1, LON 5, or LON 8 in accordance with

§419.241(b) of this title (relating to Level of Need Criteria), due to a person's dangerous behavior:

(A) the person's IPP;

(B) the person's ICAP assessment booklet;

(C) the person's person directed plan (PDP), if available;

(D) the person's behavior intervention plan; and

(E) written descriptions (e.g. incident reports or progress notes) of specific incidents of the dangerous behavior and the staff interventions;

(2) if a request is made for an LON 9 in accordance with §419.241(c) of this title (relating to Level of Need Criteria), due to the person's extremely dangerous behavior:

(A) the person's IPP;

(B) the person's ICAP assessment booklet;

(C) the person's PDP, if available;

(D) the person's behavior intervention plan;

(E) written descriptions (e.g. incident reports or progress notes) of specific incidents of the extremely dangerous behavior and the staff interventions; and

(F) time sheets that verify the assignment of a staff member to exclusively and constantly supervise the person during the person's waking hours, which must be at least 16 hours per day;

(3) if a request is made to increase an LON 1, LON 5, or LON 8 in accordance with §419.241(d) of this title (relating to Level of Need Criteria), due to a person's extraordinary medical needs:

(A) the person's IPP;

(B) the person's ICAP assessment booklet;

(C) the person's PDP, if available; and

(D) description, frequency, and duration of each type of nursing treatment; and

(4) if a request is made to increase an individual's existing LON based on the results of an ICAP assessment:

(A) the individual's previous ICAP assessment booklet;

(B) the individual's latest ICAP

reassessment;

- (C) the individual's IPP;
- (D) program progress notes; and
- (E) the individual's PDP, if available.

**§9.243. Reconsideration of Level of Need.**

*Effective: September 1, 2001*

(a) If a program provider who has requested an LON for a person disagrees with the LON assigned by the department, the program provider may request that the department reconsider the LON.

(b) A program provider may receive reconsideration only if the program provider submitted the supporting documentation as required by §419.240(b) of this title (relating to Level of Need).

(c) To request reconsideration of an LON assigned by the department, a program provider must submit a written request for reconsideration to the department within 10 days after receiving notice that the recommended LON was denied. The program provider must include additional clinical and supporting documentation with the request.

(d) Within 21 days after receiving a request for reconsideration from a program provider, the department will electronically approve the recommended LON or send written notification to the program provider that the recommended LON has been denied.

**§9.244. Applicant Enrollment in the ICF/MR Program.**

*Effective: September 1, 2006*

(a) Except as provided in subsection (b) of this section, only an MRA may request enrollment of an applicant by DADS.

(b) A program provider may request enrollment of an applicant by DADS in accordance with subsection (k) of this section if the applicant:

(1) has received ICF/MR services from a non-state operated facility during the 180 days before the enrollment request; and

(2) is not moving from or seeking admission to a state school or state center.

(c) An MRA must request an applicant's

enrollment if:

(1) the program provider selected by the applicant or LAR notifies the MRA in writing that admission to the program provider's facility has been offered to the applicant; and

(2) the applicant or LAR notifies the MRA that the applicant or LAR chooses to accept the admission offered by the program provider.

(d) If an MRA receives the notifications described in subsection (c) of this section, the MRA must comply with §5.159(c) of this title (relating to Assessment of Individual's Need for Services and Supports) including providing an explanation to the applicant or LAR of the services and supports for which the applicant may be eligible. For an applicant under 22 years of age, an MRA must also comply with the following requirements:

(1) Except as provided in paragraphs (2) and (3) of this subsection, before placement of an applicant in a facility, the MRA must inform the LAR:

(A) of the benefits of living in a family or community setting;

(B) that the placement of the applicant is considered temporary; and

(C) that an ongoing permanency planning process is required.

(2) If an MRA is notified of a request for enrollment after the applicant is admitted to the facility, the MRA must provide the information described in paragraph (1) of this subsection to the LAR not later than the 14th working day after the date the MRA is notified of the request for the enrollment, unless this time period is extended by the LAR.

(3) An MRA does not have to comply with paragraph (1) or (2) of this subsection if the applicant has been committed to a facility under Chapter 46B, Code of Criminal Procedure, or Chapter 55, Family Code.

(e) To request an applicant's enrollment, an MRA must, within 15 working days after the MRA receives both notifications described in subsection (c) of this section:

(1) initiate, monitor, and support the processes necessary to obtain a financial eligibility determination for the applicant if Medicaid

DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS)  
40 TAC, CHAPTER 9, SUBCHAPTER E  
ICF/IID PROGRAMS – CONTRACTING

financial eligibility has not been established;

(2) obtain an ICAP score for the applicant by:

(A) reviewing and endorsing an existing ICAP for the applicant; or

(B) administering the ICAP if an ICAP score for the applicant does not exist, is not available, or is not endorsed by the MRA; and

(3) request or review an LOC determination and LON for the applicant by:

(A) completing and electronically submitting an MR/RC Assessment, if the applicant does not have a current LOC determination; or

(B) reviewing the existing MR/RC Assessment for the applicant if the applicant has a current LOC determination and:

(i) if the MRA does not endorse the existing MR/RC Assessment, completing and electronically submitting a new MR/RC Assessment recommending a revised LOC or LON; or

(ii) if the MRA endorses the existing MR/RC Assessment, notifying the selected program provider in writing that no changes to the current LOC or LON are recommended.

(f) Upon notification of a request for enrollment of an applicant under 22 years of age, an MRA must take or ensure that the following actions are taken to conduct permanency planning:

(1) The MRA must convene a permanency planning meeting with the LAR and, if possible, the applicant before admission or, if notified of a request for enrollment after the applicant's admission, not later than the 14th working day after the date the MRA is notified of the request.

(2) Before the permanency planning meeting, the MRA staff must review the applicant's records and, if possible, meet the applicant.

(3) During the permanency planning meeting, the meeting participants must discuss and choose one of the following goals:

(A) for an applicant under 18 years of age:

(i) to live in the applicant's family home where the natural supports and strengths of the applicant's family are supplemented, as

needed, by activities and supports provided or facilitated by the MRA or program provider; or

(ii) to live in a family-based alternative in which a family other than the applicant's family:

(I) has received specialized training in the provision of support and in-home care for an individual under 18 years of age with mental retardation;

(II) will provide a consistent and nurturing environment in a family home that supports a continued relationship with the applicant's family to the extent possible; and

(III) if necessary, will provide an enduring, positive relationship with a specific adult who will be an advocate for the applicant; or

(B) for an applicant 18-22 years of age, to live in a setting chosen by the applicant or LAR in which the applicant's natural supports and strengths are supplemented by activities and supports provided or facilitated by the MRA or program provider, and to achieve a consistent and nurturing environment in the least restrictive setting, as defined by the applicant and LAR.

(4) To accomplish the goal chosen in accordance with paragraph (3) of this subsection, the meeting participants must discuss and identify:

(A) the problems or issues that led the applicant or LAR to request admission to a facility;

(B) the applicant's daily support needs;

(C) for an applicant under 18 years of age:

(i) barriers to having the applicant reside in the family home;

(ii) supports that would be necessary for the applicant to remain in the family home; and

(iii) actions that must be taken to overcome the barriers and provide the necessary supports;

(D) for an applicant 18-22 years of age, the barriers to the applicant moving to a consistent and nurturing environment as defined by the applicant and LAR;

(E) the importance for the applicant to live in a long-term nurturing relationship with a

family;

(F) alternatives to the applicant living in an institutional setting;

(G) the applicant's and LAR's need for information and preferences regarding those alternatives;

(H) how, after admission to the facility, to facilitate regular contact between the applicant and the applicant's family, and, if desired by the applicant and family, between the applicant and advocates and friends in the community to continue supportive and nurturing relationships;

(I) natural supports and family strengths that will assist in accomplishing the identified permanency planning goal;

(J) activities and supports that can be provided by the family, MRA, or program provider to achieve the permanency planning goal;

(K) assistance needed by the applicant's family:

(i) in maintaining a nurturing relationship with the applicant; and

(ii) preparing the family for the applicant's eventual return to the family home or move to a family-based alternative; and

(L) action steps, both immediate and long term, for achieving the permanency plan goal.

(5) The MRA must make reasonable accommodations to promote the participation of the LAR in a permanency planning meeting, including:

(A) conducting a meeting in person or by telephone, as mutually agreed upon by the MRA and LAR;

(B) conducting a meeting at a time and, if the meeting is in person, at a location that is mutually agreed upon by the MRA and LAR;

(C) if the LAR has a disability, providing reasonable accommodations in accordance with the Americans with Disabilities Act, including providing an accessible meeting location or a sign language interpreter, if appropriate; and

(D) providing a language interpreter, if appropriate.

(6) The MRA must develop a permanency plan using, as appropriate:

(A) the Permanency Planning Instrument for Children Under 18 Years of Age; or

(B) the Permanency Planning Instrument for Individuals 18-22 Years of Age.

(7) The MRA must:

(A) complete the Permanency Planning Review Screen in CARE before an applicant is admitted to a facility unless the MRA is not given prior notice of the admission;

(B) keep a copy of the Permanency Planning Review Approval Status View Screen from CARE in the applicant's record; and

(C) provide a copy of the permanency plan to the program provider, the applicant, and the LAR.

(g) If an applicant is under 22 years of age, the MRA must inform the applicant and LAR that they may request a volunteer advocate to assist in permanency planning. The applicant or LAR may:

(1) select a person who is not employed by or under contract with the MRA or a program provider; or

(2) request the MRA to designate a volunteer advocate.

(h) If an applicant or LAR requests that the MRA designate a volunteer advocate or the MRA cannot locate the LAR, the MRA must attempt to designate a volunteer advocate to assist in permanency planning who is, in order of preference:

(1) an adult relative who is actively involved with the applicant;

(2) a person who:

(A) is part of the applicant's natural support network; and

(B) is not employed by or under contract with the MRA or a program provider; or

(3) a person or a child advocacy organization representative who:

(A) is knowledgeable about community services and supports;

(B) is familiar with the permanency planning philosophy and processes; and

(C) is not employed by or under contract with the MRA or a program provider.

(i) If the MRA is unable to locate a volunteer advocate locally, the MRA must request assistance from a statewide advocacy organization in

identifying an available volunteer advocate who meets the requirements described in subsection (h) of this section. If the statewide advocacy organization is unable to assist the MRA in identifying a volunteer advocate, the MRA must document all efforts to designate a volunteer advocate in accordance with subsection (h) of this section.

(j) If DADS notifies an MRA that it has authorized an applicant's LOC, the MRA must immediately notify the applicant or LAR of such authorization and provide the selected program provider with copies of all enrollment documentation and associated supporting documentation including relevant assessment results and recommendations and the applicant's ICAP booklet and, if available, the applicant's service plan.

(k) To request an applicant's enrollment as permitted by subsection (b) of this section, a program provider must ensure that the applicant has a current LOC.

(1) If an applicant does not have a current LOC, the program provider must complete and electronically submit an MR/RC Assessment to DADS.

(2) If the program provider submits an MR/RC Assessment, DADS notifies the program provider electronically if the LOC is authorized or sends written notification to the program provider and the applicant or LAR if the LOC is denied.

(l) An applicant's enrollment is complete if:

(1) DADS has authorized an LOC for the applicant;

(2) the Social Security Administration has determined that the applicant is eligible for SSI or the Health and Human Services Commission determines the applicant is financially eligible for Medicaid;

(3) the program provider has electronically submitted a completed Client Movement Form to DADS; and

(4) admission to the facility has been approved by the DADS commissioner or designee for the applicant who is under 22 years of age, based on information submitted as described in subsection (f) of this section.

(m) A program provider must maintain a paper

copy of the completed MR/RC Assessment with all the necessary signatures and documentation supporting the recommended LOC and LON.

#### **§9.245. Renewal of Level of Care.**

*Effective: September 1, 2001*

(a) To avoid interruption in payment from the department, a program provider must request to renew an individual's existing LOC prior to its expiration date.

(b) To request to renew an individual's existing LOC, a program provider must follow the procedures for requesting an LOC described in §419.237 of this title (relating to Level of Care).

(c) The department will make an LOC determination and notify the program provider of its determination in accordance with §419.237 of this title (relating to Level of Care).

(d) The effective date of a renewed LOC is:

(1) the date the MR/RC was electronically transmitted to the department, if a different date is not requested; or

(2) a requested effective date within 45 days after the MR/RC was electronically transmitted to the department.

(e) A renewed LOC is valid for 364 days after its effective date.

#### **§9.246. Renewal and Revision of Level of Need.**

*Effective: September 1, 2001*

(a) A program provider must request to renew an individual's existing LON when renewing an existing LOC in accordance with §419.245(b) of this title (relating to Renewal of Level of Care).

(b) A program provider must request to revise an individual's existing LON if:

(1) the individual's adaptive functioning or behavioral or medical condition changes such that the individual's current LON is no longer accurate;

(2) the results of an ICAP assessment indicate that the individual's current LON is no longer accurate; or

(3) the information submitted for the individual's current LON resulted in an inaccurate LON.

(c) To request to renew or revise an individual's existing LON, a program provider

must follow the procedures for requesting an LON described in §419.240 of this title (relating to Level of Need).

(d) The department will assign an LON and notify the program provider of the assignment in accordance with §419.240 of this title (relating to Level of Need).

#### **§9.247. Re-administration of the ICAP.**

*Effective: September 1, 2001*

(a) A program provider must re-administer the ICAP to an individual if:

(1) three years have elapsed since the ICAP was last administered to the individual;

(2) changes in the individual's functional skills or behavior occur that are not expected to be of a short duration or cyclical in nature; or

(3) the individual's skills and behavior are inconsistent with the individual's LON.

(b) If the results from the ICAP indicate that the individual's LON is no longer accurate, a program provider must request a revision to the LON in accordance with §419.246(b) of this title (relating to Renewal and Revision of Level of Need).

#### **§9.248. Lapsed Level of Care.**

*Effective: September 1, 2001*

(a) The department will not pay a program provider for ICF/MR Program services provided during a period of time in which the individual's LOC lapsed unless the program provider requests and is granted a reinstatement of the LOC in accordance with this section.

(b) To request reinstatement of an LOC, a program provider must electronically transmit to the department an MR/RC Assessment indicating:

(1) a code "E" in the "Purpose" section; and

(2) the beginning and ending dates of the period of time for which the individual's LOC lapsed.

(c) The department will not grant a request for reinstatement of an LOC:

(1) if the individual does not have a current LOC;

(2) to establish program eligibility;

(3) to renew an LOC;

(4) to obtain an LOC for a period of time for which an LOC has been denied;

(5) to revise an LON; or

(6) for a period of time during which the individual is not eligible for Medicaid.

(d) If the department grants a reinstatement, the reinstatement will be for a period of not more than 180 days prior to the date of electronic transmission of the MR/RC Assessment described in subsection (b) of this section.

(e) A program provider must maintain a paper copy of the completed MR/RC Assessment with all necessary signatures in the individual's record. The signed MR/RC Assessment must contain information identical to the information on the electronically transmitted MR/RC Assessment.

#### **§9.249. Fair Hearing.**

*Effective: September 1, 2001*

Any individual whose request for eligibility for the ICF/MR Program is denied or is not acted upon with reasonable promptness, or whose ICF/MR Program services have been terminated, suspended or reduced by the department is entitled to a fair hearing in accordance with Chapter 419, Subchapter G of this title (relating to Medicaid Fair Hearings).

#### **§9.250. Permanency Planning Reviews.**

*Effective: September 1, 2006*

An MRA must, within six months after the initial permanency planning meeting and every six months thereafter until an individual either turns 22 years of age or leaves the facility to live in a family setting:

(1) provide written notice to the LAR of a meeting to conduct a review of the individual's permanency plan no later than 21 days before the meeting date and include a request for a response from the LAR;

(2) convene a meeting to review the individual's permanency plan in accordance with §9.244(f)(2)-(5) of this subchapter (relating to Applicant Enrollment in the ICF/MR Program), with an emphasis on changes or additional information gathered since the last permanency plan was developed;

(3) develop a permanency plan in

accordance with §9.244(f)(6) of this subchapter;

(4) perform actions regarding a volunteer advocate as described in §9.244(g)-(i) of this subchapter;

(5) complete the Permanency Planning Review Screen in CARE within 10 days after the meeting;

(6) ensure that approval for the individual to continue to reside in the facility is obtained every six months from the DADS commissioner and the Health and Human Services Commission executive commissioner;

(7) keep a copy of the Permanency Planning Review Approval Status View Screen from CARE in the individual's record; and

(8) provide a copy of the permanency plan to the program provider, the individual, and the LAR.

## **DIVISION 6. PERSONAL FUNDS**

### **§9.251. Protecting Individuals' Personal Funds.**

*Effective: November 4, 2013*

(a) A program provider must implement this division according to the generally accepted accounting principles of the American Institute of Certified Public Accountants.

(b) A program provider must develop and implement written policies and procedures regarding personal funds that protect the financial interest of an individual and, at a minimum, require the program provider:

(1) to instruct an individual in handling personal funds consistent with the individual's abilities and understanding;

(2) to allow an individual to hold and manage personal funds to the extent of the individual's abilities; and

(3) to comply with 20 CFR Part 404, Subpart U, and 20 CFR Part 416, Subpart F, if the Social Security Administration has appointed the program provider as the representative payee.

(c) A program provider must reimburse an individual for personal funds lost or stolen while the funds are under the program provider's control.

### **§9.252. Notice Regarding Personal Funds.**

*Effective: November 4, 2013*

At the time of admission to a facility, and if changes to services or charges occur, a program provider must provide each individual or LAR with written notification containing the following information:

(1) a written explanation of §9.253(d) and (e) of this division (relating to Determining Management of Personal Funds), which describe who may manage personal funds;

(2) a list of items and services included in the program provider's ICF/IID Program reimbursement rate for which the individual will not be charged;

(3) a list of items and services for which the individual may be charged;

(4) a statement that the individual or LAR may have the Social Security Administration appoint a representative payee to receive the individual's federal benefits in accordance with 20 CFR Part 404, Subpart U, and 20 CFR Part 416, Subpart F;

(5) a statement that, if the Social Security Administration has appointed the program provider as the representative payee for an individual's social security benefits, the provider must comply with 20 CFR Part 404, Subpart U, and 20 CFR Part 416, Subpart F;

(6) a statement that, if the program provider manages the individual's personal funds, the program provider will make available the individual's personal funds record, as described in §9.256(h) of this division (relating to Program Provider-Managed Personal Funds), upon the request of the individual or LAR within 72 hours after receiving a request for a copy of the personal funds record from the individual or LAR; and

(7) a statement that, if the individual or LAR requests withdrawal of all personal funds managed by the program provider or if the individual is discharged from the facility, the program provider will disburse funds managed by the program provider in accordance with §9.258 of this division (relating to Closing Trust Fund Accounts) and, if the program provider is the representative payee, in accordance with 20 CFR Part 404, Subpart U, and 20 CFR Part 416, Subpart F.

**§9.253. Determining Management of Personal Funds.**

*Effective: January 1, 2001*

(a) Within 30 days after an individual is admitted to a facility, the IDT must determine if the individual has the ability to:

- (1) manage his or her personal funds; and
- (2) decide who manages his or her personal funds.

(b) The determination must be based on an assessment of the individual's understanding of financial management, including:

- (1) mathematical concepts;
- (2) budgeting personal funds;
- (3) monetary denominations; and
- (4) financial obligations.

(c) The results of the assessment and the IDT's determination must be documented, signed by the IDT, and made a part of the individual's IPP.

(d) If an individual does not have an LAR and is determined to have the ability to decide who manages his or her personal funds or if an individual has an LAR, a program provider must allow the individual or LAR to choose one of the following to manage his or her personal funds and document such choice in the individual's IPP:

- (1) the individual, if the individual is determined to have the ability to manage his or her personal funds;
- (2) the individual's LAR;
- (3) the program provider; or
- (4) another person identified by the individual or LAR who has agreed in writing to manage the individual's personal funds.

(e) If an individual is determined not to have the ability to decide who manages his or her personal funds and the individual has no LAR, a program provider must manage the individual's personal funds in accordance with this subchapter.

(f) A program provider must reassess an individual's understanding of financial management at least annually and if the program provider has reason to believe that the individual's ability has changed.

**§9.254. Items and Services Provided by the Program Provider.**

*Effective: January 1, 2006*

A program provider must not charge an individual or require an individual to expend personal funds for items and services that are the program provider's responsibility to provide, except as authorized by §419.255(a)(1) of this title (relating to Items and Services Purchased with Personal Funds), because they are included in the ICF/MR Program reimbursement rate or are covered by other Medicaid programs. These items and services include:

- (1) medical services and therapies, e.g., physical exams, physical therapy, occupational therapy, and nutritional, speech, audiological, psychological, social, and medical evaluations;
- (2) prescribed and over-the-counter medication;
- (3) medical equipment and supplies, e.g., nasogastric tubes, feeding pumps, catheters, sheepskins, and egg crate pads;
- (4) laboratory services;
- (5) eye exams and eyeglasses, except:
  - (A) the difference between the Medicaid payment and the actual cost of the eyeglasses as authorized by §419.255(a)(2) of this title (relating to Items and Services Purchased with Personal Funds); or
  - (B) as authorized by §419.255(a)(6) of this title (relating to Items and Services Purchased with Personal Funds).
- (6) non-cosmetic dental services and items, e.g., intra- and extra-oral examinations, prescribed dental treatments and follow-up visits, dentures, braces, crowns, toothbrushes, toothpaste, mouthwash, dental floss, and disclosing solution;
- (7) specialized equipment and adaptive devices that are medically necessary or are necessary to meet the objectives in the individual's IPP, e.g., hearing aids, hearing aid batteries, electric razor, shoe closures, and shoe insoles;
- (8) training and habilitation services, e.g., vocational training, congregate training, and day activity services;
- (9) behavioral reinforcers used in behavior modification programs, e.g., candy, soft drinks, cereal, coffee, toys, and magazines;

(10) meals, snacks, and special diets, as listed on the program provider's menu, whether provided at the facility or elsewhere;

(11) non-cosmetic personal hygiene items, e.g., shampoo, conditioner, soap, deodorant, anti-perspirant, body lotion, insect repellent, sunscreen, shaving supplies, comb, hair brush, facial tissues, toilet tissue, sanitary napkins, tampons, and diapers;

(12) shampooing, haircutting, basic hairstyling, and shaving, including mustache and beard trimming;

(13) laundering personal clothing;

(14) facility furnishings and housewares, e.g., bedroom furniture, kitchenware, bath towels, dish towels, and bed linens;

(15) repairing and maintaining the facility's physical plant, including training and day activity areas;

(16) expenses that are associated with activities that are part of the program provider's recreational program e.g., meals, lodging, registrations, and tickets;

(17) transportation costs to and from:

(A) an activity included in an individual's IPP, including health care services, congregate training, day activity services and supported employment, except for competitive employment; or

(B) an activity that is part of the program provider's recreational program.

(18) fees charged by financial institutions, including service fees and check printing charges, if an individual's personal funds are managed in a pooled account or if the program provider chooses to manage those funds in a separate account;

(19) managing an individual's personal funds; and

(20) a charge incurred if the program provider mismanages an individual's personal funds.

**§9.255. Items and Services Purchased with Personal Funds.**

*Effective: September 1, 2001*

(a) A program provider may charge an individual or allow an individual to expend

personal funds for the following items and services:

(1) an item or service that the program provider is responsible for providing, if the individual requests a specific type or brand of item or service that the program provider does not provide, and the program provider documents in the individual's record:

(A) the individual's written, signed request for a specific type or brand and the reason a specific type or brand has been requested or if the individual is determined not to have the ability to make such a request, the IDT's approval for a specific type or brand;

(B) the type or brand that is provided at the program provider's expense; and

(C) the reason the program provider does not provide the type or brand requested;

(2) the difference between the Medicaid payment and the actual cost of the eyeglasses, if the individual chooses a style or feature not paid for by Medicaid;

(3) clothing;

(4) cosmetic dental procedures;

(5) transportation costs, other than those described in §419.254(17) of this title (relating to Items and Services Provided by the Program Provider):

(A) if reimbursement to a third party for private transportation does not exceed the current state mileage reimbursement rate; and

(B) if adequate documentation is provided by a third party to the program provider to support the expenditure;

(6) repair or replacement of personal property that is damaged, lost, or stolen by the individual, if the expenditure is approved by the committee;

(7) snacks and meals, if the individual chooses items not listed on the program provider's menu;

(8) the individual's budgeted amount;

(9) activities that are not part of the program provider's recreational program and are independently chosen by the individual;

(10) dry cleaning;

(11) hair setting, permanent waves, hair color treatments, and beauty supplies, such as hair

rollers and hair spray;

(12) cosmetics and perfume;

(13) cosmetic manicures, pedicures, and facials;

(14) charges to hold the individual's residential placement in the facility as described in §419.227(j) of this title (relating to Discharge From a Facility)

(15) school supplies, school fees, and other educational expenses;

(16) fees charged by a financial institution, if the individual manages his or her personal funds or the individual requests that the program provider manage his or her personal funds in a separate account; and

(17) applied income.

(b) Items purchased with an individual's personal funds must not be available for general use by program provider staff or other individuals.

### **§9.256. Program Provider-Managed Personal Funds.**

*Effective: November 4, 2013*

(a) Accounting for personal funds. If a program provider manages personal funds, the program provider must comply with this section and ensure that:

(1) a complete accounting of personal funds entrusted to the program provider is maintained;

(2) personal funds are not commingled with program provider funds or the funds of any person other than another individual for whom the program provider manages personal funds; and

(3) personal funds are only expended for the individual's use and benefit and in a manner and for purposes determined to be in the individual's best interest.

(b) Account requirements. A program provider must manage personal funds in a trust fund account.

(1) The program provider may manage personal funds in a pooled account or a separate account. If the program provider chooses a pooled account, an individual may request and receive a separate account. The program provider may also maintain some personal funds in a petty cash fund.

(2) Trust fund accounts must be insured

under federal or state law.

(3) The program provider must retain all statements from financial institutions regarding trust fund accounts.

(4) The program provider must reconcile such statement with the account ledger as described in subsection (c)(1)(A) and (2)(A) of this section and personal ledger as described in subsection (h)(1)(F) of this section within 30 days after receiving such statement.

(c) Types of accounts.

(1) Pooled accounts. If a program provider manages personal funds in a pooled account, the program provider must:

(A) maintain an account ledger that separately identifies each financial transaction, including:

(i) the name of the individual for whom the transaction was made;

(ii) the date and amount of the transaction, including interest; and

(iii) the balance after the transaction;

(B) title the account "(Name of facility), Resident Trust Fund Account" or a similar title that shows a fiduciary relationship exists between an individual and the program provider; and

(C) if the personal funds of Medicaid and private-pay individuals are pooled, obtain a signed, dated statement from private pay individuals allowing the program provider to release financial information to DADS, Health and Human Services Commission, Texas Attorney General's Medicaid Fraud Control Unit, and US Department of Health and Human Services.

(2) Separate accounts. If a program provider manages personal funds in a separate account, the program provider must:

(A) maintain an account ledger that identifies each financial transaction, including:

(i) the date and amount of the transaction, including interest; and

(ii) the balance after the transaction; and

(B) title the account "(Program Provider's Name), (Individual's Name) Trust Fund Account" or a similar title that shows a fiduciary

DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS)  
40 TAC, CHAPTER 9, SUBCHAPTER E  
ICF/IID PROGRAMS – CONTRACTING

relationship exists between an individual and the program provider.

(d) Petty cash fund. If a program provider maintains some personal funds in a petty cash fund, the program provider must:

(1) set a limit on the amount maintained in the petty cash fund;

(2) set a limit on the amount of a single expenditure from the petty cash fund;

(3) maintain a petty cash fund ledger that includes:

(A) the date and amount of each transaction;

(B) the name of the individual for whom each transaction was made; and

(C) the balance after each transaction.

(e) Interest. If personal funds accrue interest, a program provider must prorate and distribute the interest earned to each participating individual.

(f) Depositing personal funds. A program provider must deposit in a trust fund account all funds that it receives on behalf of the individual. If the deposit slip documents deposits for more than one individual, the program provider must indicate on the deposit slip the amount allocated to each individual.

(g) Access to personal funds.

(1) An individual's IDT must, based on the individual's assessment described in §9.253 of this division (relating to Determining Management of Personal Funds), determine:

(A) if there is a need for a budgeted amount and, if so, set the amount; and

(B) if there is a need to restrict the individual's use of personal funds and, if so, make a recommendation to the specially constituted committee.

(2) If the individual's IDT makes a recommendation to the specially constituted committee to restrict an individual's use of personal funds, the specially constituted committee's decision is documented, signed by the specially constituted committee members, and made a part of the individual's IPP.

(h) Personal funds record.

(1) A program provider must maintain a personal funds record for each individual that includes:

(A) the name of the individual;

(B) the name of the individual's LAR and representative payee, as applicable;

(C) the date of the individual's admission to the facility;

(D) the individual's budgeted amount;

(E) the account number and location of all accounts in which the individual's personal funds are managed;

(F) a personal ledger that includes the date and amount of each transaction and the balance after each transaction; and

(G) any contribution acknowledgment as described in §9.261 of this division (relating to Contributions).

(2) The personal ledger reconciled in accordance with subsection (b)(4) of this section must not be less than zero. If reconciled balance is less than zero, the program provider must deposit in and credit to the individual's trust fund account the amount that increases such balance to zero.

(3) At least quarterly, and within 72 hours after receiving a request from the individual or LAR, the program provider must provide to the individual or LAR a copy of the individual's personal ledger.

(i) Documenting expenditures and deposits.

(1) Expenditures.

(A) Except as provided in subparagraph (C) of this paragraph, a program provider must retain a sales receipt for each expenditure.

(i) If a sales receipt documents an expenditure for more than one individual, the program provider must indicate on the sales receipt the amount allocated to each individual.

(ii) If a sales receipt does not include the specific item or service purchased or the name of the seller, the program provider must attach such documentation.

(B) The program provider must explain each expenditure to the individual and request that the individual sign the receipt. If the program provider determines that the individual does not understand the explanation, the individual does not sign the receipt, or the individual's signature is illegible, a witness to the expenditure must sign the receipt. The witness must not be responsible

for managing personal funds or responsible for supervising persons performing such duties.

(C) A sales receipt is not required for an expenditure:

(i) if the program provider makes a purchase on behalf of an individual from a vending machine;

(ii) if an expenditure is within the individual's budgeted amount and the program provider obtains an acknowledgment signed by the individual indicating that the funds were received;

(iii) if the program provider releases funds in response to a written request in accordance with §9.257 of this division (relating to Requests for Personal Funds from Trust Fund Accounts); or

(iv) if the program provider obtains written approval for alternative documentation from DADS before the expenditure is made.

(2) Deposits. Except for deposits made electronically, a program provider must retain a deposit slip issued by the financial institution for each deposit.

### **§9.257. Requests for Personal Funds from Trust Fund Accounts.**

*Effective: January 1, 2001*

If a program provider receives a request from an individual or other person except program provider staff to expend an individual's personal funds without obtaining a receipt and the individual's IDT determines that the expenditure is in the best interest of the individual, the program provider may release such funds to the requestor.

(1) The request must be written, signed by the requestor, and specify the amount and purpose of the expenditure.

(2) A check is not considered a written request for personal funds, even if it is written and signed by the individual.

### **§9.258. Closing Trust Fund Accounts.**

*Effective: January 1, 2001*

(a) Ownership change. Within 30 days after the effective date of a change in facility ownership, the previous program provider must:

(1) reconcile each statement issued by a financial institution with the account ledger and

the personal ledger;

(2) provide the new program provider with a list of all individuals whose personal funds were managed by the previous program provider and their trust fund account balances and personal ledger balance as of the effective date of the transfer;

(3) transfer to the new program provider all personal funds managed by the previous program provider;

(4) retain a receipt from the new program provider indicating the amount of the transfer; and

(5) submit to the department any unidentified personal funds.

(b) Written notice. If the individual or LAR provides written notice that another person has been chosen to manage the individual's personal funds, a program provider must, within 30 days after receiving the notice:

(1) reconcile the individual's statement issued by the financial institution with the account ledger and the personal funds ledger;

(2) transfer all of the individual's personal funds to the person chosen;

(3) retain a receipt from the person indicating the amount of the transfer; and

(4) provide to the person a copy of the individual's current personal funds record.

(c) Discharge. If the individual is discharged from the facility, a program provider must, within 30 days after the discharge:

(1) reconcile the individual's statement issued by a financial institution with the account ledger and personal funds ledger;

(2) transfer all personal funds managed by the program provider:

(A) to the admitting facility, if the individual is discharged to another facility; or

(B) to the individual or LAR, if the individual is not discharged to another facility;

(3) retain a receipt from the admitting facility, individual, or LAR indicating the amount of the transfer; and

(4) provide to the admitting facility, individual, or LAR the individual's current personal funds record.

(d) Unclaimed personal funds. Within 180 days after identifying any unclaimed personal

funds, a program provider must make a good faith effort to locate the individual to whom the funds belong or LAR. If the individual or LAR:

(1) is located, the program provider must transfer the funds to the individual or LAR; or

(2) is not located, the program provider must send to TDMHMR, Attn: Cashier, P.O. Box 12668, Austin, Texas 78691:

(A) a statement that the funds are unclaimed;

(B) the program provider's name, address, and vendor identification number;

(C) the individual's name, social security number, date of birth, and last known address;

(D) the LAR's name and address;

(E) a check payable to TDMHMR for the amount of the unclaimed personal funds; and

(F) documentation of the program provider's efforts to locate the individual or LAR.

#### **§9.259. Refunds.**

*Effective: January 1, 2001*

A program provider must refund any private payment it received for services provided during a period covered by Medicaid, including retroactive coverage, within 30 days after accepting the Medicaid payment.

#### **§9.260. Applied Income.**

*Effective: September 1, 2001*

(a) A program provider may only collect applied income in accordance with the procedures authorized by TDHS.

(b) If an individual's applied income has not been determined or the individual's earned or unearned income changes, a program provider must report such information to the TDHS Medicaid eligibility worker.

(c) A program provider must maintain an applied income ledger for each individual that includes the amount of:

(1) applied income owed by the individual;

(2) applied income paid by the individual;

(3) the difference between the applied income owed and the applied income paid by the individual; and

(4) charges paid by the individual to hold

the individual's residential placement in the facility as described in §419.227(j) of this title (relating to Discharge From a Facility)

(d) Within 72 hours after receiving a request from the individual or LAR, a program provider must provide to the individual or LAR a copy of the individual's applied income ledger.

#### **§9.261. Contributions.**

*Effective: January 1, 2001*

If the individual or LAR makes a contribution to a program provider using personal funds, the program provider and the contributor must sign and date an acknowledgement that the program provider's services are not predicated on a contribution and the contribution is voluntary. The acknowledgement must be made a part of the individual's personal funds record.

#### **§9.262. Trust Fund Monitoring and Audits.**

*Effective: November 4, 2013*

(a) DADS may periodically monitor a trust fund account to assure compliance with this section. DADS notifies a program provider of monitoring plans and gives a report of the findings to the program provider.

(b) DADS may, as a result of monitoring, refer a program provider to the Health and Human Services Commission Office of Inspector General (OIG) for an audit.

(c) The program provider must provide all records and other documents required by §9.256 of this division (relating to Program Provider-Managed Personal Funds) to DADS upon request.

(d) DADS provides the program provider with a report of the findings, which may include corrective actions that the program provider must take and internal control recommendations that the program provider may follow.

(e) To dispute the report of findings, the program provider may request:

(1) an informal review in accordance with §9.263(a) of this division (relating to Informal Review and Administrative Hearing); or

(2) an administrative hearing in accordance with §9.263(b) of this division.

(f) If the program provider does not request an informal review or an administrative hearing and

the report of findings requires corrective actions, the program provider must complete corrective actions within 60 days after receiving the report of findings.

(g) If the program provider does not complete corrective actions required by DADS within 60 days after receiving the report of findings, DADS may impose a vendor hold on payments due to the program provider under the provider agreement until the program provider completes corrective actions.

(h) If DADS imposes a vendor hold in accordance with subsection (g) of this section, the program provider may request an administrative hearing in accordance with §9.263(b)(5) of this division. If the failure to correct is upheld, DADS continues the vendor hold until the program provider completes the corrective actions.

### **§9.263. Informal Review and Administrative Hearing.**

*Effective: November 4, 2013*

(a) Informal review.

(1) A program provider that disputes the report of findings described in §9.262(d) of this division (relating to Trust Fund Monitoring and Audits) may request an informal review. The purpose of an informal review is to provide for the informal and efficient resolution of the matters in dispute. An informal review is conducted according to the following procedures:

(A) DADS must receive a written request for an informal review by United States (U.S.) mail, hand delivery, special mail delivery, or fax no later than 15 days after the date on the written notification of the report of findings described in §9.262(d) of this division.

(i) If the 15th day is a Saturday, Sunday, national holiday, or state holiday, then the first working day after the 15th day is the final day the written request is accepted.

(ii) A request for an informal review that is not received by the stated deadline is not accepted.

(B) A program provider must submit a written request for an informal review:

(i) by U.S. mail to DADS Trust Fund Monitoring Unit, Attn: Manager, P.O. Box

149030, Mail Code W-340, Austin, Texas 78714-9030;

(ii) hand delivery or special mail delivery to 701 West 51st Street, Austin, Texas 78751-2321; or

(iii) by fax to (512) 438-3639.

(C) A program provider must, with its request for an informal review:

(i) submit a concise statement of the specific findings it disputes;

(ii) specify the procedures or rules that were not followed;

(iii) identify the affected cases;

(iv) describe the reason the findings are being disputed; and

(v) include supporting information and documentation that directly demonstrates that a disputed finding is not correct.

(D) DADS does not grant a request for an informal review that does not meet the requirements of this subsection.

(2) Upon receipt of a request for an informal review, the Trust Fund Monitoring Unit Manager coordinates the review of the information submitted.

(A) Additional information may be requested by DADS and must be received in writing by U.S. mail, hand delivery, special mail, or fax in accordance with paragraph (1)(B)(i)-(iii) of this subsection no later than 15 days after the date the program provider receives the written request for additional information. If the 15th day is a Saturday, Sunday, national holiday, or state holiday, then the first working day after the 15th day is the final day the additional information is accepted.

(B) DADS sends its written decision to the program provider by certified mail, return receipt requested.

(i) If the original findings are upheld, DADS continues the schedule of deficiencies and requirement for corrective action.

(ii) If the original findings are reversed, DADS issues a corrected schedule of deficiencies with the written decision.

(iii) If the original findings are revised, DADS issues a revised schedule of deficiencies including any revised corrective

action.

(iv) If the original findings are upheld or revised, the program provider may request an administrative hearing in accordance with subsection (b) of this section.

(v) If the original findings are upheld or revised and the program provider does not request an administrative hearing, the program provider has 60 days from the date of receipt of the written decision to complete the corrective actions.

(I) If the program provider does not complete the corrective actions by that date, DADS may impose a vendor hold. If DADS imposes a vendor hold, the program provider may request an administrative hearing in accordance with subsection (b)(5) of this section.

(II) If the failure to correct is upheld, DADS continues the vendor hold until the program provider completes the corrective action.

(b) Administrative hearing.

(1) The program provider must submit a written request for an administrative hearing under this section to: HHSC Appeals Division, P.O. Box 149030, Mail Code W-613, Austin, Texas 78714-9030.

(2) The written request for a formal hearing must be received within 15 days after:

(A) the date on the written notification of the report of findings described in section §9.262(d) of this division; or

(B) the program provider receives the written decision sent as described in subsection (a)(2)(B) of this section.

(3) An administrative hearing is conducted in accordance with 1 TAC Chapter 357, Subchapter I (relating to Hearings Under the Administrative Procedure Act).

(4) No later than 60 days after a final determination is issued as a result of an administrative hearing requested by a program provider under §9.262(e)(2) of this division or subsection (a)(2)(B)(iv) of this section, the program provider must complete any corrective action required by DADS or be subject to a vendor hold on payments due to the program provider under the provider agreement until the program provider completes corrective action. If DADS

imposes a vendor hold, the program provider may request an administrative hearing in accordance with paragraph (5) of this subsection. If the failure to correct is upheld, DADS continues the vendor hold until the program provider completes the corrective action.

(5) If DADS imposes a vendor hold under §9.262(g) of this division, subsection (a)(2)(B)(v) of this section, or paragraph (4) of this subsection, the program provider may request an administrative hearing within 15 days after receiving notice of the failure to correct and the vendor hold. The administrative hearing is limited to the issue of whether the program provider completed the corrective action.

**§§9.264-9.265. (Reserved.)**

## **DIVISION 7. PROVIDER AGREEMENT SANCTIONS**

### **§9.266. DADS Review of Inspection or Survey Findings.**

*Effective: November 4, 2013*

(a) DADS may impose a directed plan of correction (DPoC) on one or more of a program provider's facilities, a vendor hold on payments due under one or more of a program provider's agreements, or both if:

(1) the program provider is determined as a result of an inspection or survey to not meet one or more of the federal ICF/IID standards of participation (SoPs) or conditions of participation (CoPs) and DADS determines that the program provider's failure to meet such SoPs or CoPs resulted in or may result in serious injury to or death of an individual residing in the program provider's facility;

(2) the program provider is determined as a result of an inspection or survey to not meet one or more of the SoPs and DADS determines that the program provider's failure to meet such SoPs indicates a pervasive lack of active treatment;

(3) the program provider is determined as a result of an inspection or survey to not meet one or more of the SoPs or CoPs or to not be compliant with one or more state rules applicable to the

ICF/IID program and DADS determines, based on its review of previous inspection or survey findings related to the program provider, that the program provider's failure to meet the SoPs or CoPs or noncompliance with state rules indicates:

(A) a pattern of error in a particular discipline, such as nursing or psychology; or

(B) deficient program provider practices or procedures, such as inadequate staffing or insufficient staff training; or

(4) it is determined:

(A) during a follow-up certification review that the program provider failed to correct previous findings of the survey and did not meet one or more additional SoPs, CoPs, or state rules; and

(B) that the program provider's continued failure to meet the SoPs, CoPs, or state rules indicates significant deficient practices that resulted in or may result in serious injury to or death of an individual residing in the program provider's facility.

(b) When making a determination in accordance with subsection (a) of this section, DADS reviews the inspection or survey reports documenting the program provider's failure to meet the SoPs, CoPs, or state rules, which may include a description of:

(1) the situation or occurrence that led to the deficiency;

(2) the program provider's response to the situation or occurrence; and

(3) the program provider's practices at the time of the situation or occurrence.

(c) DADS imposes a DPoC or vendor hold in accordance with subsection (a) of this section only on a facility that has been determined to meet the criteria described in subsection (a)(1), (2), (3), or (4) of this section.

### **§9.267. Directed Plan of Correction and Vendor Hold Based on State Survey Agency Findings.**

*Effective: March 31, 2002*

(a) The department will send written notice to the program provider of its intent to impose a DPoC, a vendor hold, or both in accordance with §419.266 of this title (relating to Department Review of State Survey Agency Findings).

(b) Within 10 days after receipt of a notice of intent to impose a DPoC sent in accordance with subsection (a) of this section, a program provider may submit written recommendations to the department regarding the content of the DPoC.

(c) The department will send the final DPoC to the program provider within 30 days after the date of the notice sent in accordance with subsection (a) of this section.

(d) The department will monitor a program provider to determine if the program provider has implemented or completed the DPoC. Such monitoring may include reviews of documentation and on-site facility visits.

(e) If a facility is the subject of a DPoC and the facility fails to implement the DPoC, the department may impose a vendor hold on payments due under the provider agreement for that facility.

(f) The department will release a vendor hold imposed in accordance with subsection (e) of this section if the department determines that the program provider has implemented the DPoC.

(g) The department will release a vendor hold imposed in accordance with §419.266 of this title (relating to Department Review of State Survey Agency Findings) if the state survey agency determines that the program provider meets the SoPs, CoPs, or state rules that caused the vendor hold. Prior to such a determination, the department may release such a vendor hold if the state survey agency determines that circumstances of immediate jeopardy identified by the state survey agency have been removed.

### **§9.268. Termination of Provider Agreement.**

*Effective: November 4, 2013*

(a) DADS may terminate a provider agreement:

(1) for reasons set forth in federal or state laws, rules or regulations, including this subchapter and 1 TAC Chapter 355 (relating to Reimbursement Rates);

(2) if the program provider fails to comply with the terms of the provider agreement, including failure of the program provider's facility to maintain ICF/IID Program certification;

(3) if federal or state laws, rules or

DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS)  
40 TAC, CHAPTER 9, SUBCHAPTER E  
ICF/IID PROGRAMS – CONTRACTING

regulations are enacted, amended, repealed or judicially interpreted so as to render the fulfillment of the provider agreement by either the program provider or DADS unfeasible or impossible, and DADS and program provider cannot agree upon amendments to the provider agreement necessary to comply with such changes to laws, rules or regulation;

(4) if a certification made by the program provider in the provider agreement is false or becomes inaccurate;

(5) if DADS determines that a program provider has failed to implement a DPoC in accordance with §9.267 of this division (relating to Directed Plan of Correction and Vendor Hold Based on State Survey Agency Findings); or

(6) if, during an 18-month period, three vendor holds are imposed on payments due under that provider agreement in accordance with §9.267 of this division.

(A) A vendor hold may be used to terminate a provider agreement in accordance with this paragraph regardless of whether there was an actual interruption of payment to the program provider.

(B) A vendor hold may be used no more than once to terminate a provider agreement in accordance with this paragraph.

(b) If DADS proposes to terminate a provider agreement, DADS may place a vendor hold on payments due to the program provider under the provider agreement until:

(1) an audit of the program provider's financial records, conducted in accordance with §9.269 of this division (relating to Audits) is completed;

(2) a review of the program provider's fiscal accountability cost report, conducted in accordance with 1 TAC §355.452 (relating to Cost Reporting Procedures) and 1 TAC §355.457 (relating to Cost Finding Methodology) is completed; and

(3) any amounts owed to DADS as a result of the audit and review are resolved.

(c) If DADS proposes to terminate a provider agreement, DADS sends a written notice of the proposed termination to the program provider. The program provider may submit a written request for

an informal reconsideration (IR) in accordance with paragraph (1) of this subsection.

(1) DADS considers a request for an IR only if the program provider submits the request and any supporting documentation the program provider wants DADS to consider to DADS, within seven days after receiving DADS notice of proposed termination.

(2) If the program provider submits a timely request for an IR, DADS provides a written response to the program provider affirming or reversing the proposed termination.

(3) If the program provider does not submit a timely request for an IR, or DADS affirms the proposed termination, DADS proceeds with the proposed termination in accordance with subsection (d) of this section.

(d) If DADS proposes to terminate a provider agreement after the process described in subsection (c) of this section, DADS sends a second written notice of the proposed termination to the program provider. The program provider may submit a written request for an administrative hearing in accordance with 1 TAC §357.484 (relating to Request for a Hearing).

(e) If DADS proposes to terminate a provider agreement and the program provider requests an administrative hearing in accordance with 1 TAC §357.484, DADS does not terminate the provider agreement before the completion of the administrative hearing, but payments to the program provider may be withheld by DADS.

(1) If the final decision of the administrative hearing is favorable to DADS or the program provider does not make a timely request for an administrative hearing, then payments withheld will not be made by DADS to the program provider.

(2) If the final decision is favorable to the program provider, then DADS pays amounts withheld and resumes payment under the provider agreement.

(f) If DADS terminates a provider agreement, DADS does not enter into a new provider agreement with the program provider until at least two days have elapsed from the effective date of the termination.

(g) DADS may enter into a new provider

DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS)  
40 TAC, CHAPTER 9, SUBCHAPTER E  
ICF/IID PROGRAMS – CONTRACTING

agreement with a program provider that has had its provider agreement terminated if:

(1) within 30 days after termination, the program provider requests a new provider agreement; and

(2) within 90 days after termination, DADS determines that all deficiencies or actions that led to termination of the provider agreement have been corrected and the program provider is otherwise qualified to enter into a provider agreement.

(h) In determining whether to enter into a new provider agreement with a program provider that has had its provider agreement terminated, DADS considers:

(1) the nature, severity, and pervasiveness of the deficiencies or actions that led to termination of the provider agreement; and

(2) the facility's or the program provider's history of compliance with ICF/IID Program requirements.

(i) The term and effective date of a new provider agreement entered into in accordance with subsection (f) of this section will be determined by DADS.

(j) If DADS determines not to enter into a new provider agreement:

(1) a local authority must assist DADS in relocating individuals who choose to move from the facility; and

(2) the program provider must assist DADS or the local authority in relocating individuals who choose to move from the facility.

**§9.269. Audits.**

*Effective: September 1, 2001*

(a) The department will periodically audit a program provider to monitor compliance with §419.219 of this subchapter (relating to Provider Reimbursement) and Division Six (relating to Personal Funds). The department will notify the program provider of the audit date.

(b) A program provider must maintain the following records;

(1) personal funds records, as described in §419.256(h) of this title (relating to Program Provider-Managed Personal Funds);

(2) trust fund account ledgers, as described

in §419.256(c)(1)(A) and (c)(2)(A) of this title (relating to Program Provider-managed Personal Funds);

(3) statements from financial institutions regarding trust fund accounts;

(4) petty cash fund ledgers as described in §419.256(d)(3) of this title (relating to Program Provider-Managed Personal Funds);

(5) written requests for personal funds from trust fund accounts, as described in §419.257 of this title (relating to Requests for Personal Funds from Trust Fund Accounts);

(6) documentation of expenditures and deposits of personal funds, as described in §419.256(i) of this title (relating to Program Provider-Managed Personal Funds);

(7) documentation of an individual's ability to manage personal funds and decisions regarding management of personal funds, as described in §419.253 of this title (relating to Determining Management of Personal Funds);

(8) documentation regarding requests for specific types or brands of items and services, as described in §419.255(a) of this title (relating to Items and Services Purchased With Personal Funds);

(9) applied income ledgers, as described in §419.260(c) of this title (relating to Applied Income);

(10) applied income payment plans from TDHS;

(11) agreements to hold the individual's residential placement in the facility as described in §419.227(j) of this title (relating to Discharge From a Facility);

(12) statements from financial institutions regarding operating accounts;

(13) facility census and admission/discharge records;

(14) leave records as described in §419.226 of this title (relating to Leaves); and

(15) IPP's and supporting documentation.

(c) If the records required by subsection (b) of this section, or any other records required to be maintained by this subchapter, are not made available by the program provider when requested by the department, or the department determines

that the records are not auditable, the department may impose a vendor hold on payments due to the program provider under the provider agreement until the records are available and auditable. If the program provider does not provide such records in accordance with instructions from the department, the department may terminate the provider agreement.

(d) The department will provide the program provider with a report of the audit findings, which may include corrective actions that must be taken by the program provider and internal control recommendations that may be followed by the program provider. Corrective actions include making refunds to individuals or the department, entering ledger adjustments, submitting unidentified funds to the department, and establishing and maintaining records and systems. The program provider may request an administrative hearing in accordance with Division Eight of this subchapter (relating to Administrative Hearings) to contest corrective actions required by the department pursuant to this subsection.

(e) If the report of audit findings requires corrective actions and the program provider does not make a request for an administrative hearing in accordance with Division 8 of this subchapter (relating to Administrative Hearings), the program provider must complete corrective actions within 60 days after receiving the report of audit findings.

(f) If the program provider does not complete corrective actions required by the department within 60 days after receiving the report of audit findings, the department may:

(1) impose a vendor hold on payments due to the program provider under the provider agreement until the program provider completes corrective actions;

(2) recoup payments due to the program provider under the provider agreement to make refunds to individuals or the department; and

(3) terminate the provider agreement.

(g) Notwithstanding the other provisions set forth in this section, the department may terminate the provider agreement for repeated failure to comply with §419.219 of this subchapter (relating to Provider Reimbursement) and Division Six

(relating to Personal Funds), as determined by audits conducted in accordance with this section.

#### **§9.270. Suspension of Payments.**

*Effective: November 4, 2013*

(a) DADS suspends payments owed to a program provider under a provider agreement if DADS is notified by the Health and Human Services Commission Office of Inspector General (OIG) that payments must be withheld because of receipt of reliable evidence involving fraud or willful misrepresentation under the Medicaid Program in accordance with 42 CFR §455.23(a).

(b) DADS suspends payments in accordance with subsection (a) of this section until:

(1) OIG notifies DADS that it must pay amounts suspended and resume payment under the provider agreement; or

(2) OIG notifies DADS that it must terminate the provider agreement in accordance with §9.268 of this division (relating to Termination of Provider Agreement.)

#### **§§9.271.-9.272. (Reserved.)**

### **DIVISION 8. ADMINISTRATIVE HEARINGS**

#### **§9.273. Administrative Hearings.**

*Effective: July 26, 2001*

(a) A program provider may request an administrative hearing in accordance with Chapter 409, Subchapter B of this title (relating to Adverse Actions) if the department takes or proposes to take the following action:

(1) vendor hold;

(2) termination of a provider agreement;

(3) recoupment of payments made to the program provider; or

(4) denial of a program provider's request for payment.

(b) If the basis of an administrative hearing requested under subsection (a) of this section is a dispute regarding a LON assignment, a program provider may receive an administrative hearing only if reconsideration was requested by the program provider in accordance with department rule.

## **DIVISION 9. HOSPICE SERVICES**

### **§9.274. Hospice Services.**

*Effective: January 5, 2003*

(a) An individual may elect to receive hospice care in a facility if the individual is eligible for such care in accordance with 40 TAC §30.10 (relating to Eligibility Requirements). An individual's LAR or surrogate decision-maker, appointed in accordance with §405.237 of this title (relating to Appointment and Qualifications of a Surrogate Decision-Maker), may elect hospice care for the individual.

(b) If hospice care is elected for an individual in accordance with 40 TAC §30.16 (relating to Election of Hospice Care), the program provider for the individual must contract with the designated hospice or discharge the individual in accordance with §419.227 of this title (relating to Discharge from a Facility).

(c) Before hospice care is provided to an individual at a facility:

(1) the program provider and the hospice must execute a contract, as described in subsection (d) of this section;

(2) the program provider and the hospice must review the individual's MR/RC Assessment to determine if a revision to the individual's LON is needed in accordance with §419.246 of this subchapter (relating to Renewal and Revision of Level of Need);

(3) the program provider must provide a signed copy of the completed MR/RC Assessment to the hospice; and

(4) the program provider must notify the TDMHMR Help Desk at (888) 952-4357 that the individual has elected to receive hospice care.

(d) A contract between a program provider and a hospice must establish the amount the hospice will pay the program provider for the individual's room and board and must require the hospice and the program provider to develop a plan of care for the individual. In this section, "room and board" includes performance of personal care services, including assistance with activities of daily living, administration of medication, maintaining the cleanliness of an individual's room, and supervision and assistance with durable medical

equipment and prescribed therapies.

(e) A program provider must continue to provide services in accordance with this subchapter to an individual receiving hospice care in a facility. If the individual, or the LAR on the individual's behalf, chooses continued participation in active treatment and such treatment, in the opinion of the individual's physician, is not contraindicated by the individual's condition, it must be provided in accordance with the individual's ability to participate in it.

(f) A program provider must pay the quality assurance fee described in 1 TAC Chapter 352 (relating to Quality Assurance Fee for Long-Term Care Facilities) for an individual receiving hospice care in a facility of the program provider.

(g) Hospice staff will not be considered facility staff to establish or maintain a staff-to-client ratio.

## **DIVISION 10. SURROGATE DECISION-MAKING**

### **§9.281. Purpose.**

*Effective: July 1, 2007*

(a) The purpose of this division is to describe a process by which certain treatment decisions are made by an IDT, surrogate decision-maker, or surrogate consent committee on behalf of an individual who lacks the capacity to make an informed decision about the proposed treatment, medication, or procedure and has no LAR. A treatment decision involves giving or denying consent for a treatment, medication, or procedure for an individual.

(b) The process described in this division applies only to a treatment decision for an individual regarding:

- (1) the use of a psychoactive medication;
- (2) a highly restrictive procedure;
- (3) major medical treatment;
- (4) major dental treatment;
- (5) a risk to individual protection and rights; or
- (6) the release of records related to the individual's condition or treatment to facilitate the

treatment to which a surrogate decision-maker or surrogate consent committee has consented.

(c) This division does not apply to a decision for an individual regarding:

- (1) experimental research;
- (2) sterilization;
- (3) management of funds;
- (4) electroconvulsive treatment; or
- (5) abortion.

### **§9.282. Application.**

*Effective: July 1, 2007*

This division applies to a community program provider. It does not apply to a program provider acting on behalf of a campus-based facility.

### **§9.283. Informed Decision Assessment.**

*Effective: July 1, 2007*

(a) If a community program provider is seeking a decision regarding any of the matters described in §9.281(b)(1)-(5) of this division (relating to Purpose) for an adult individual who does not have an LAR, the community program provider must conduct an assessment of the individual to determine whether the individual has the capacity to make an informed decision.

(b) To conduct the assessment, the community program provider must:

(1) provide the following information to the individual:

(A) a description of the condition that the proposed treatment, medication, or procedure is intended to improve or cure;

(B) a description of the proposed treatment, medication, or procedure, including:

(i) the individual's need for it; and  
(ii) the potential benefits and risks of it to the individual;

(C) a description of any generally accepted alternatives to the proposed treatment, medication, or procedure, including the risks and potential benefits of the alternatives to the individual;

(D) the reasons the alternatives were not proposed for the individual, if applicable;

(E) the time frames involved, such as immediacy of the need for the proposed treatment,

medication, or procedure and the length of time that consent will be effective; and

(F) that the individual has the right to refuse to give consent or withdraw consent;

(2) take into consideration the individual's values and beliefs; and

(3) determine whether the individual has the capacity to make an informed decision by demonstrating a basic understanding of the information provided in paragraph (1) of this subsection and communicating a decision, free from coercion or undue influence, about the proposed treatment, medication, or procedure.

(c) The community program provider must provide the information described in subsection (b)(1) of this section in non-technical terminology by using the individual's primary language or mode of communication.

(d) The community program provider must document the following:

(1) the specific information provided to the individual as described in subsection (b)(1) of this section; and

(2) the reasons the community program provider determined that the individual does or does not have the capacity to make an informed decision.

### **§9.284. Making Informed Decisions.**

*Effective: July 1, 2007*

(a) If, based on the assessment described in §9.283 of this division (relating to Informed Decision Assessment), a community program provider determines that an individual has the capacity to make an informed decision and to communicate the decision, free from coercion or undue influence, about the proposed treatment, medication, or procedure, the community program provider must allow the individual to consent to or refuse the proposed treatment, medication, or procedure.

(b) If, based on the assessment described in §9.283 of this division, the community program provider determines that the individual does not have the capacity to make an informed decision about the proposed treatment, medication, or procedure, the community program provider must obtain an informed decision from:

(1) the individual's IDT, in accordance with §9.285 of this division (relating to IDT Decisions);

(2) a surrogate decision-maker in accordance with §9.286 of this division (relating to Surrogate Decision-Maker); or

(3) a surrogate consent committee in accordance with §9.288 of this division (relating to Surrogate Consent Committee Decisions), §9.289 of this division (relating to Submission of Application Packet for Surrogate Consent Committee), §9.291 of this division (relating to Notice of Hearing and Documents Provided to Surrogate Consent Committee), and §9.293 of this division (relating to Surrogate Consent Committee Hearing).

#### **§9.285. IDT Decisions.**

*Effective: July 1, 2007*

(a) An IDT may:

(1) consent to the following changes regarding administration of a psychoactive medication subsequent to the initial consent for the medication given by a surrogate consent committee, if such changes pose no significant risk to an individual based on the judgment of the prescribing health care professional and other health care professionals involved in the individual's care:

(A) an increase or decrease in the dosage of the medication; and

(B) a change of medication within the same therapeutic drug class; and

(2) make a decision that involves risk to the individual protection and rights not specifically reserved to a surrogate decision-maker or a surrogate consent committee.

(b) An IDT's consent to a change regarding the administration of a psychoactive medication, as described in subsection (a)(1) of this section, is only valid until the expiration of the initial consent by the surrogate consent committee.

(c) The IDT must document, in the individual's record, a decision made in accordance with subsection (a) of this section, including the deliberations of the IDT in reaching the decision.

#### **§9.286. Surrogate Decision-Maker.**

*Effective: July 1, 2007*

(a) A community program provider must develop and implement written procedures for identifying and using a surrogate decision-maker in accordance with the provisions of this division.

(b) A surrogate decision-maker may:

(1) consent to major medical treatment;

(2) consent to major dental treatment;

(3) consent to release of records related to the individual's condition or treatment to facilitate the treatment to which the surrogate decision-maker has consented; and

(4) make a decision that involves risk to individual protection and rights.

(c) A surrogate decision-maker may not consent to the use of psychoactive medication or a highly restrictive procedure.

(d) If, based on the assessment described in §9.283 of this division (relating to Informed Decision Assessment), a community program provider determines that an individual does not have the capacity to make an informed decision about matters listed in subsection (b) of this section, the community program provider must determine if one of the following persons, in order of descending preference, is available and willing to act as the surrogate decision-maker for the individual:

(1) an actively involved spouse;

(2) an actively involved adult child who has the waiver and consent of all other actively involved adult children of the individual to act as the sole decision-maker;

(3) an actively involved parent or stepparent;

(4) an actively involved adult sibling who has the waiver and consent of all other actively involved adult siblings of the individual to act as the sole decision-maker; or

(5) any other actively involved adult relative who has the waiver and consent of all other actively involved adult relatives of the individual to act as the sole decision-maker.

(e) If a community program provider is aware of a dispute as to the right of a person to act as a surrogate decision-maker, the community program provider must inform the persons involved that the

dispute may be resolved only by a court of record under the Texas Probate Code, Chapter XIII.

(f) If a community program provider identifies a person to be a surrogate decision-maker in accordance with subsection (d) of this section, the community program provider must document the identity of that person in the individual's record.

(g) If a community program provider is unable to identify a surrogate decision-maker in accordance with subsection (d) of this section, including because of an unresolved dispute, the community program provider must document the reason the community program provider was unable to identify a surrogate decision-maker.

**§9.287. Provider Responsibilities Regarding Surrogate Decision-Maker.**

*Effective: July 1, 2007*

(a) A community program provider must provide the following information to a person identified as a surrogate decision-maker in accordance with §9.286 of this division (relating to Surrogate Decision-Maker):

(1) a description of the condition that the proposed treatment, medication, or procedure is intended to improve or cure;

(2) a description of the proposed treatment, medication, or procedure, including:

(A) the individual's need for it; and

(B) the potential benefits and risks of it to the individual;

(3) a description of any generally accepted alternatives to the proposed treatment, medication, or procedure, including the risks and potential benefits of the alternatives to the individual;

(4) the reasons the alternatives were not proposed for the individual, if applicable;

(5) the time frames involved, such as immediacy of the need for the proposed treatment, medication, or procedure and the length of time that consent will be effective; and

(6) that the surrogate decision-maker may:

(A) refuse to give consent or withdraw consent after it is given;

(B) defer to a surrogate consent committee for a specific decision; and

(C) withdraw as the surrogate decision-maker.

(b) A community program provider must document in the individual's record:

(1) the specific information provided to the surrogate decision-maker as described in subsection (a) of this section;

(2) the decision made by the surrogate decision-maker, and:

(A) if consent is given, include a copy of the written consent given by the surrogate decision-maker; or

(B) if consent is denied, document the reason for the denial, if known;

(3) withdrawal of consent after it is given by the surrogate decision-maker and, if known, the reason for the withdrawal;

(4) deferral by the surrogate decision-maker for a specific decision and, if known, the reason for the deferral; and

(5) withdrawal of the surrogate decision-maker and, if known, the reason for the withdrawal.

**§9.288. Surrogate Consent Committee Decisions.**

*Effective: July 1, 2007*

A surrogate consent committee may:

(1) consent to the use of a psychoactive medication;

(2) consent to the use of a highly restrictive procedure;

(3) consent to major medical treatment;

(4) consent to major dental treatment;

(5) make a decision that involves risk to individual protection and rights; and

(6) consent to release of records related to the individual's condition or treatment to facilitate the treatment to which the surrogate consent committee has consented.

**§9.289. Submission of Application Packet for Surrogate Consent Committee.**

*Effective: July 1, 2007*

(a) A community program provider must submit an application packet for a treatment decision by a surrogate consent committee, as described in §9.288 of this division (relating to Surrogate Consent Committee Decisions), if:

(1) the community program provider is unable to identify a surrogate decision-maker in accordance with §9.286(d) of this division (relating to Surrogate Decision-Maker), including because of an unresolved dispute described in §9.286(e) of this division;

(2) an identified surrogate decision-maker has deferred a specific decision to the surrogate consent committee; or

(3) the community program provider is seeking a decision regarding the use of a psychoactive medication or a highly restrictive procedure.

(b) A community program provider must submit an application packet for a treatment decision in accordance with written instructions from DADS. The application packet must include:

(1) a completed, original SDM Form 2700, Application for a Treatment Decision by a Surrogate Consent Committee;

(2) a completed, original SDM Form 2725, List of Persons to Receive Notification of SCC Hearing;

(3) a completed, original SDM Form 2750, SDM Data Form;

(4) the applicable certification of need form; and

(5) appropriate supporting documentation.

(c) The instructions and forms described in subsection (b) of this section are available on the DADS website at [www.dads.state.tx.us](http://www.dads.state.tx.us).

(d) Upon request by DADS, the community program provider must submit additional information related to the application packet for a treatment decision.

(e) If DADS determines that the community program provider has not completed the application process within a reasonable period of time, DADS does not proceed with the application process and closes the case.

(f) If DADS closes the case and a treatment decision is still required in accordance with subsection (a) of this section, the community program provider must submit a new application packet in accordance with subsection (b) of this section.

(g) DADS notifies the community program provider, in writing, if DADS closes the case.

(h) If DADS approves an application packet for a treatment decision, DADS appoints a surrogate consent committee in accordance with §9.290 of this division (relating to Appointment and Qualifications of a Surrogate Consent Committee).

### **§9.290. Appointment and Qualifications of a Surrogate Consent Committee.**

*Effective: July 1, 2007*

(a) If DADS approves an application packet for a treatment decision, DADS appoints a surrogate consent committee that:

(1) is composed of at least three but not more than five volunteers who:

(A) are 18 years of age or older;

(B) are not employees or contractors of the community program provider;

(C) do not manage or exercise supervisory control over:

(i) the community program provider or the employees of the community program provider; or

(ii) any company, corporation, or other legal entity that manages or exercises control over the community program provider or the employees of the community program provider;

(D) do not have a financial interest in the community program provider or in any company, corporation, or other legal entity that has a financial interest in the community program provider;

(E) are not parents, siblings, spouses, or children of the individual for whom a treatment decision is being sought; and

(F) have completed a training program conducted by DADS; and

(2) includes at least one volunteer who:

(A) is a health care professional who is licensed or registered in Texas and who has specialized training in medicine, psychopharmacology, nursing, or psychology; or

(B) has demonstrated expertise or interest in the care and treatment of individuals with mental retardation.

(b) DADS appoints one of the volunteers on the surrogate consent committee to be chairperson of the committee.

**§9.291. Notice of Hearing and Documents Provided to Surrogate Consent Committee.**

*Effective: July 1, 2007*

(a) DADS sends notice of a surrogate consent committee hearing to:

(1) each volunteer on the surrogate consent committee; and

(2) the community program provider.

(b) The notice described in subsection (a) of this section includes:

(1) the date, time, and location of the hearing;

(2) the name of the individual for whom a treatment decision is sought; and

(3) the type of treatment decision to be considered at the hearing.

(c) DADS sends each volunteer on the surrogate consent committee, in addition to the notice of hearing described in subsection (a) of this section:

(1) relevant portions of the application packet; and

(2) a written consultation from a DADS health care professional licensed or registered in Texas to assist the committee in determining the individual's best interest regarding the treatment decision.

(d) A community program provider must give notice of the surrogate consent committee hearing to:

(1) the individual for whom a treatment decision is being sought;

(2) the individual's actively involved spouse, adult child, parent, adult sibling, stepparent, or other adult relative; and

(3) any person known to have a demonstrated interest in the care and welfare of the individual, such as an advocate or a friend identified by the individual.

(e) Concerning a notice required by subsection (d)(1) of this section, a community program provider must:

(1) include in the notice:

(A) the date, time, and location of the hearing; and

(B) the type of treatment decision to be considered at the hearing;

(2) explain the notice to the individual

using the individual's primary language or mode of communication; and

(3) document that the explanation required in paragraph (2) of this subsection was given.

(f) Concerning a notice required by subsection (d)(2) and (3) of this section, a community program provider must:

(1) include in the notice:

(A) the date, time, and location of the hearing;

(B) the name of the individual for whom a treatment decision is sought;

(C) the type of treatment decision to be considered at the hearing;

(D) a copy of the completed, original SDM Form 2700, Application for a Treatment Decision by a Surrogate Consent Committee; and

(E) a statement concerning the opportunity to:

(i) attend the hearing and present evidence or testimony personally or through a representative; and

(ii) appeal the surrogate consent committee's decision in accordance with THSC, §597.053; and

(2) send the notice in writing and by certified mail.

**§9.292. Review and Consultation Prior to Hearing.**

*Effective: July 1, 2007*

(a) Before a surrogate consent committee hearing, the chairperson of the committee must review the documentation described in §9.291(c) of this division (relating to Notice of Hearing and Documents Provided to Surrogate Consent Committee) and determine if additional information is needed to assist the committee in making a treatment decision.

(b) If the chairperson determines that additional information is needed, the chairperson must request the information from DADS.

(c) Before the hearing, a volunteer on the surrogate consent committee may interview and observe the individual for whom the treatment decision is sought and consult with a person who may be able to provide information to assist the committee in making the treatment decision,

including information about the personal opinions, beliefs, and values of the individual.

**§9.293. Surrogate Consent Committee Hearing.**

*Effective: July 1, 2007*

(a) A person notified of a surrogate consent committee hearing, as required by §9.291(a) and (d) of this division (relating to Notice of Hearing and Documents Provided to Surrogate Consent Committee), is entitled to be present at the hearing and to present evidence or testimony personally or through a representative.

(b) A community program provider must ensure that:

(1) the individual for whom the treatment decision is sought is present at the hearing, if practicable;

(2) the individual's record is at the hearing; and

(3) an audio recording of the hearing is made.

(c) At a surrogate consent committee hearing, the committee:

(1) must review the documentation described in §9.291(c) of this division and any additional information provided to the committee by DADS;

(2) must interview and observe the individual, if practicable, and document its impressions of the interview and observation;

(3) must review evidence or hear testimony from a person notified of the hearing as required by §9.291(a) and (d) of this division, or the person's representative, if the person or the person's representative makes a request to present evidence or testimony at the hearing; and

(4) may review evidence or hear testimony from any person who may be able to assist the committee in making a treatment decision.

(d) After the surrogate consent committee has reviewed all evidence and heard all testimony, the committee must enter into closed deliberations and make the treatment decision.

(e) In making the treatment decision, the surrogate consent committee must determine, based on clear and convincing evidence, whether the proposed treatment, medication, or procedure is in the best interest of the individual.

(1) If a majority of the volunteers on the surrogate consent committee determine that the proposed treatment, medication, or procedure is in the best interest of the individual, the committee must consent to the proposed treatment, medication, or procedure.

(2) If a majority of the volunteers on the surrogate consent committee determine that the proposed treatment, medication, or procedure is not in the best interest of the individual, the committee must deny consent to the proposed treatment, medication, or procedure.

(f) If the surrogate consent committee consents to the proposed treatment, medication, or procedure, the committee must determine the date on which the consent becomes effective and the duration of the consent.

(g) If an application for a guardianship proceeding for the individual has been filed before the surrogate consent committee makes a treatment decision, the committee must, before continuing with the hearing, make one of the following determinations:

(1) a person has not been appointed guardian of the person for the individual within five days after suspension of the committee proceeding in accordance with §9.294 of this division (relating to Notice of Guardianship Proceeding); or

(2) there is a medical necessity, based on clear and convincing evidence, that the treatment decision be made within five days after the hearing date.

(h) Formal rules of evidence are not applicable to a surrogate consent committee hearing.

(i) A surrogate consent committee must conduct the hearing and document its treatment decision in accordance with written instructions from DADS available at [www.dads.state.tx.us](http://www.dads.state.tx.us).

(j) A community program provider must:

(1) send to DADS in accordance with written instructions from DADS available at [www.dads.state.tx.us](http://www.dads.state.tx.us):

(A) the audio recording of a hearing made in accordance with subsection (b) of this section;

(B) the documentation completed by the surrogate consent committee; and

(C) the written evidence presented at the hearing; and

(2) send to a person notified of a surrogate consent committee hearing, as required by §9.291(a) and (d) of this division, the documentation completed by the surrogate consent committee.

**§9.294. Notice of Guardianship Proceeding.**

*Effective: July 1, 2007*

(a) If before a surrogate consent committee makes a treatment decision, the committee is informed that an application for a guardianship proceeding for an individual has been filed with a court, the chairperson of the committee must suspend the committee proceeding for five days unless a medical necessity exists that requires a treatment decision to be made during the five-day period.

(b) If the chairperson suspends a committee proceeding and a person has not been appointed guardian for the individual within five days after the suspension, the chairperson must resume the committee proceeding.

**§9.295. Liability for Treatment Decision.**

*Effective: July 1, 2007*

A surrogate decision-maker or volunteer on a surrogate consent committee who consents or denies consent on behalf of an individual and who acts in good faith, reasonably, and without malice is not criminally or civilly liable for that action.

# COMMUNITY ICF/MR LIVING OPTIONS INSTRUMENT

## Purpose

*The Community ICF/MR Living Options instrument was designed to standardize criteria and objectify the process of making living option recommendations upon admission into the ICF/MR program, at the annual planning conference, or any time interest is indicated in an alternative living arrangement by an individual or legally authorized representative (LAR).*

## Instructions

1. The Living Options Instrument must be utilized by the Interdisciplinary Team as a guide to planning conferences with the individual/LAR when living options are discussed.
2. Prior to using the Living Options Instrument, the ICF/MR provider will ensure that facility staff participating in planning conferences with the individual/LAR have received adequate training on the use of the instrument.
3. Items on the Living Options Instrument will be incorporated as an essential element of interdisciplinary team policy and procedure at each facility, and will serve as the basis for all planning conferences with the individual/LAR at which living options are discussed.
4. Staff at each facility will coordinate monitoring of planning conferences to assure the process is being utilized as designed.
5. Staff at each facility will coordinate monitoring of record documentation (on a random basis) to evaluate the written product for a specified period of time.

**Questions**

Staff is encouraged to obtain this information using an approach that is focused on the preferences of the individual/LAR. Each of the factors below should be addressed by the IDT. Documentation in the IDT staffing summary will include: a) source of the information; b) relevant deliberation; and c) outcome of the discussion. Final recommendations will address individual/LAR preferences regarding living options.

Information obtained from this instrument should be used to update the individual's program plan for the ICF/MR program. Additionally, when an alternative living arrangement is requested, the information will be used by the MRA to identify appropriate community resources and to develop the individual's service coordination plan.

<b>FACTORS</b>	<i>ESSENTIAL ELEMENTS</i>
<b>Person's Preference</b>	<ul style="list-style-type: none"> <li>• Does the latest planning conference with the individual indicate a clear preference of where the individual wishes to live? If so, where?</li> <li>• What information has been provided to the individual related to living options?</li> <li>• What is the source of this information? Where is this documented?</li> <li>• What was the individual's preference in his/her last planning conference?</li> <li>• Is there a noted change in his/her preference compared to the previous planning conference? If so, why?</li> </ul>
<b>LAR/Family Preference</b>	<ul style="list-style-type: none"> <li>• Does the individual have a legally authorized representative (LAR)?</li> <li>• If there is no LAR, does the individual have family involvement and/or other natural supports?</li> <li>• What information has been provided to the LAR and family/natural supports related to living options and permanency planning?</li> <li>• What is the LAR and family/natural support's stated preference?</li> <li>• What is the source of this information? Where is this documented?</li> </ul>
<b>Medical Issues</b>	<ul style="list-style-type: none"> <li>• Does this individual have medical/nursing needs? If so, what are they?</li> <li>• What would enable these needs to be met in an alternative living arrangement?</li> <li>• What can facility/MRA staff do to support/facilitate these needs being met in an alternative living arrangement (e.g., in-service training, extended trial visits, professional consults, provision of adaptive equipment, respite, etc.)?</li> </ul>
<b>Behavioral/Psychiatric Issues</b>	<ul style="list-style-type: none"> <li>• Does the individual have behavioral/psychiatric treatment needs?</li> <li>• If so, what are the treatment needs (e.g., behavior management plan, psychoactive medication, etc.)?</li> <li>• What would enable these needs to be met in an alternative setting?</li> <li>• What can facility/MRA staff do to support/facilitate these needs being met in an alternative living arrangement (e.g., in-service training, extended trial visits, psychiatric/ psychological consultation, respite, etc.)?</li> </ul>
<b>Quality of Life</b>	<ul style="list-style-type: none"> <li>• If the individual is a minor, has permanency planning been incorporated in the minor's service plan and reviewed as required?</li> <li>• If the individual is a minor, what efforts have been made to ensure LAR/family participation in service planning activities (including permanency planning issues)?</li> <li>• If a minor, have educational issues been addressed, including contact with the local school district?</li> <li>• What factors are most important to this person in choosing a place to live (e.g., family, friends, employment, special communication needs, leisure, living arrangements, daily routine, privacy, eating, community integration, etc.)?</li> <li>• What would enable these factors to take place for the individual in an alternative living arrangement?</li> <li>• What can facility/MRA staff do to support/facilitate these factors being met in an alternative living arrangement?</li> </ul>
<b>MRA Recommendations/Input</b> <i>(required when an individual/LAR requests an alternative living arrangement)</i>	<ul style="list-style-type: none"> <li>• What alternative living arrangements are available to meet the individual's needs?</li> <li>• Within what timeframe could placement in an alternative living arrangement occur?</li> <li>• Was an MRA representative present at the planning conference?</li> <li>• If not, what was the source of the MRA input?</li> </ul>
<b>Other Issues</b>	<ul style="list-style-type: none"> <li>• Were other factors (issues) discussed at the planning conference? If so, explain.</li> </ul>