Amendment No. 3
1915(c) Home and Community-Based Services Waiver
Consolidated Waiver Program (CWP) HCBSW-#0373

SUMMARY OF AMENDMENT

Replace Reference to Texas Index for Level of Effort (TILE) with Generic Language

Pages 2, 83

This amendment replaces language specific to the Texas Index for Level of Effort (TILE) with generic language referring to the reimbursement rate. This is in anticipation of the implementation, scheduled for September 1, 2008, of the Resource Utilization Group (RUG) rates that will replace the TILE.

Replace Current Cost Ceiling with New Cost Ceiling

Pages 2, 83, new Appendix B-2

This amendment replaces the cost ceilings in the current waiver with the new cost ceilings as a result of the 2008-09 General Appropriations Act (Article II, Texas Department of Aging and Disability Services, Rider 45, 80th Texas Legislature, 2007), effective September 1, 2007. For this reason a new Appendix B-2 is submitted, in the version 3.4 format.

Change in Utilization Review (UR) Procedures

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With the increase in the cost ceiling, UR will become more important. DADS staff will conduct a UR at the time of initiation of the Individual Service Plan (ISP), at the annual renewal of the ISP, and any time that a review is warranted, rather than limiting UR to a specific target.

New Appendix B-2

A new Appendix B-2, Individual Cost Limit, is being submitted in the version 3.4 format. This discusses the cost limits now being applied.

Appendix B-2: Individual Cost Limit

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*:

○	**No Cost Limit**. The State does not apply an individual cost limit. *Do not complete Item B-2-b or Item B-2-c.*
X	**Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.* The limit specified by the State is *(select one)*:
	○ ____ %, a level higher than 100% of the institutional average
	X Other *(specify)*:
	200 percent of the costs that would have been paid for that same individual age 21 or over to receive services in a nursing facility; 50 percent of the costs that would have been paid for that same individual under age 21 to receive services in a nursing facility.
○	**Institutional Cost Limit**. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
○	**Cost Limit Lower Than Institutional Costs**. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. *Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*
	The cost limit specified by the State is *(select one)*:
	○ The following dollar amount: $ ____
	The dollar amount *(select one)*:
	○ Is adjusted each year that the waiver is in effect by applying the following formula:
	○ May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.
	○ The following percentage that is less than 100% of the institutional average: ____ %
	○ Other – *Specify:*

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

The Interdisciplinary Team (IDT) includes the individual, often together with any family or other representative; the DADS case manager; the Home and Community Support Services Agencies (HCSSA) registered nurse; and any other individuals identified by the individual/representative, or by the IDT. The IDT supports the individual's/representative's active participation in the assessment and planning process. The individual/representative has the opportunity to review the assessment of services and to make choices regarding the annual plan of care The DADS case manager informs the individual/representative of the overall cost ceiling and of the individual service cost caps. The IDT reviews evaluative information on the individual, and develops a person-directed plan that includes a description of the current natural supports and non-waiver services that will be available to the individual, as well as a description of the waiver services and supports required for the individual to continue living in his or her own or family home in the community. The members of the IDT sign the plan of care prior to implementation and certify that the waiver services are necessary as an alternative to institutionalization and that they are appropriate to meet the needs of the individual.
An individual whose request for admittance to the waiver is denied or is not acted upon with reasonable promptness is entitled to a fair hearing in accordance with 1 TAC, Part 15, Chapter 357, Subchapter A. DADS must send written notification to the individual or to his/her legally authorized representative (LAR), indicating the individual's right to a fair hearing and the process to follow to request a fair hearing.

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

☐	The participant is referred to another waiver that can accommodate the individual's needs.
☐	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
X	Other safeguard(s) *(specify)*:
	All waiver participants must have a plan of care at a reimbursement rate within the cost ceiling for their age (200 percent of nursing facility reimbursement rate for individuals 21 years of age and older; 50 percent of nursing facility reimbursement rate for individuals under 21 years of age). For CWP participants with needs that exceed the cost ceiling, the State has a process to ensure that their needs are met. The process includes examining third-party resources, other options, or institutional services. The individual will be informed of, and given, the opportunity to request a fair hearing in accordance with 1 TAC, Part 15, Chapter 357, Subchapter A, if the State proposes to terminate the individual's eligibility for the waiver.

d.____ mentally retarded

e.____ developmentally disabled

f.____mentally retarded and/or developmentally disabled

g.____ chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

a. ____ Waiver services are limited to the following age groups (specify): Age 21 and above.

b.____ Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):

c.____ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.

d.__X__ Other criteria. (Specify): Waiver services are limited to individuals who: 1. Live in the geographic area defined in item 9 below; 2. Meet the level of care criteria defined in Appendix D; 3. Have an individual service plan, which does not exceed ~~150% of the Texas Index for Level of Effort (TILE) payment rates as corresponds to the level of care~~ **50 percent of the reimbursement rate that would have been paid for that same individual under age 21 to receive services in a nursing facility; or 200 percent of the reimbursement rate that would have been paid for that same individual age 21 or over to receive services in a nursing facility**; and 4. Is not enrolled in any other 1915(c) Medicaid waiver program.

e.____ Not applicable.

5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.

6. This waiver program includes individuals who are eligible under medically needy groups.

a.____ Yes b.__X__ No

7. A waiver of 1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.

a.____ Yes b.__X__ No c.____ N/A

APPENDIX E-2

a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the ISP is made subject to the approval of the Medicaid agency:

The individual, who is on the interest list for 1915(c) waiver services, is contacted by the staff of DADS to determine if he is interested in CWP. If he chooses to apply for CWP services, a case manager meets with the individual to complete a functional assessment. Medicaid eligibility is verified or the case manager takes an application. The individual's goals, preferences, available third party resources, needs, choice of providers, individuals who they would want to be on the IDT and appropriate living arrangements are considered. Client's rights and responsibilities are discussed. A referral is completed and the applicant is referred to the HCSSA for assessments. The HCSSA provider completes the assessment and it is sent to the case manager. The IDT develops a proposed ISP.

DADS will conduct a utilization review **on each initial and reassessment ISP, and on ISP changes as necessary.** ~~if the proposed ISP has a cost that exceeds 100% of the Nursing Facility Texas Index for Level of Effort for individuals who meet the level of care criteria for medical necessity for nursing facility care; or the estimated annualized per capita cost for ICF/MR services.~~ DADS staff will review the proposed ISP to determine if the type and amount of CWP program services specified in the ISP are appropriate, necessary to prevent institutionalization, and supported by documentation. After reviewing the proposed ISP and supporting documentation, DADS may request additional documentation. DADS will review any additional documentation submitted in accordance with its request. DADS may modify an ISP based on its review and approve the recommended ISP or send written notification that the recommended ISP has been approved with modifications.

The applicant's LOC and/or Medical Necessity, Medicaid eligibility, cost of the ISP, freedom of choice, and any additional eligibility criteria is reviewed to determine and confirm eligibility for CWP services. If the applicant is not approved for services, the enrollment process stops and he is given the opportunity to appeal the decision and have a fair hearing and is referred to appropriate resources. If the applicant is approved for enrollment, the ISP is data entered into the automated system, the case manager authorizes services, and providers initiate the delivery of CWP services.

The case manager has primary responsibility for assessing the participant's need for services, service planning, authorizing services, utilization of non-waiver resources, and monitoring of services. A level of care assessment is conducted at least annually or more frequently if the individual condition changes. The case manager completes a reassessment to review goals, and needs of the participant annually. Services are monitored with quarterly face-to-face visits, and more frequent contact by home visits or telephone when appropriate. A consumer satisfaction survey is conducted quarterly to assure adequacy and appropriateness of services, and to reevaluate goals and preferences. Utilization review may be requested on any ongoing service plan. Participants always have the right to choose or change providers, change their service plan, and revise goals on the person directed plan of care.