SERVICE CUTS IN MEDICAID WAIVER PROGRAMS—
WHO WILL BE AFFECTED,
HOW WILL CUTS BE IMPLEMENTED
AND WHAT ARE YOUR RIGHTS?

Materials Developed by:
The Arc of Texas, Coalition of Texans with Disabilities, EveryChild, Inc., and Disability Rights Texas

In collaboration with:
Texas Council for Developmental Disabilities, Texas Center for Disability Studies at the University of Texas at Austin, and Center on Disability and Development at Texas A&M University

November 2011
Purpose

- Discuss new service limits in the MDCP, CLASS, HCS and CBA Medicaid Waiver Programs*

- Discuss the process being used to reduce service plans or to justify the need for continued services

- Inform individuals of the ability to request exceptions to the new limits

- Make sure individuals know they have right to appeal any service reductions and how to maintain services while the appeal is pending

- Let people know of other ways they might get involved

* Full Medicaid program titles next page
What Is Happening and Why?

The Texas Legislature made cuts to critical Medicaid Waiver Programs (budget cut to waiver programs = $31 million in state funds)

Only higher cost “service plans” will be cut beginning December 1, 2011

Affected Medicaid Waiver Programs:

- Home and Community-Based Services (HCS)
- Community Living Assistance and Support Services (CLASS)
- Medically Dependent Children Program (MDCP)
- Community Based Alternatives (CBA)
The Texas Legislature classified Medicaid Waiver Program Services into two categories:

“Essential” Services include: nursing, emergency respite, home delivered meals, day habilitation, selected residential services, nutritional services, etc.

“Non-Essential” Services are all other Waiver Program services including: adaptive aids, medical supplies, dental, supported home living, personal attendant services, minor home modifications, supported employment, dietary, and therapies (behavioral, occupational, speech, physical). **These services may be critical and essential to you or your family member.

Next, the Texas Legislature wrote and passed a state budget that cuts Medicaid Waiver Program “Non-Essential” services to the 90th percentile AND it goes another step further and calls for the reduction of all CLASS Specialized Therapies to the 75th percentile.
“Percentiles”—What Does That Mean??

Easy Answer:

Higher cost “service plans” may be cut beginning December 1, 2011.
For Those Of You Who Want To Know More About “Percentiles”…

Budget writers took a very detailed look at the costs for delivering every “non-essential service” provided to Texans in the Medicaid Waiver Programs. Remember—The service may be the same (i.e. PHYSICAL THERAPY) but the units of service per person varies depending on the needs of the individual.

- **The “1st Percentile” = lowest cost** (The lowest number of PHYSICAL THERAPY units provided to an individual.)

- **The “50th Percentile” = median / average cost** (The median / average number of PHYSICAL THERAPY units provided to an individual.)

- **The “100th Percentile” = highest cost** (The highest number of PHYSICAL THERAPY units provided to an individual.)
Final Decisions on “Percentile” Reductions

By Texas Legislators

75th Percentile
75% of the individuals receiving SPECIALIZED THERAPIES receive units at or below this cost.

90th Percentile
90% of the individuals receiving “NON-ESSENTIAL SERVICES” receive units at or below this cost.
In order to meet the legislative goal to cut $31 million in the Waiver Programs by limiting the scope, amount and duration of services, the Texas Department of Aging and Disability Services (DADS) lowered the caps for what the Texas Legislature calls “non-essential” services in the HCS, CLASS, MDCP and CBA Medicaid Waiver Programs.

In other words, the 90th and 75th Percentiles mark the new (and much lower!) “caps” for services.

Higher cost “service plans” in HCS, CLASS, MDPC and CBA will be cut beginning December 1, 2011 in order to comply with the new caps for services, unless:

- a Request for Request for Exception to Service Limit Form is submitted and approved by DADS,
- or
- you have requested an appeal within 10 calendar days of receiving a Medicaid fair hearing notice.
What “New Service Limits” Mean For You

Letters from DADS about the “new service limits” were mailed to program providers on September 8th and to program participants on September 23rd.

Those persons over the “new service limits” will be subject to a service plan review process beginning NOW through November 30, 2011.

During the service plan reviews, it will be important that individuals/families be prepared to justify (or prove) their need for services at the current approved levels. There may be some cases where the individual can do with less, but there will also be some cases where any reduction to the number of hours of a particular service will negatively affect the person’s health, safety and welfare in the community.
“New Service Limits”

- Service limit refers to a set amount of units or dollars of services you can get per service plan year.

- The Legislature made budget cuts to the MDCP, CLASS, HCS and CBA Waiver programs and directed DADS to implement the budget cuts by setting “new service limits” for some services in these programs.*

- Service limits on all services **CAN** be exceeded **IF** the person can justify or prove their need for more services.

*Some services already had limits (home modifications).
Important Things to Know About “New Service Limits”

- Limits **CAN BE** exceeded for people who require more services.

- Limits **DO NOT** affect everyone in the waivers:
  - Those that fall below 90th percentile of service utilization for most services or
  - Those that fall below 75th percentile for CLASS Specialized Therapies
  - Those that use “Essential Services” since these service types are not subject to “New Service Limits”

- Limits **DO NOT** change the total maximum cost cap in a waiver and they are not meant to impact waiver eligibility.

- New limits **DO NOT** apply to the Texas Home Living, Deaf Blind with Multiple Disabilities, and Star+Plus Medicaid Waiver programs.

- **EXCEPTIONS TO LIMITS REQUIRE** that exception requests be submitted to DADS by the provider or case manager by a certain date.

- Service reductions **CAN** be appealed and services can remain in place during the appeal process if appealed within 10 calendar days of the receipt of notice.
How and When
Will I Know If I Am Affected?

If one or more service on your service plan has a “new service limit,” you should have been contacted (October 2011).

You should be contacted either in person or by telephone by the following individuals:

<table>
<thead>
<tr>
<th>If You Are In This Program:</th>
<th>Then You Should Be Contacted By:</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDCP</td>
<td>DADS Case Manager</td>
</tr>
<tr>
<td>CLASS</td>
<td>CLASS Case Manager</td>
</tr>
<tr>
<td>HCS</td>
<td>HCS Program Provider or Service Coordinator</td>
</tr>
<tr>
<td>CBA</td>
<td>DADS Case Manager</td>
</tr>
</tbody>
</table>

If you have not received a call or letter and you believe that your current services exceed the new service limits, call your case manager or provider immediately.
What If I Need More Services Than Allowed Under the New Limits?

- Tell your provider, service coordinator, case manager and/or service planning team that:
  1. Your needs require more services than are allowed under the new service limits, AND
  2. That you would like for them to complete and submit a Request for Exception to Service Limit Form on your behalf.

- You are encouraged to work closely with your provider, case manager and/or service planning team to discuss and justify the need for services that exceed the new service limits.
What If I Need More Services Than Allowed Under the New Limits?

Completing the DADS Request for Exception to Service Limit Form

- To justify the need for an exception, you must include information about how the service:
  - Is beneficial
  - Is needed to ensure the person’s health, safety and welfare in the community
  - Is necessary to prevent institutionalization
  - Impacts community involvement
  - Is cost effective
  - What will happen if the service is not available or reduced (i.e. regression, more costly services)
What If I Need More Services Than Allowed Under the New Limits?

Request for Exception to Service Limit Form Must Be Submitted In A Timely Manner

- Make sure the provider and case manager submit the form *within the required time frame*.

<table>
<thead>
<tr>
<th>If They Do Not Meet the Deadline:</th>
<th>If They Meet the Deadline and DADS Denies The Exceptions Request:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your services over the new limits <strong>WILL</strong> be reduced on December 1, 2011.</td>
<td>If you disagree with DADS findings, then appeal the denial or reduction through a Medicaid fair hearing.</td>
</tr>
<tr>
<td>If your services are being reduced, then you should receive a letter from DADS notifying you about the reduction in services. This letter will include a notice of your right to appeal.</td>
<td>NOTE: If you appeal within TEN (10) CALENDAR DAYS, then your current services are maintained during the appeals process.</td>
</tr>
<tr>
<td>NOTE: If you appeal within TEN (10) CALENDAR DAYS, then your current services are maintained during the appeals process.</td>
<td></td>
</tr>
</tbody>
</table>
What If I Need More Services Than Allowed Under the New Limits AND My Needs Are Not Being Represented?

If the service planning team is unable to come to a consensus about what action to take in response to the new service limits (i.e. you state your need to maintain current services levels and the service planning team disagrees with you), you should request your provider or case manager submit a Request for Exception to Service Limit Form on your behalf.

If you believe your provider, case manager or service planning team is NOT adequately representing you and your needs and, they do not submit a Request for Exception to Service Limit Form on your behalf, then contact DADS Consumer Rights & Services (CRS) IMMEDIATELY!

- Be sure to keep note of the date and time you called, as well as the CRS Representative’s name.
- DADS should follow up with you on any specific cases that are reported.
- Remember—you have the right to transfer to another provider and, in CLASS, another case management agency if you feel you are not being served adequately.

DADS Consumer Rights & Services
Call: 1-800-458-9858
Or Email: CRSComplaints@dads.state.tx.us
Community Living Assistance and Support Services (CLASS)
## CLASS Services With New Service Limits
(Updated 10/28/11)

<table>
<thead>
<tr>
<th>CLASS Service</th>
<th>Highest Number of Units Provided Today (Per Year)</th>
<th>New Service Limits—Per Year</th>
<th>Cannot Exceed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptive Aids and Dental</td>
<td>$10,000</td>
<td>$6,935</td>
<td>$10,000</td>
</tr>
<tr>
<td>Minor Home Mods</td>
<td>$10,000 Lifetime Limit</td>
<td>$7,515 Lifetime Limit</td>
<td>$10,000 Lifetime Limit</td>
</tr>
<tr>
<td>Respite</td>
<td>30 Days</td>
<td>29 Days</td>
<td>30 Days (per IPC year)</td>
</tr>
<tr>
<td>Behavioral Support</td>
<td>600 hours</td>
<td>192 hours</td>
<td></td>
</tr>
<tr>
<td>Habilitation</td>
<td>7,305 hours</td>
<td>3,312 hours</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>154 hours</td>
<td>83 hours</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>213 hours</td>
<td>91 hours</td>
<td></td>
</tr>
<tr>
<td>Prevocational Services</td>
<td>$43,656</td>
<td>$13,965</td>
<td></td>
</tr>
<tr>
<td>Specialized Therapies—combined (aquatic, massage, music, recreational, hippo/horseback riding)</td>
<td>$41,733 (combined)</td>
<td>$10,118 (combined)</td>
<td></td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>84 hours</td>
<td>56 hours</td>
<td></td>
</tr>
</tbody>
</table>
# CLASS Services That Do Not Have New Limits

(Updated 10/28/11)

<table>
<thead>
<tr>
<th>CLASS Service</th>
<th>No New Limits Calculated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auditory Integration/Auditory Enhancement Training</td>
<td>N/A</td>
</tr>
<tr>
<td>Behavior Supports</td>
<td>N/A Per DADS 10/28/11</td>
</tr>
<tr>
<td>Case Management</td>
<td>N/A</td>
</tr>
<tr>
<td>Continued Family Services</td>
<td>N/A</td>
</tr>
<tr>
<td>Financial Management Services</td>
<td>N/A</td>
</tr>
<tr>
<td>Nursing Services</td>
<td>N/A</td>
</tr>
<tr>
<td>Nutritional Services</td>
<td>N/A</td>
</tr>
<tr>
<td>Support Consultation</td>
<td>N/A</td>
</tr>
<tr>
<td>Support Family Services</td>
<td>N/A</td>
</tr>
<tr>
<td>Supported Employment</td>
<td>N/A</td>
</tr>
<tr>
<td>Transition Assistance Services</td>
<td>N/A</td>
</tr>
</tbody>
</table>
The Exceptions Process for CLASS
(Additional DADS Second Level Review as of 10/28/11)

You will be contacted by your CLASS case manager.

Your case manager will convene a meeting (in person or on the phone) of your service planning team to review your Individual Plan of Care (IPC).

Discuss with your case manager and/or service planning team your reasons for needing to receive the service in an amount that exceeds the new service limit.

If your case manager and/or service planning team agrees that services are needed in an amount that exceeds the new service limits, your case manager (Case Management Agency) submits to DADS a Request for Exception to Service Limit Form (DADS Form 3626) that explains the reasons (as identified by you, your service planning team and, if needed, your treating professional(s), and Direct Service Agency) you need to receive the service(s) in an amount that exceeds the new service limits.

DADS will review the form and determine whether providing the service(s) in excess of the service limits meets the IPC criteria described in the CLASS program rules.

DADS “second level review” for exception denials and plan of care service reductions/revisions - follow-up with case managers and providers who denied exceptions and program participants who signed revised plans with reductions to ensure understanding and get more information as appropriate.

If services are reduced by DADS, then a Medicaid notice/letter of service reduction is sent to the individual along with the right to appeal through a fair hearing.
The Exception Criteria for CLASS

- If you believe you need to receive the service(s) in an amount that exceeds the new service limits, you must answer the following questions:
  - Why the service is necessary to protect the individual’s health and welfare in the community
  - How the service addresses the individual’s related condition
  - How the service is the most appropriate type and amount of CLASS program service to meet the individual’s needs
  - How the service is cost effective
  - Why the service is not available to the individual through any other source, including the Medicaid State Plan, other governmental programs, private insurance or the individual’s natural supports
  - List non-CLASS resources contacted/accessed
What If I Am Dissatisfied With the Process or Denied an Exception?

- If the service planning team is unable to come to a consensus about what action to take in response to the new service limits (i.e. you state your need to maintain current services levels and the service planning team disagrees with you), you should request case manager (CMA) submit a Request for Exception to Service Limit Form (DADS Form 3626) on your behalf.

- If dissatisfied with how your case manager, program provider and/or service planning team handled your exception request, you should contact DADS Consumer Rights and Services (CRS) by calling 1-800-458-9858 or emailing CRScomplaints@dads.state.tx.us.

- If not granted an exception, you will receive a notice explaining how you can request a fair hearing to appeal the decision. Appeal the decision within 10 calendar days in order to keep the same amount of services during the appeals process.
On September 7, 2011, a list of individuals who exceed one or more service limit was sent to Case Management Agencies (CMA) and Direct Service Agencies (DSA).

Service Planning Teams will meet and IPC revisions and/or exception requests are due to DADS by the following dates:

<table>
<thead>
<tr>
<th>Deadlines</th>
<th>10/1/2011</th>
<th>10/15/2011</th>
<th>10/31/2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPC End Date</td>
<td>12/31/2011</td>
<td>4/30/2012</td>
<td>8/31/2012</td>
</tr>
<tr>
<td></td>
<td>1/31/2012</td>
<td>5/31/2012</td>
<td>9/30/2012</td>
</tr>
<tr>
<td></td>
<td>2/28/2012</td>
<td>6/30/2012</td>
<td>10/31/2012</td>
</tr>
<tr>
<td></td>
<td>3/31/2012</td>
<td>7/31/2012</td>
<td>11/30/2012</td>
</tr>
</tbody>
</table>

If the deadlines for submission of revised IPCs and exception requests are not met by the CMA, then DADS will reduce service amounts on the IPC to comply with the new limits and send the individual a notice with the right to appeal.

**New** - If DADS second level reviews are delayed past Dec. 1, services will continue at the current levels until a final decision is made.
Where Can I Find the Forms and Instructions for CLASS?

- **New Service Limits and Elimination of Requisition and Specification Fees**

- **CLASS Request for Exception to Service Limit Form (DADS Form 3626) and Instructions**
  [http://www.dads.state.tx.us/forms/3626/](http://www.dads.state.tx.us/forms/3626/)
Home and Community-Based Services (HCS)
## HCS Services With New Limits
(Updated 10/28/11)

<table>
<thead>
<tr>
<th>HCS Service</th>
<th>Highest Number of Units Provided Today (Per Year)</th>
<th>New Service Limits– Per Year</th>
<th>Cannot Exceed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptive Aids/Durable Medical Equipment</td>
<td>$10,000</td>
<td>$1,057</td>
<td>$10,000 (Per Year)</td>
</tr>
<tr>
<td>Audiology</td>
<td>3 hours</td>
<td>3 hours</td>
<td></td>
</tr>
<tr>
<td>Behavioral Support</td>
<td>216 hours</td>
<td>10 hours</td>
<td></td>
</tr>
<tr>
<td>Dietary Services</td>
<td>71</td>
<td>3 hours</td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td>$1,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>104 hours</td>
<td>8 hours</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>152 hours</td>
<td>30 hours</td>
<td></td>
</tr>
<tr>
<td>Social Work</td>
<td>300 hours</td>
<td>10 hours</td>
<td></td>
</tr>
<tr>
<td>Speech and Language Pathology</td>
<td>119 hours</td>
<td>49 hours</td>
<td></td>
</tr>
<tr>
<td>Supported Employment</td>
<td>150 hours</td>
<td>126 hours</td>
<td>150 hours (Per Year)</td>
</tr>
<tr>
<td>Supported Home Living For each Level of Need (LON)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LON 1</td>
<td>3,099 hours</td>
<td>923 hours</td>
<td>3,546 hours</td>
</tr>
<tr>
<td>LON 5</td>
<td>4,373 hours</td>
<td>1,337 hours</td>
<td></td>
</tr>
<tr>
<td>LON 8</td>
<td>4,656 hours</td>
<td>1,868 hours</td>
<td></td>
</tr>
<tr>
<td>LON 6</td>
<td>5,286 hours</td>
<td>2,098 hours</td>
<td></td>
</tr>
<tr>
<td>LON 9</td>
<td>6,542 hours</td>
<td>3,546 hours</td>
<td></td>
</tr>
</tbody>
</table>
# HCS Services That Do Not Have New Limits  (Updated 10/28/11)

<table>
<thead>
<tr>
<th>Service</th>
<th>No New Service Limit Calculated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Habilitation</td>
<td>N/A</td>
</tr>
<tr>
<td>Behavioral Support</td>
<td>N/A per DADS information letter 10/28/11</td>
</tr>
<tr>
<td>Nursing Services</td>
<td>N/A</td>
</tr>
<tr>
<td>Residential Assistance</td>
<td>N/A</td>
</tr>
<tr>
<td>Foster/Companion Care</td>
<td>N/A</td>
</tr>
<tr>
<td>Residential Support</td>
<td>N/A</td>
</tr>
<tr>
<td>Supervised Living</td>
<td>N/A</td>
</tr>
<tr>
<td>Financial Management Services</td>
<td>N/A</td>
</tr>
<tr>
<td>Support Consultation</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Current Service Limit – No Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental</td>
<td>$1,000</td>
</tr>
<tr>
<td>Minor Home Modifications</td>
<td>$7,500 lifetime</td>
</tr>
<tr>
<td>Respite</td>
<td>300 hours</td>
</tr>
</tbody>
</table>
The Exceptions Process for HCS
(Additional DADS Second Level Review as of 10/28/11)

- If you are enrolled in the Home and Community-Based Services (HCS) Program and you receive at least one service that exceeds the new service limits, your service provider or service coordinator will discuss this with you.

- Your HCS program provider may convene a meeting of your service planning team.

- Explain to your HCS program provider and/or service planning team your reasons for needing to receive the service in an amount that exceeds the new service limit.

- Your HCS program provider will submit to DADS a Request for Exception to Service Limit Form (DADS Form 5035) with the information you and your HCS provider supply, including any new documentation from your treating professionals, if needed. Sign and date the materials (Individual Plan of Care (IPC), Person Directed Plan (PDP) if you are in agreement.

- For individuals only receiving Supported Home Living through Consumer Directed Services (CDS), the HCS service coordinator will be responsible for submitting a Request for Exception to Service Limit Form (DADS Form 5035) to DADS.

- DADS will review the form and determine whether providing the service in excess of the service limit meets the Individual Plan of Care (IPC) criteria described in the HCS Program rules.

- DADS “second level review” for exception denials and plan of care service reductions/revisions - follow-up with case managers and providers who denied exceptions and program participants who signed revised plans with reductions to ensure understanding and get more information as appropriate.

- If services are reduced by DADS, then a Medicaid notice/letter of service reduction is sent to the individual along with the right to appeal through a fair hearing.
If you believe you need to receive the service(s) in an amount that exceeds the new service limits, you must answer the following questions:

- How the IPC is based on the Person Directed Plan
- The specific type and amount of each service component to be provided to the individual
- The services and supports that are provided by other sources during the IPC year
- How the type and amount of each service is supported by:
  - Documentation that other sources for the service are unavailable and that the service does not replace existing supports, including natural supports or other sources for the service
  - Assessments that demonstrate that the service is necessary to assist the individual to live in the community, ensure the individual's health, safety and welfare, and prevent institutionalization
  - Documentation of deliberations and conclusions of the service planning team that show the services are based on desired outcomes of the person directed plan and ensure health, safety and welfare and prevent institutionalization
What If I Am Dissatisfied With the Process or Denied an Exception?

- If the service planning team is unable to come to a consensus about what action to take in response to the new service limits (i.e. you state your need to maintain current services levels and the service planning team disagrees with you), you should request your provider or case manager submit a Request for Exception to Service Limit Form (DADS Form 5035) on your behalf.

- If dissatisfied with how your service planning team, program provider, or service coordinator if you are in CDS, handled your exception request, you should contact DADS Consumer Rights and Services (CRS) by calling 1-800-458-9858 or emailing CRScomplaints@dads.state.tx.us.

- If not granted an exception, you will receive a notice explaining how you can request a fair hearing to appeal the decision. Appeal the decision within 10 calendar days in order to keep the same amount of services during the appeals process.
Important Dates for HCS

- DADS will notify providers of individuals that have a service on the Individual Plan of Care (IPC) that exceeds the new limits.

- All revised IPCs and exception requests must be entered into the CARE computer database system and faxed or mailed to DADS no later than October 31, 2011.

- If an exception request is not submitted along with the required documentation to DADS by November 15, 2011, then DADS will reduce the IPC and send a notice of the right to appeal the reduction to the individual with a copy to the provider and/or HCS service coordinator.

- If DADS decisions on second level reviews are delayed past Dec. 1, services will continue at the current levels until a final decision is made.
Where Can I Find the Forms and Instructions for HCS?

- **New Service Limits in the Home and Community-Based Service (HCS) Program**

- **HCS Request for Exception to Service Limit Form (DADS Form 5035) and Instructions** [http://www.dads.state.tx.us/forms/5035/](http://www.dads.state.tx.us/forms/5035/)
Medically Dependent Children Program (MDCP)
## MDCP Services

### Highest Number of Units Provided Today (Per Year) vs. The New Service Limits (Per Year)

<table>
<thead>
<tr>
<th>MDCP Service</th>
<th>Highest Number of Units Provided Today (Per Year)</th>
<th>The New Service Limits (Per Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjunct Support Services</td>
<td>3,164 hours</td>
<td>1,875 hours</td>
</tr>
<tr>
<td>Respite</td>
<td>3,887 hours</td>
<td>2,096 hours</td>
</tr>
</tbody>
</table>

### Current Limit (Per Year), No Changes

<table>
<thead>
<tr>
<th>MDCP Service</th>
<th>Current Limit (Per Year), No Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptive Aids</td>
<td>$4,000</td>
</tr>
<tr>
<td>Minor Home Modifications</td>
<td>$7,500</td>
</tr>
</tbody>
</table>

### Service Limit

<table>
<thead>
<tr>
<th>MDCP Service</th>
<th>Service Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Management Services</td>
<td>N/A</td>
</tr>
<tr>
<td>Transition Assistance Services</td>
<td>N/A</td>
</tr>
</tbody>
</table>
The Exceptions Process for MDCP?
(Additional DADS Second Level Review as of 10/28/11)

- Your DADS case manager will discuss the new service limits, your individual plan of care (IPC), and the exception process with you.
- Discuss with the DADS case manager the reasons you need to receive the service in an amount that exceeds the new service limit.
- Your DADS case manager will consider the information, request new evidence or information if needed, and make a determination of whether providing the service in excess of the service limit meets the IPC criteria described in the MDCP rules.
- If the case manager denied an exception or if you signed a service plan revision with service reductions, DADS conducts a second level review.
- DADS “second level review” for exception denials and plan of care service reductions/revisions - follow-up with case managers and providers who denied exceptions and program participants who signed revised plans with reductions to ensure understanding and get more information if appropriate.
- If services are reduced by DADS, then a Medicaid notice/letter of service reduction is sent to the individual along with the right to appeal through a fair hearing.
If you believe you need to receive the service(s) in an amount that exceeds the new service limits, you must answer the following question:

- Does the amount of services requested above the new service limit support the individual’s primary caregiver and enable the individual to remain safely in the home?
What If I Am Dissatisfied With the Process or Denied an Exception?

- If dissatisfied with how your case manager handled your exception request, you should contact your DADS local office and ask to speak to your case manager’s supervisor. You should also contact DADS Consumer Rights and Services (CRS) by calling 1-800-458-9858 or emailing CRScomplaints@dads.state.tx.us.

- If not granted an exception, you will receive a notice explaining how you can request a fair hearing to appeal the decision. Appeal the decision within 10 calendar days in order to keep the same amount of services during the appeals process.
Important Dates for MDCP
(Updated 10/28/11)

- DADS will notify case managers of all individuals whose authorized amount of service exceeds the new limits.
- By October 17, 2011, case managers must complete a desk review of all the IPCs that exceed one or more of the new service limits to determine whether to submit an exception request or to reduce, deny or remove a service from the plan.
- Case managers must contact all individuals with IPCs ending after December 1, 2011, that will exceed the new limit. If the case manager grants an exception no further action is needed.
- If the case manager does not grant the exception then a meeting with the individual, the family, the case manager and the provider is convened in mid-October.
- If sufficient evidence is presented to support the need for an exception then no further action is needed.
- If the case manager does not believe an exception should be granted, DADS will conduct a second level review.
- If DADS decisions on second level reviews are delayed past Dec. 1, services will continue at the current levels until a final decision is made.
Where Can I Find the Forms and Instructions for MDCP?

- **New Service Limits in the Medically Dependent Children Program (MDCP)**

- **MDCP New Service Limit Exception Criterion Form (DADS Form 2444) and Instructions**
  [http://www.dads.state.tx.us/forms/2444/](http://www.dads.state.tx.us/forms/2444/)

- **Memorandum to DADS regional offices and case managers about the new limits with guidelines on criteria for exceeding limits**
  [http://www.dads.state.tx.us/handbooks/cm-mdcp_policy/09-08-11_003.pdf](http://www.dads.state.tx.us/handbooks/cm-mdcp_policy/09-08-11_003.pdf)
Community Based Alternatives (CBA)
## CBA Services With New Limits

<table>
<thead>
<tr>
<th>CBA Service</th>
<th>Highest Number of Units Provided Today (Per Year)</th>
<th>New Service Limits- Per Year</th>
<th>Cannot Exceed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptive Aids/Durable Medical Equipment</td>
<td>$10,000 (Cap)</td>
<td>$2,050.00</td>
<td></td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>$10,000 (Cap)</td>
<td>$1,736.00</td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td>$10,000 (Cap)</td>
<td>$4,675.00</td>
<td>$10,000</td>
</tr>
<tr>
<td>Minor Home Modifications</td>
<td>$7,500 (Cap)</td>
<td>$6,550.00</td>
<td></td>
</tr>
<tr>
<td><em>Lifetime Limit</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>85 hours</td>
<td>61 hours</td>
<td></td>
</tr>
<tr>
<td>Personal Assistance Services</td>
<td>7,625 hours</td>
<td>2,135 hours</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>120 hours</td>
<td>86 hours</td>
<td></td>
</tr>
<tr>
<td>Respite</td>
<td>30 days (Cap)</td>
<td>24 days</td>
<td></td>
</tr>
<tr>
<td>Speech, Hearing and Language Therapy</td>
<td>151 hours</td>
<td>69 hours</td>
<td></td>
</tr>
</tbody>
</table>
# CBA Services

**That Do Not Have New Limits**

<table>
<thead>
<tr>
<th>Service</th>
<th>No New Service Limit Calculated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Foster Care</td>
<td>N/A</td>
</tr>
<tr>
<td>Assisted Living</td>
<td>N/A</td>
</tr>
<tr>
<td>Emergency Response Services</td>
<td>N/A</td>
</tr>
<tr>
<td>Financial Management Services</td>
<td>N/A</td>
</tr>
<tr>
<td>Home Delivered Meals</td>
<td>N/A</td>
</tr>
<tr>
<td>Nursing</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescribed Medications</td>
<td>N/A</td>
</tr>
<tr>
<td>Support Consultation</td>
<td>N/A</td>
</tr>
<tr>
<td>Transition Assistance Services</td>
<td>N/A</td>
</tr>
</tbody>
</table>
The Exception Process for CBA
(Additional DADS Second Level Review as of 10/28/11)

- If you are enrolled in the Community Based Alternatives (CBA) program, your DADS case manager will discuss the new service limits, your Individual Service Plan (ISP), and the exception process with you.
- Discuss with the DADS case manager your reasons for needing to receive the service in an amount that exceeds the new service limit.
- Your DADS case manager will consider the information, request new documentation if needed, and make a determination of whether providing the service in excess of the service limit meets the ISP criteria described in the CBA program rules.
- If the case manager denied an exception or if you signed a service plan revision with service reductions, DADS conducts a second level review.
- DADS “second level review” for exception denials and plan of care service reductions/revisions - follow-up with case managers who denied exceptions and program participants who signed revised plans with reductions to ensure understanding and get more information as appropriate.
- If services are reduced by DADS, then a letter of service reduction is sent to the individual along with the right to appeal through a fair hearing. Appeal within 10 calendar days.
- If services are reduced by DADS, then a Medicaid notice/letter of service reduction is sent to the individual along with the right to appeal through a fair hearing.
If you believe you need to receive the service(s) in an amount that exceeds the new service limits, you must answer the following questions:

- Is the amount of services above the service limit necessary to protect the individual’s health and welfare in the community?
- Does the amount of services above the service limit supplement rather than replace the individual’s natural supports and other non-waiver services for which the individual may be eligible?
- Will the amount of service above the service limit prevent admission to an institution?
- Is the request to exceed the service limit the most appropriate type and amount to meet the individual’s needs?
- Is the amount above the limit cost effective?
What If I Am Dissatisfied With the Process or Denied an Exception?

- If dissatisfied with how your case manager handled your exception request, you should contact your DADS local office and ask to speak to your case manager’s supervisor. You should also contact DADS Consumer Rights and Services (CRS) by calling 1-800-458-9858 or emailing CRScomplaints@dads.state.tx.us.

- If not granted an exception, you will receive a notice explaining how you can request a fair hearing to appeal the decision. Appeal the decision within 10 calendar days in order to keep the same amount of services during the appeals process.
Important Dates for CBA
(Updated 10/28/11)

- DADS will notify case managers of all individuals whose authorized amount of service exceeds the new limits.
- By **October 31, 2011**, case managers must complete a desk review of all the Individual Service Plans (ISPs) that exceed one or more of the new service limits to determine whether to submit an exception request or to reduce, deny or remove a service from the plan.
- By **October 31, 2011**, case managers must contact all individuals with ISPs ending after **December 1, 2011**, that will exceed the new limit. Your case manager will discuss the new service limits, your ISP and the exceptions process with you at this time. Explain to your case manager your reasons for needing to receive the service in an amount that exceeds the new service limit.
- If the case manager grants an exception, no further action is needed.
- If the case manager does not grant the exception, then a service planning meeting with the individual, the family, the case manager and the provider is convened in **November**.
- If sufficient evidence is presented to support the need for an exception, then no further action is needed.
- If the case manager denied an exception or you signed a service plan revision with service reductions, DADS conducts a second level review.
- If **DADS decisions on second level reviews are delayed past Dec. 1**, services will continue at the current levels until a final decision is made.
- If services are reduced by DADS, then a Medicaid notice/letter of service reduction is sent to the individual along with the right to appeal through a fair hearing.
Where Can I Find the Forms and Instructions for CBA?

- Service Limits and Elimination of Requisition and Specification Fees in the Community Based Alternatives (CBA) Program

- CBA New Service Limit Exception Criteria Form (DADS Form 3669) and Instructions [http://www.dads.state.tx.us/forms/3669/](http://www.dads.state.tx.us/forms/3669/)

- Memorandum to DADS regional offices and case managers about the new limits with guidelines on criteria for exceeding limits [http://www.dads.state.tx.us/handbooks/cm-cba-hb_policy/cba/09-08-11_004.pdf](http://www.dads.state.tx.us/handbooks/cm-cba-hb_policy/cba/09-08-11_004.pdf)
Appeals

- Using the Medicaid Fair Hearings Process to Appeal a DADS Decision To Reduce Your Services
If I Disagree With a Service Reduction
To My Services, What Else Can I Do?

☐ Make sure you request an exception for each of your necessary services.

☐ If an exception is not approved, a notice of DADS decision to reduce your services will be mailed to you. This letter will include notice of the right to appeal the DADS decision. The notice must be addressed to the individual and must describe the reason for the reduction of services.

☐ Request an appeal upon receipt of notice of any reduction, denial, suspension or termination of services.

☐ According to the Health and Human Services Commission (HHSC) Medicaid Uniform Fair Hearing rules, all individuals need to be given notice of a reduction in service:
   90 days to request an appeal
   **Must** appeal within **10 calendar days** in order to have services continue at the same level until the appeal is decided.
How Long
Are the Reductions in Effect?

- The service reductions begin on December 1, 2011.
- The rules governing the service reductions are set to expire on August 31, 2013.
  - NOTE: Decisions on whether or not to continue and/or worsen service limits will likely be made by Texas Legislators during the next legislative session (January-May 2013).
Key Things to Remember

- Find out your status as soon as possible.
- Watch for deadlines for submitting exceptions to prevent automatic reductions.
- Check your mail and phone messages.
- Make sure you know if you need to appeal and, if so, meet the appeal timelines.
How Else Can I Get Involved?

- Attend the Public Hearing regarding the revised waiver program rules that implement the new service limits!
  
  Tuesday, October 18, 2011 at 8:30 a.m.
  DADS Headquarters—Austin, TX
  John H. Winters, Public Hearing Room
  701 W. 51st St., Austin, Texas 78751

  **AND/OR** Send Written Comments: RulesComments@dads.state.tx.us
  *(Deadline For Written Comments: Midnight on Sunday, November 6th)*

- Share your story with elected officials.
- Share this information with other individuals.
- Let DADS know if the process is not working.
Still Having Problems?

If you are a person with a disability or know someone with a disability who is having trouble with this process or needs help with an appeal, call Disability Rights Texas immediately:

(800)252-9108 Statewide Intake
(866)362-2851 Toll free video phone

www.disabilityrightstx.org
Experienced staff are available to take your call Monday through Thursday 8am-7pm and Friday 8am-5pm.

Please note that the demand for our services far exceeds the availability of our staff and attorneys. Cases are selected based on available resources and our priority areas. If your problem is not accepted as a case, you have the right to appeal our decision.

In deciding whether we can represent you directly, we will consider:

- The merits of your case
- Other resources available to you
- Your ability to advocate for yourself
- Whether your problem falls within one of our priority areas
- Availability of resources within our organization
- The extent to which your case may benefit others with disabilities

(800)252-9108
Statewide Intake

(866)362-2851
Toll free video phone
www.disabilityrightstx.org
Important Terms

Advocate – Person who speaks for you at a meeting or hearing

Amount, Scope and Duration – How much service, frequency of service, the type of service and the period of time during which services are to be provided

Appeal – Request to go to a hearing to ask a hearing officer to change a decision affecting your services

Assessment – test, evaluation or judgment based on an understanding of the situation or a condition, refers to the process of identifying an individual's specific strengths, developmental needs and need for services

Authorize – Allow, give permission, okay

Community Involvement – Participate or join in activities of interest with the public, the general population, your town or neighborhood
Important Terms

Consensus – Agreement among all members of a group (non-consensus - lack of agreement among group)

Cost Effective – Worth the amount of money spent considering what is accomplished or as compared to a different service or item

DADS – Department of Aging and Disability Services

Exceed – Go beyond the limit

Evidence – Proof, facts or the truth of something that helps somebody to make a clear decision

Exception – Excused from, not included, or not affected by the rule or limit

Justify – Give an acceptable reason or explanation
Important Terms

Level of Need – Process used by DADS to determine the intensity of supports needed as defined by the Inventory for Client and Agency Planning (ICAP) Service Level score (considering both adaptive and maladaptive behavior), behavioral status, medical status and cognitive/adaptive functioning.

Medicaid Fair Hearing – A chance to tell your story to a hearing officer who will decide who is right, you or DADS (You can ask for a fair hearing if you do not agree with your services being reduced, suspended, or terminated and when your request for new services is denied. You will get a written decision.)

Medicaid Waiver program - For this discussion, the following programs serving as an alternative to services in an institution are:

- Community Based Alternatives (CBA) – for adults age 21 or older who meet medical necessity eligibility for a nursing facility
- Community Living Assistance and Support Services (CLASS) – for children and adults with a “related condition” eligible for an Intermediate Care Facility
- Home and Community-based Services (HCS) – for individuals with an intellectual disability or related condition with an IQ of 75 or less eligible for an Intermediate Care Facility
- Medically Dependent Children Program (MDCP) – for children and young adults less than 21 years of age who meet medical necessity eligibility for a nursing facility.
Important Terms

Participant – Person receiving the services

Pending – Waiting for a decision to be made

Prevent institutionalization – avoid or stop placement in some other place of care or confinement

Reduction – Less, a cut or cutback, decrease in the amount

Relevant – Having an important connection to something, like related to a disability need

Review – Study, look at, examine, analyze

Risk of institutionalization – danger that loss of services may result in harm or be dangerous to the extent that someone might be recommended for or consider admission to a nursing facility, Intermediate Care Facility, State Supported Living Center, State Hospital or some other place of care or confinement not of their choosing
Important Terms

Second Level Review – DADS will contact and work with providers, legally authorized representatives and case managers to ensure awareness of the exceptions process and determine if additional information may support an exception request (new process as of 10/28/11)

Service Limit – Cutoff point, maximum amount, cap

Service Planning Team - A group of individuals including the individual receiving services, the Legally Authorized Representative LAR (guardian or parent of minor child), other individuals invited by the individual or LAR, professionals, paraprofessionals and non-professionals who know the person and/or possess the knowledge, skill and expertise necessary to accurately identify the comprehensive array of the individual's needs and design appropriate services and specialized programs responsive to those needs and the person’s preferences (varies by program and situation)

Utilization – Use of a particular service within a specific time period

Unit - Measurement in minutes, hours, days or dollars
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