



A Roadmap to Understanding Texas Medicaid Waivers

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Introduction

A Roadmap to Understanding Texas Medicaid Waivers provides basic information with tips on access and use of Texas Medicaid Waivers. The information pulls from a variety of resources and experts, intended to assist a person with a disability or others who provide support to make decisions about getting on the waiver interest list, choosing between different waivers and making the most of their waiver services.

The Roadmap relies on current information available. Just like the highway system, there is always something new under construction or old roads under repair. Be sure and use your local or state resource people to find out the most current funding amounts, rules or changes that affect the Medicaid waiver that interests you.

People who are offered a Medicaid waiver often hear advice to “get the most out of your Medicaid waiver.” But, how to make that happen is the challenge! Waivers offer opportunity - but it is most effective when the person using the waiver (or their allies) knows what they want and uses a few tools to get it. A concept embedded in the program policy and embraced by many in the advocacy and provider community is self-determination. It is not easy to achieve, but the decisions you make along the way to working through your waiver will make a difference in what you can achieve.

These *guiding principles of self-determination* (<http://www.self-determination.com/principles/index.html>) can be used to ensure your Medicaid waiver services are delivered in a way that results in a life that YOU want:

Principles of Self-Determination

- **Freedom** to choose a meaningful life in the community
- **Authority** over a targeted amount of dollars
- **Support** to organize resources in ways that are life enhancing and meaningful to the individual with a disability
- **Responsibility** for the wise use of public dollars and recognition of the contribution individuals with disabilities can make to their communities
- **Confirmation** of the important leadership role that individuals with disabilities and their families must play in a newly re-designed system and support for the self-advocacy movement

The Roadmap combines the principles of self-determination with the rules and guidelines of the Medicaid waivers to give you a chance of getting to where you want to go with your life. Like taking a trip, if you determine your destination (Freedom), you are more successful getting to where you want to go in your life if you plan well for making decisions (Authority), use your financial resources (Responsibility), get the assistance you need when you need it (Support), and you remain central in making all the decisions that affect you (Confirmation).

Creation of **The Roadmap** is made possible through funding from the Texas Council for Developmental Disabilities so that more people with disabilities have access to more information to make better decisions.



The Basics

Medicaid and Entitlement

Established in 1965, Medicaid provides medical health coverage for low-income individuals and families who fit into an eligibility group that is recognized by federal and state law. Eligibility Groups may include your age, whether you are pregnant, disabled, blind, or aged; your income and resources (like bank accounts, real property, or other items that can be sold for cash); and whether you are a U.S. citizen or a lawfully admitted immigrant. Texas has its own guidelines regarding eligibility and services defined in the Texas Medicaid State Plan.

Basic Medicaid coverage pays for health care, such as doctor's visits, hospitalizations and medication. Medicaid also pays for durable medical equipment and supplies such as wheelchairs and augmentative communication devices. Some people may (or may not) also receive cash assistance from the Temporary Assistance for Needy Families (TANF) program or from the Supplemental Security Income (SSI) program. Persons who qualify for Medicaid based on disability and income are *entitled* to basic services. *Entitlement* means there is no wait for the services.

For people with disabilities and seniors, Medicaid is also a major funding stream of *Long-Term Care*. Historically, Medicaid covers the expenses of institutional and nursing facility care, called Intermediate Care Facilities (ICF). The ICF service model and criteria for placement uses traditional assessments for medical and psychiatric diagnosis. ICF facilities can be as small as six people living in a home, or as large as 600 people in a facility or institution. ICF services are an *entitlement* for eligible persons.

Advances in medical, educational and habilitation services for seniors as well as children and adults with disabilities, makes it possible for more people to stay in their own home or in a small, personalized living arrangement in a typical community. Medicaid Long-Term Care now includes a **waiver** called 'Home and Community-Based Services'. This "waives" the institutional (ICF) rules to create community services and supports – more than the basic health care in the Medicaid State Plan but not a traditional ICF facility. Waiver services are not an entitlement.

How to Apply for Basic Medicaid Services

Even if you are not sure whether you qualify, if you or someone in your family needs health care, you should apply for Medicaid and have a qualified caseworker evaluate your situation.

Call 2-1-1: It's a free, easy-to-remember phone number connecting callers with health and human services in their area. Knowledgeable staff will speak with you and answer your questions. You can call for assistance seven days a week, 24 hours a day.

Note: If you are calling from outside of Texas, or have technical difficulties when dialing from your cell phone, voice-over-IP, or office location, then please dial the alternate access number at 1-877-541-7905. You can also visit the 2-1-1 Texas website at <https://www.211texas.org/211/> to find the phone number to your local 2-1-1 Area Information Center.

Fill out an application - The first page of the application includes instructions about mailing or faxing your completed application in English or Español.

<https://www.yourtexasbenefits.com/wps/themes/html/SSPortal/downloads/AppIntegratedApplication.pdf>

Visit a HHSC Benefits Office - Call 2-1-1 or visit the <https://www.yourtexasbenefits.com/wps/portal> site to find the HHSC benefits office closest to you.

What is a Medicaid Waiver?

A Medicaid waiver allows the state to be more flexible in how it spends money to provide some long-term services to some people with disabilities or elderly citizens who are eligible for Medicaid. In the past, people had to be in nursing homes/facilities or other large institutions for Medicaid to pay for long-term services.

Waivers override certain rules for how Medicaid funding can be used. If they meet the eligibility requirements, people can get the services they need in their own homes or other community settings, instead of having to go into a nursing facility or institution.

In Texas, there are several different waiver programs that offer a broad range of home and community-based services to people with disabilities and elderly citizens. There are different rules and funding amounts for each of the different waivers. In general, though, they all help people get the supports they need in the community.

About the Interest Lists

The Department of Aging and Disability Services (DADS) maintains an “Interest List” (previously known as the “Waiting List”) for individuals with disabilities and their families who are requesting Medicaid waiver services. Due to a variety of reasons, the interest lists move at a different pace for each of the waivers. Some waivers are available immediately, while others have a wait time up to 9 years. To find out the amount of time an individual typically waits for services, click on the following link: <http://www.dads.state.tx.us/services/interestlist/index.html#time>

Tips:

_____ Sign up for all interest lists that you or your family member may be eligible for or interested in, even if you’re not sure you qualify.

_____ Always get the *name & contact information* of the person who records your information and keep it with your records. You should receive a letter of confirmation.

Waiver:

Agency:

Name:

Contact Info:

_____ If you receive a letter or phone call from the agency regarding the interest list ALWAYS respond. Your name may be “scrubbed” from the list if there is no response.

_____ Ask:

How many people are on the list? _____

Is it organized by state or county? _____

When and how will they contact you? _____

_____ If you change your address or phone number make sure that you call the DADS office or the local MRA to give them the correct information. Also, call at least one time a year to verify that your name is still on the list and that your contact information is still correct.

Agency Contacts to Get On the Interest List

WAIVERS: CBA, CLASS, DBMD and MDCP

Texas Department of Aging & Disability Services (DADS)

- DADS local offices website: <http://www.dads.state.tx.us>

- Call DADS 1-877-438-5658 (toll free)

- Call 211

WAIVERS: HCS and TxHmL

Mental Retardation Authority (MRA)

- MRA local offices website: <http://www.dads.state.tx.us/contact/mra.cfm>

- Check your phone book for the local MRA office number

- Call 211

Texas Health and Human Services Commission

- HHSC Benefits offices website:

<https://www.yourtexasbenefits.com/wps/themes/html/SSPortal/officeLocator/results.html>

- Your Texas Benefits website: <https://www.yourtexasbenefits.com/wps/portal>

- Call 211

Waiver Eligibility

***Remember: Medicaid waiver services are NOT an entitlement.**

WAIVER: Community Based Alternatives (CBA)

Services and supports provided to persons in their own home, an assisted living facility or in an adult day care setting as an alternative to institutional care in a nursing facility. These services may include adaptive aids and medical supplies, adult foster care, assisted living, residential care services, consumer directed services, emergency response services, home delivered meals, minor home modifications, nursing services, occupational therapy, physical therapy, personal assistance services, respite care, speech and/or language pathology services and prescription drugs (if not covered through Medicare).

- Age: A person must be 21 years or older
- Medical Necessity: Must meet the medical necessity determination for nursing facility care
- Income: Up to 300% of SSI (or \$1,911 per month)
- Resources: No more than \$2,000 in countable resources for an individual
- Cost of Individual Service Plan cannot exceed 200% of the nursing home or facility payment rate for that same individual

How to Apply for Services

Contact your local Department of Aging and Disability Services (DADS) office. The website to locate the office is: <http://www.dads.state.tx.us/contact/combined.cfm> or call 1-877-438-5658.

WAIVER: Community Living Assistance and Support Services (CLASS)

Home and community based services and supports, such as habilitation, minor home modifications, nursing, specialized therapies, respite and case management, available for persons with developmental disabilities other than mental retardation as an alternative to institutional placement.

- Age: No limit (note: age of onset of disability must be prior to age 22)
- Level of Care: Must meet the criteria of a Related Condition: a developmental disability that occurred before the age of 22 and with significant impairment in 3 major life activity areas
- Demonstrated need for Habilitation Services
- Income: Up to 300% of SSI (\$1,911 per month); *for children under the age of 18, parent's income is not counted*
- Resources: No more than \$2,000 in countable resources for an individual
- Cost of Individual Service Plan cannot exceed 200% of the cost of a group home or institutional placement (Intermediate Care Facilities for People with Mental Retardation/Related Conditions, IFC-MR/RC)

For a list of Related Conditions click on link below:

http://www.dads.state.tx.us/providers/guidelines/ICD-9-CM_Diagnostic_Codes.pdf

How to Apply for Services

Contact your local Department of Aging and Disability Services (DADS) office. The website to locate the office is: <http://www.dads.state.tx.us/contact/combined.cfm> or call 1-877-438-5658.

WAIVER: Deaf Blind with Multiple Disabilities Waiver (DB-MD)

Home and community based services for persons who have legal blindness; a chronic, severe hearing impairment; or a condition that leads to deaf-blindness and a third disability that results in impairment to independent functioning. This program is an alternative to institutional care and offers services such as attendant care, orientation and mobility, and assisted living.

- Age: 18 years or older
- Income: Up to 300% of SSI (\$1,911 per month),
- Resources: No more than \$2,000 in countable resources for an individual
- Disability: Individual must be legally deaf, blind with a third disability resulting in a demonstrated need for daily habilitation services
- Cost of Individual Service Plan cannot exceed 200% of the cost of Intermediate Care Facilities for People with Mental Retardation/Related Conditions (IFC-MR/RC)

- Level of Care: Must meet the Level-of-Care criteria for ICF-MR/RC
- Demonstrated need for habilitation

How to Apply for Services

Contact your local Department of Aging and Disability Services (DADS) office. The website to locate the office is: <http://www.dads.state.tx.us/contact/combined.cfm> or call 1-877-438-5658.

WAIVER: Medically Dependent Children Program (MDCP)

Services and supports to families caring for medically dependent child in their home who is less than 21 years of age. These services may include adaptive aids, adjunct support services (such as those that support independent living, participation in child care and participation in post-secondary education), minor home modifications, respite and transition assistance services.

- Age: Under 21 years of age
- Income: 300% of SSI (\$1,911 per month) based on child's income. *The income of the parent's is not considered*
- Resources: No more than \$2,000 in countable resources for an individual
- Cost of Individual Service Plan cannot exceed 50% of the cost of nursing facility
- Medical Necessity: Must meet the medical necessity determination for nursing facility care.

Income Limitations For Eligibility

All of the Texas Medicaid waivers have different eligibility criteria; however, the following income rules are true of all the waivers except the Texas Home Living* waiver:

- Waiver eligibility is based on the person's income, not the families. If a child is under the age of 18, a parent's income does **not** get counted when determining eligibility for the waiver. This is very important because some families make too much money to qualify for Supplemental Security Income (SSI) and have been denied Medicaid. *Once a child gets a Medicaid waiver, he/she qualifies for all of the services under Medicaid regardless of parental income.* The child may still not qualify for the SSI cash subsidy, but will get Medicaid health insurance. The family should make sure to reapply for SSI if the income of the family changes or when the child turns 18.
- Waivers allow adults who make up to three times the SSI limit to qualify for services. This means that a person can make \$1,911 each month and still qualify for waiver services. The SSI payment amount changes each year so this amount usually increases slightly each year.

** The Texas Home Living waiver requires that the applicant must be Medicaid eligible prior to enrollment in the program.*

How to Apply for Services

Contact your local Department of Aging and Disability Services (DADS) office. The website to locate the office is: <http://www.dads.state.tx.us/contact/combined.cfm> or call 1-877-438-5658.

WAIVER: Home and Community Services (HCS)

Services and supports available in a person's own home or family home, or in a small residential program. Services include day habilitation, employment assistance, respite and specialized therapies.

- Age: No limit
- Level of Care:
 - Documentation must show the person has mental retardation with an IQ below 69 made in accordance with state law, or have been diagnosed by a physician as having a related condition with an IQ below 75. Autism and other developmental disabilities such as cerebral palsy, seizure disorders, and spina-bifida are related conditions
 - Qualify for an ICF/MR Level of Care (LOC) I or qualify for an ICF/MR LOC VIII and have been determined by the Department of Aging and Disability Services to have mental retardation or a related condition, need specialized services, and be inappropriately placed in a Medicaid certified nursing facility
- Have a demonstrated need for habilitation
- Income: Up to 300% of SSI (\$1,911 per month). For children under the age of 18 parent's income is not counted
- Resources: No more than \$2,000 in countable resources for an individual

- Cost of Individual Service Plan cannot exceed 200% of the cost of a group home or institutional placement (Intermediate Care Facilities for People with Mental Retardation/Related Conditions, IFC-MR/RC)

For a list of Related Conditions click on link below:

http://www.dads.state.tx.us/providers/guidelines/ICD-9-CM_Diagnostic_Codes.pdf

How to Apply for Services

To seek enrollment, contact the local Mental Retardation Authority for referral and interest list registration. To find your Mental Retardation Authority, go to the following website:

<http://www.dads.state.tx.us/contact/combined.cfm>

WAIVER: Texas Home Living Waiver (TxHmL)

Services and supports, such as day habilitation, respite and employment assistance, for persons who live in their own home or their family's home.

- Age: No limit (but age of onset of disability must be prior to age 22)
- Income: The applicant must be Medicaid eligible prior to enrollment in the program
- Resources: No more than \$2,000 in resources for an individual
- Cost of Individual Service Plan does not exceed the \$13,000 annual dollar limit for services
- Level of Care:
 - Qualify for an ICF/MR Level of Care I
 - Have a determination of mental retardation with an IQ below 69 made in accordance with state law, or have been diagnosed by a physician as having a related condition with an IQ below 75
 - Must not be assigned a Pervasive Plus Level of Need (LON 9)
- Must live in own or family home
- Demonstrated need for habilitation

How to Apply for Services

To seek enrollment, contact the local Mental Retardation Authority for referral and interest list registration. To find your Mental Retardation Authority, go to the following website:

<http://www.dads.state.tx.us/contact/combined.cfm>

WAIVER: Consolidated Waiver Program (CWP) – Bexar County/San Antonio Only

- Age: No limit
- Income: Up to 300% of SSI (\$1,911 per month); for children under the age of 18, parent's income is not counted
- Resources: No more than \$2,000 in countable resources for an individual
- Individual Service Plan: Must be developed by a DADS case manager through a person-directed planning process in conjunction with the individual and other persons
- Interest List: Currently on an interest list in Bexar County for CBA, CLASS, DBMD, MDGP or HCS.
- Level-of-Care: Must meet the institutional LOC criteria for ICF-MR/RC LOC I or LOC VIII
- Cost of Individual Services Plan cannot exceed:
 - 200% of the amount paid to a nursing facility for someone over 21 years
 - 50% of the amount paid to a nursing facility for someone under 21
 - 200% of the cost of Intermediate Care Facilities for People with Mental Retardation/Related Conditions (IFC-MR/RC)

How to Apply for Services

Contact your local Department of Aging and Disability Services (DADS) office. The website to locate the office is: <http://www.dads.state.tx.us/contact/combined.cfm> or call 1-877-438-5658.

Consumer Directed Services (CDS) Option

Consumer Directed Services (CDS) increases the amount of control and responsibility a participant has over the services delivered and over the decisions related to the wages and the benefits available, primarily for the attendant and respite services. The CDS option is available to implement specific services in the following DADS Medicaid waivers:

Community Based Alternatives (CBA)

- o Personal Assistance Services
- o Respite
- o Effective 8/08 – Professional Therapies, Nursing

Community Living Support Services (CLASS)

- o Habilitation Services
- o Respite

Deaf-Blind Multiple Disabilities (DBMD)

- o Habilitation
- o Intervenor
- o Respite

Home and Community-based Services (HCS)

- o Supported Home Living
- o Respite

Medically Dependent Children Program (MDCP)

- o Adjunct Support Services
- o Respite

Texas Home Living (TxHmL)

- o All Services
- o Support Consultation

More information on Consumer Directed Services can be found at:

<http://www.dads.state.tx.us/providers/CDS/index.cfm>

In the Consumer Directed Services option, the person eligible for the program, or a guardian, becomes the employer, frequently referred to as the “employer of record,” and assumes all responsibilities and consequences for specified (CDS) services. As the employer, the participant controls the recruitment, hiring, training, management, evaluation and firing/termination of the attendant(s), back-up attendant(s), and respite providers.

A Consumer Directed Services Agency (CDSA) must be selected from

http://www.dads.state.tx.us/providers/CDS/CDSA_HCS.html contracted CDSA's available through DADS. The CDSA chosen by the participant will orient and train the participant on how to be an employer. The CDSA handles employer-related functions that include issuing payroll checks, making deductions, and filing employment-related taxes and reports. The CDSA provides reimbursement for approved employer-related expenses incurred by the participant. Employer-related administrative expenses may include travel, advertisement, background checks and other allowable expenses.

Assessment and the Level of Need (LON) Determination

The individual's Level of Need **determines the funding available**. This assignment is a number (LON1, LON 5, LON 8, LON 6, LON 9). LON is assigned by the state through the Texas Department of Aging and Disability Services (DADS) based on information provided through an assessment process. Level of Need is based on information gathered from observation, a family/individual interview and other assessments. Find out more at: http://www.dads.state.tx.us/providers/guidelines/lon_1.html

The LON matters because money is tied to the assignment, specifically:

- Reimbursement rates
- Limits on *amount* of service available

Provide detailed information that accurately depicts your service needs. It is important that accurate LON assignments are made to ensure you receive the services you need. Ask questions to understand how the LON is obtained and the assignment given. Ask about the service amounts, limits and funds.

Cost of Services

Each person enrolled in a Medicaid waiver is assigned an annual dollar amount that he/she cannot exceed without the permission of the Texas Department of Aging and Disability Services. This total amount is called a cost ceiling or cap.

A person's cost ceiling is determined through an assessment that assigns a Level of Need or Resource Utilization Group score.

Once a person is enrolled in a waiver, the plan and budget are developed. The plan states what specific services are needed and the budget shows how much all of the services will cost. People who have many support needs may come close to their cost ceiling while others may not come close at all.

The total cost of the individual budget cannot exceed the cost ceiling – which makes it very important that the Level of Need or Resource Utilization Group score accurately depicts the services and supports the person will need. *(See page 11 for further explanation)*

All of the waivers have different cost ceilings based on what it would cost to serve the individual in an institution. The cost ceiling or cap on many of the waivers cannot exceed 200% of that it would cost to serve the same person in an institution. The Medically Dependent Childrens Program and the Texas Home Living waivers have a lower cost ceiling that is described in the waiver definition section of this Roadmap.

Assessment Tools Impacting the LON

Inventory for Client and Agency Planning (ICAP): A standard assessment at intake and every three years to determine the level of support and supervision a person needs, including behavior. The ICAP rating determines the services a person could warrant in the Level of Need (LON) assignment.

Mental Retardation/Related Condition (MR/RC) Assessment Form: The assessment used by ICF/MR, HCS, TxHmL, CLASS, DBMD programs to assign a Level of Care (LOC) and Level of Need (LON) determination that follows the federal requirements.

Client Assessment, Review and Evaluation (CARE) Form 3652-A: Determines if the person meets the Level of Care criteria for Nursing Facility care in order to receive the CBA waiver.

Resident Assessment Instrument-Home Care Assessment for Nursing Home Risk: Evaluation to determine if the person meets two or more of the criteria for nursing home risk for the CBA waiver.

Individual Behavior Program in both the HCS and ICFMR programs documents dangerous behaviors that require intervention and additional staff.

Medical Increase is ICFMR only and documents medical issues/problems and the need for additional nursing interventions.

Planning - Get the Most Out of Waiver Services

Self-Determination

Public funding for community-based services improves the lives of thousands of Texans with disabilities daily. As in most publicly funded programs, lots of rules and regulations accompany those services and supports. Those rules are there for a reason, but they can also interfere with doing things the way anyone else would or could do something if they didn't have a disability. Self-determination, or the process by which a person controls their own life, is not easy to achieve for anyone, much less a person with a disability who depends on others to assist them. However, knowing these *five principles* and using them in the **assessment, planning, budgeting and service delivery process** as much as possible, may help to achieve self-determination. Every person needs:

Freedom to choose a meaningful life in the community

Authority over a targeted amount of dollars

Responsibility for the wise use of public dollars and recognition of the contribution individuals with disabilities can make to their communities

Support to organize resources in ways that are life enhancing and meaningful to the individual with a disability

Confirmation of the important leadership role that individuals with disabilities and their families must play in a newly re-designed system and support for the self-advocacy movement

Resources: <http://www.self-determination.com> and <http://www.selfdetermined.org>

Good Services Start with a Good Plan

The most important step in developing the waiver Individual Service Plan and Individual Plan of Care is to know and use a person-centered planning process. Person-centered means the process from the perspective of the person with the disability; what is important to them; what are their greatest needs, desires and life goals; and what it will take to get them there.

The traditional approach to planning looks at what the provider has available. It may be described as an array of services and look like a menu where you select the best available.

A plan that is person-centered describes how you want to live in the community, what you have now and what you need to achieve your personal goals. It describes supports and services in a meaningful way, linking a goal such as "work in the community" to a real service, such as "supported employment." A person-centered approach can be used and meet the requirements of the Individual Service Plan (ISP). Remember that the ISP must include an assessment, discussion and - most important - justification of each service paid by the Medicaid waiver. The outcomes identified in the person-centered plan should direct the type and amount of services.

Person Centered Planning Websites

Pacer Center

<http://www.pacer.org/tatra/resources/personal.asp>

Allen, Shea and Associates

<http://www.allenshea.com>

Capacity Works

<http://www.capacityworks.com>

Center on Human Policy

<http://disabilitystudies.syr.edu/>

Essential Lifestyle Planning Network

<http://www.elpnet.net>

Training Resource Network, Inc.

<http://www.trninc.com>

Imagine Enterprises

http://www.imagineenterprises.com/person_centered_planning.html

Plan, Budget & Services

Waiver recipients must have a PLAN and a BUDGET in place before they can receive services. The planning process, documentation and delivery and must meet federal and state guidelines for payment of services. Unfortunately, the planning terminology across all of the waivers is not the same and begins to look like 'alphabet soup'. The Case Manager should assist in deciphering the process. Never hesitate to ask for clarification when someone uses an acronym such as ISP, IPP, IPC, PCP, LOC, LON, I, 5, 8, 6, 9, etc. etc..

THE PLAN – Depending on the waiver the plan is documented in the Individual Service Plan (ISP), Individual Program Plan (IPP) or Permanency Plan. The plan describes all the assessment that identifies services necessary for the person to live in the community and provides the basis for a service and support plan, from which the budget is derived. Here are the basic plan development rules:

- The plan process and report includes the assessments, recommendations, discussions, conclusions, justifications and outcomes for the individual.
- A plan is never based solely on what services are available. The plan should reflect services and outcomes based on assessment of the individual's strengths, family and/or personal supports, personal goals and individual needs.
- The plan must include documentation of discussions and conclusions by the team that the *services are justified and necessary*. A service cannot be provided just because it is wanted. The individual and their family must help the service provider justify why the service is important and needed.
- The plan must support every service listed on the IPC. In addition the ISP must document that other service sources are unavailable and that services do not replace existing supports.

THE BUDGET – Depending on the waiver, the budget is documented in the Individual Plan of Care (IPC) or the Individual Service Plan (ISP). The budget describes the allowable services to be provided to the waiver recipient and the annual cost of those services. The budget specifies the type and amount of each waiver service that is to be provided to the person.

The annual budget is the estimated cost of program services for a 12-month period starting on the date that the initial or renewal service plan begins. It is an essential feature of the plan and the waiver recipient can ask to see their budget and have it explained. Although the plan is updated annually, it can also be changed ***whenever a person's needs for services and supports change***.

Allowable Services & Why They Must Be Needs Based

Allowable services are the service components provided by the waiver program. Each waiver program offers an array of services. Service components and service definitions differ between the Medicaid waiver programs. I may be helpful to look at the Medicaid Waiver Services Comparison chart found in Which Waiver Does What to best determine which service within a waiver meets a specific outcome or identified need.

Services selected for the individual plan must be based on needs identified in the intake, assessment and interview process. 'Needs based' is a justification for each of the services you are requesting to include in the plan and the funding that is allocated to provide that service. All the services selected must relate back to some need identified, some problem that seeks resolution, or some goal that the individual wishes to attain that they need support in order to complete.

Services can change from year to year, so it is a good idea to learn to negotiate, problem solve and plan over several years of services. The person-centered planning process helps a person to identify service needs that are non-negotiable, meaning they must have them in order to resolve or accomplish the most essential needs. They take priority over everything else. Then there are negotiable needs that can be very important, but the limits on resources may result in waiting a while, finding another resource or designing another way to accomplish the goal.

Identifying Non-Waiver Services

The plan and budget will also refer to services that can be provided by other resources than the waiver. This often includes generic community services such as transportation, housing, food subsidies, support from other organizations such as Vocational Rehabilitation and schools. Tapping into multiple community and neighborhood resources is a good way to broaden the possibilities and maximize the use of your Medicaid waiver resources.

Commonly Used Terms & Agency Jargon

ADA: The Americans with Disabilities Act of 1990. An Act of Congress that protects the rights of persons with disabilities from discrimination in employment, government services and public accommodations.

ADVOCACY, INC.: An agency that advocates for, protects and advances the legal, human and service rights of people with disabilities.
<http://www.advocacyinc.org>

ASSESSMENTS:

Inventory for Client and Agency Planning (ICAP): A standard assessment at intake and every three years to determine the level of support and supervision a person needs, including behavior. The ICAP rating determines the services a person could warrant in the Level of Need (LON) assignment.

Mental Retardation/Related Condition (MR/RC) Assessment Form: The assessment used by ICF/MR, HCS, TxHmL, CLASS, DBMD programs to assign a Level of Care (LOC) and Level of Need (LON) determination that follows the federal requirements.

Client Assessment, Review and Evaluation (CARE) Form 3652-A: Determines if the person meets the level of care criteria for Nursing Facility care in order to receive the CBA waiver.

Resident Assessment Instrument-Home Care Assessment for Nursing Home Risk: Evaluation to determine if the person meets two or more of the criteria for nursing home risk for the CBA waiver.

ASSISTIVE TECHNOLOGY (AT): Includes both devices and services. AT devices are items, equipment or products used to maintain or improve a person's ability to function.

COLLABORATION: Working cooperatively with others to achieve common goals.

COMMUNITY-BASED: Focuses on providing services in the community. This approach allows a person with a disability to participate as fully as possible in all aspects of family and community life.

COMMUNITY BASED ALTERNATIVES

(CBA): Services and supports provided to persons age 21 or older in their own home, an assisted living facility or an adult day care setting as an alternative to institutional care in a nursing facility.

COMMUNITY LIVING & SUPPORT SERVICES (CLASS):

Home and community based services and supports, such as habilitation, minor home modifications, nursing, specialized therapies, respite and case management, available for persons with developmental disabilities other than mental retardation as an alternative to institutional placement.

CONSENT/INFORMED CONSENT: When you agree to do something or give permission to do something. To give informed consent, you must understand what you are agreeing to, be over the age of 18 and not have a guardian.

CONSOLIDATED WAIVER PROGRAM

(CWP): Only available to people living in Bexar County. More information about CWP is available through the Department of Aging and Disability Services (DADS).

CONSUMER DIRECTED SERVICES (CDS):

An option in some waivers, allowing the person to become the "employer of record" and manage their personal assistance and respite care services.

CONSUMER DIRECTED SERVICES

AGENCY (CDSA): Consumers select an agency to perform payroll functions, employer orientation, training and support, and administrative and financial responsibilities on their behalf.

DEAF BLIND WITH MULTIPLE DISABILITIES (DBMD):

Home and community based services for persons who have legal blindness; a chronic, severe hearing impairment; or a condition that leads to deaf-blindness and a third disability that results in impairment to independent functioning. This program is an alternative to institutional care and offers services such as attendant care, orientation and mobility, and assisted living.

DEVELOPMENTAL DISABILITY: A disability which results from a mental or physical impairment, begins before age 22, is likely to be lifelong, results in major limitations in everyday functioning (self-care, language, mobility, self-direction, capacity for independent living, and economic self-sufficiency) and reflects a child's need for special services that are individually planned and coordinated.

DUE PROCESS: Usually refers to the procedures set up for parents of children with special education needs or the public agency to challenge decisions about the evaluation, placement or services for a child. It is mandated by the Individuals with Disabilities Education Act (IDEA).

ELIGIBILITY: When specific conditions or criteria are satisfied, you meet the requirements to receive that service. Because Medicaid waivers are not an entitlement, many people who are eligible remain on a interest (waiting) list.

ENTITLEMENT: When eligibility criteria is met, the person has the right to receive the service. Basic Medical health coverage for low-income individuals is an entitlement.

FUNCTIONAL SKILLS: Skills that are important for everyday living such as how to shop for groceries, talk to one's boss, dress appropriately, feed oneself or balance a checkbook with a calculator.

GOAL: The desired result that a person wants to achieve. A goal should determine the training or services a person receives. Personal goals that take a long time to achieve may be broken down into smaller, measurable objectives.

GUARDIANSHIP: The formal legal appointment of a person or a corporation as the decision-maker for an adult who has been established by a court as not able to make decisions on his or her own behalf. See *Power of Attorney*.

HOME & COMMUNITY-BASED SERVICES PROGRAM (HCS): Services and supports available in a person's own home or family home, or in a small residential program. Services include day habilitation, employment assistance, respite and specialized therapies.

ICF/MR: 24-hour residential and habilitation services provided in homes for groups ranging in size from six to more than 100 people.

INCLUSION: When persons with disabilities are not only in the same place as persons without disabilities, but also participate in the same activities at the same time.

INDEPENDENT LIVING SKILLS: Activities that a person needs to be able to do to live more independently or on his/her own with limited support (i.e. shopping, budgeting, seeking health care, getting around in the community).

INDIVIDUAL PLAN OF CARE (IPC): The individual plan of care must specify the type, units, frequency and cost of waiver services required to support the individual in the community.

INDIVIDUAL PROGRAM PLAN (IPP): Narrative report that includes a participant's service goals and objectives, the services provided, and the

status of the objectives for the CLASS, CWP and DBMD waivers.

INDIVIDUAL SERVICE PLAN (ISP): Specifies the waiver services (types, units, frequency, and duration) a participant receives. It also identifies non-waiver services that the participant accesses in the community. The ISP justifies the budget developed in the Individual Plan of Care (IPC) for the HCS, TxHmL and CBA waivers. In CLASS, CWP and DBMD this document also contains the budget.

INDIVIDUALIZED EDUCATION PROGRAM (IEP): A written plan that identifies a child's strengths, needs, education, and related service needs. The IDEA mandates that an IEP be developed for all children eligible under IDEA for special education services. The plan must be reviewed at least yearly.

INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA): The federal law that mandates a "free appropriate public education" to all eligible children with disabilities (including mental, physical, and emotional disabilities) who, because of their disability, require special instruction in order to learn.

INTEREST LIST: Applications placed on a list for DADS community-based services.

JOB PLACEMENT: When an organization helps a person find a job by matching his/her interests and skills with the needs of local employers.

LEGAL AUTHORIZED REPRESENTATIVE (LAR): A person authorized or required by law to act on behalf of an individual. The person may be a parent, guardian, managing conservator of a minor, or the guardian of an adult.

LEVEL OF CARE (LOC): A determination of eligibility for an individual in either the DADS waiver or ICF/MR programs.

LEVEL OF NEED (LON): A LON is assigned based on DAD's review of information reported on an individual's MR/RC Assessment, including ICAP service level score and any supporting documentation reviewed. There are five LONs recognized: 1,5,6,8, and 9.

LONG TERM CARE: Medical, residential and habilitation services provided over the lifetime of the person.

MEDICAID: Medical health coverage for low-income individuals and families who fit into an eligibility group that is recognized by federal and state law.

MEDICALLY DEPENDENT CHILDREN PROGRAM (MDCP): Services and supports to families caring for medically dependent child in their home, who is less than 21 years of age. These services may include adaptive aids, adjunct support services (such as those that support independent living, participation in child care and participation in post-secondary education), minor home modifications, respite and transition assistance services.

NETWORKING: Interacting and sharing ideas, resources, and services with others. Many self-advocates and parents network with others by working with parent support groups, reading newsletters and attending conferences.

OBJECTIVES: Statement(s) of what a person needs to learn or do to accomplish a goal. Objectives state specifically who, what, where, when and how training, activities or services will be provided in order to accomplish a goal.

OUTCOME-ORIENTED PROCESS: Begins with the outcome statement and has a life span that exceeds the one-year life of the program plan. The outcome statement is not a behavior objective or a goal statement; it is a destination statement pointing to where the person will be several years in the future. All outcome statements are based on a person's preferences, interests, and needs.

PERMANENCY PLAN: An evaluation and planning tool for individuals under the age of 22 residing in nursing facilities, facilities licensed by the Department of Family and Protective Services, ICFMR or HCS residences. The local Mental Retardation Authority is required to communicate with the provider of services, family members or guardians to collect information and create a plan of services.

PERSON-CENTERED PLANNING: A planning process that facilitates a new way of thinking about planning for people with disabilities and their families. The process focuses on the individual and his/her strengths and interests. The planning process is directed and controlled by the person with a disability, with involvement by individuals of their choice.

POWER OF ATTORNEY: A document used to appoint someone else (a parent, agent or friend) to act on your behalf on matters that you specify. This may be helpful when a person is 18 years of age and wishes to have a parent at educational and/or Medicaid waiver meetings. A separate *Medical Power of Attorney* form is needed for medical decisions. The authority granted in the Power of Attorney ceases at the death of the person granting the power.

RESIDENTIAL OPTIONS: Alternative living arrangements for people with disabilities other than living with their families. Residential options could include group homes, supported apartment living, adult family homes or your own home.

RESPIRE CARE: Short-term, temporary care for persons with a disabilities that relieve regular caregivers to have time for other activities. It ranges from a few hours to a few days and may be provided in or outside the home.

SECTION 504: Refers to Section 504 of the Rehabilitation Act of 1973 that guarantees the civil rights of students and adults with disabilities.

SELF-ADVOCACY: Speaking or acting for oneself in a way to provide protection for one's own rights and needs.

SHELTERED EMPLOYMENT/SHELTERED WORKSHOP: People with disabilities working in a facility with other people with disabilities. Work is typically contract work paid on a piece rate basis and wages are usually sub-minimum. Workers are typically paid by the vocational agency managing the workshop.

SOCIAL SECURITY DISABILITY INSURANCE (SSDI): A Federal payment through Social Security for workers with disabilities.

SPECIAL EDUCATION: Education provided to children with disabilities whose abilities (physical, mental, and social) and learning styles require alternative teaching methods or related support services to enable the child to benefit from the educational program.

SUPPLEMENTAL SECURITY INCOME (SSI): A monthly check through the Social Security Administration for eligible persons who do not own many things or have much income and have a physical or mental disability or blindness.

SUPPORTED EMPLOYMENT: Services assist the person to obtain full-time or part-time work for commensurate pay in regular integrated work settings with access to continuous or periodic support services necessary to maintain that employment over time.

TEXAS COUNCIL FOR DEVELOPMENTAL DISABILITIES: The mission of the Texas Council for Developmental Disabilities is to create change so that all people with disabilities are fully included in their communities and exercise control over their own lives. <http://www.txddc.state.tx.us>

TEXAS HOME LIVING PROGRAM (TXHML): Services and supports, such as day habilitation, respite and employment assistance, for persons who live in their own home or their family's home.

VOCATIONAL REHABILITATION: Vocational Rehabilitation (VR) is a nationwide program that helps people with disabilities find employment, whether they simply need a job to pay the bills or and find more meaningful, long-term careers.

Navigating Social Security

Government assistance through Social Security is one of the most common sources of income for people with disabilities. The Social Security Administration (SSA) funds two major programs that assist people with disabilities and their families. The two major programs are Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI).

Getting through the fears and myths of Social Security

- It is possible to be employed, earn money and receive Social Security benefits using SSA's work incentives.
- It is important to apply even if you are not sure you will be eligible.
- If the process seems complicated, don't get discouraged! The time and effort you put into applying are well worth the benefit.

Social Security Disability Insurance (SSDI)

Social Security Disability Insurance (SSDI) benefits are paid when a person retires or becomes disabled and cannot work. People eligible for SSDI must have worked long enough to have paid into the program. A disabled widow(er) or adult children with disabilities may also be eligible for SSDI, even if they have minimal - or no - work history.

Supplemental Security Income (SSI)

Supplemental Security Income (SSI) is a benefit program for people who are blind and/or have other physical or mental disabilities. This program pays a monthly check to people who do not qualify for SSDI benefits because they have not paid in to the Social Security system. Parental income and resources is used for deeming eligibility for SSI for children with a disability. When a child turns the age of 18, the age of majority, their own income and resources is used for deeming eligibility.

IMPORTANT NOTE: A child who receives SSI benefits MUST reapply at age 18 to determine if he or she qualifies for these benefits as an adult. To avoid an interruption in benefits—or the prospect of having to return overpayments—it's a good idea to find out about the process before the child's 18th birthday. Contact SSA (see information on this page) for more detail.

Medicaid Buy-In

Working Texans with disabilities can purchase their health insurance through Medicaid by paying a monthly premium. Those who apply for the Medicaid Buy-In program must meet work and disability requirements as well as resource and income limits.

Work requirement: The person applying must have enough earnings and FICA contributions in a calendar quarter for the Social Security Administration to count it as a qualifying quarter. Currently, this amount is \$970 a quarter.

Disability requirement: The person already receives disability benefits from the Social Security Administration, or HHSC's Disability Determination Unit will process the person's information using Supplemental Security Income criteria without consideration of earned income.

Resource limit: Excluding certain resources, have \$2,000 or less in countable resources.

Income limit: The person applying must have monthly income under 250 percent of the federal poverty level. For an individual, that means income of less than \$2,042 a month. Certain income will be excluded when determining income eligibility.

To apply for the Medicaid Buy-In program the same way you apply for other Medicaid benefits call 2-1-1, go to <https://www.yourtexasbenefits.com/wps/portal> or find your local HHSC Benefits office at <https://www.yourtexasbenefits.com/wps/themes/html/SSPortal/officeLocator/results.html>

How to Apply for Social Security Benefits

Apply via the Internet at SSA's website:
<http://www.ssa.gov>

Or, visit your local Social Security Office. To find your local SSA office:

- Call the Social Security Administration toll-free:
800-772-1213 - VOICE
800-325-0778 - TTY
- Go to the SSA website and type in your zipcode
<https://secure.ssa.gov/apps6z/FOLO/fo001.jsp>
- Check the government listings (blue pages) of your local telephone directory.

To apply for Social Security benefits, you will need:

- Your Social Security number;
- Birth certificate;
- Names, addresses and phone numbers of doctors;
- Your medications and dosages;
- Medical records from doctors and hospitals;
- A summary of your work history;
- Information about where you live and mortgage, lease or landlord information; and
- Payroll slips, banking information, insurance and car registration.

Decision Making & Legal Rights

Parents or family members may feel that they need “guardianship” in order to assist their adult son/daughter/ brother/sister with a disability to negotiate life and be safe. For many people, it is applying a legal solution to personal issues that can be handled through less intrusive means. Guardianship is a legal process designed to protect vulnerable persons from abuse, neglect (including self-neglect) and exploitation. It’s important to understand guardianship—and its consequences—some of which may not be desirable for the individuals or families:

- In the legal system, guardianship removes rights and privileges from an incapacitated person (referred to as the “ward”).
- Full guardianship removes all legal rights from the person.
- Obtaining guardianship involves the court system and, typically, attorney fees. This can create an unnecessary financial hardship on families.

There are **alternatives to guardianship** that respect the person’s rights and privileges and define the needed supports for a person with a disability to be safe. The following alternatives can help individuals with disabilities and their advocates handle decision-making in a way that enables the person the dignity and freedom to develop and participate in the lives they want and choose:

- **Person Directed Planning:** The process of planning for and supporting an individual that honors the individual’s preferences, choices and abilities, regardless of their level of disability. This process of determining preferences and choices enhances the dignity and self-determination of individuals and is far more reliable than having a single court-appointed person to make all decisions with or without the input of the individual with a disability.
- **Money Management:** Money management programs offer a less restrictive alternative to guardianship for low-income elderly individuals and adults with disabilities who are incapable of managing their money/checking accounts themselves and have no one else available or appropriate to assist them.
- **Power of Attorney:** A Power of Attorney (POA) is an instrument executed by an adult who has capacity authorizing another person to act as his or her agent. The power to the agent may be either specific or general.
- **Durable Power of Attorney:** If specifically stated in the document, the POA becomes a durable power of attorney and does not terminate upon the disability or incapacity of the principal.
- **Durable Power of Attorney for Health Care:** The durable power of attorney for health care is an instrument executed by an adult with capacity giving another person the authority to make health care decisions for him or her.
- **Social Security’s Representative Payment Program:** Provides fiduciary assistance for Social Security beneficiaries who are incapable of managing or directing someone else to manage their Social Security or SSI payments. Generally, family or friends are asked to serve in this capacity. When friends and family are not able to serve as payee, SSA looks for qualified organizations to be a representative payee. For more information, see the Social Security Administration website: <http://www.ssa.gov/payee>
- **Trustee:** If a substantial amount of money comes into the individual’s life, there are trust documents that can be drafted that can protect the governmental benefits and still use the funds to provide an enhanced life for the individual. A trustee or co-trustees can be designated to distribute the funds and see that the individual’s needs and desires are met. Such a trust can specify that someone visit the person and assure that the individual is satisfied with his or her living situation and support systems. A knowledgeable attorney or The Arc of Texas can be consulted about trust documents. The Arc of Texas website has more information: <http://www.thearcoftexas.org> (See Master Pooled Trust).

In addition to these methods, there are many more alternatives to guardianship that can be devised to fit specific issues. For more information about guardianship, check out this website: <http://www.texasguardianship.org>. Because guardianship takes away a person’s rights, the Texas courts will look for a less restrictive alternative before granting a guardianship. Texas laws also express a clear preference for partial guardianship for limited

About Providers & Your Rights

Texas Ombudsmen

An Ombudsman is a “citizen representative” who has the responsibility to assist individuals in long term care programs by identifying problems, investigating and resolving complaints on the behalf of the citizens. You can locate your local Ombudsman by calling 1-800-252-2412 or contacting your local Area Agency on Aging office. You can also receive further information by sending an email to toughenoughtocare@dads.state.tx.us

The Provider and You

After notification that you will receive services and beginning with the initial enrollment process, you will choose a provider of services. While all providers of service are required to furnish the same array of services, you will find that there is the need to shop around for the best quality of services – just as there is when choosing a phone company or a mechanic to fix your car. You will be furnished with a list of provider names and contact information. It is important that you spend some time and energy up front choosing the best provider for you. This can save you much more time, energy, and a lot of frustration down the road. Each provider is audited by the state licensing agency each year. Review the results of their most recent audit to look for trends in performance. This information can be found at the provider’s office or look up information on Long Term Care Quality Reporting System:

http://facilityquality.dhs.state.tx.us/ltcqrs_public/nq1/jsp3/qrsHomeI.en.jsp?MODE=P&LANGCD=en

Some tips for choosing your provider:

- Shop around: Contact numerous providers from the provider list so you can make an informed choice.
- Use word of mouth: Talk to others who use the same or similar services for input as to their experiences with various providers.
- Contact local advocacy groups to get information regarding provider recommendations. However, be aware that some advocacy groups may double as providers and may not be as objective as you would like. Mental Retardation Authorities and DADS offices are NOT permitted to give recommendations.
- First impressions: Go with your instincts when meeting providers for the first time. Ask yourself:
 1. “Were they friendly, courteous, helpful, and respectful?”
 2. “Did they answer my questions?”
 3. “Did they answer my questions in wording I could understand?”
 4. “Did they seem truly interested in me?”
 5. “Did they follow up when they said they would?”
 6. “Was their office clean and organized?”
 7. “Did they see me/speak with me in a timely manner?”
- Take notes when speaking with providers. The process of starting services includes a lot of details and concepts that will be new to you.
- Get copies of all paperwork reviewed with providers.
- Have a friend or family member go with you to meetings. That second set of ears may pick up on details that you miss.
- Feel free to ask a provider why you should choose them. A good provider will be happy to share information regarding those services they excel at.

Working With Your Provider

Throughout your interactions with a provider, always remember that you are the customer and the expert at knowing what you need. The provider is the professional. As the customer, you must advocate for yourself and clearly identify what you need. As the professional, the provider is paid to use their knowledge and expertise to help you meet your needs. With both you and the provider consistently working to fulfill these roles, you will have the benefit of a wonderful array of services and supports that will increase your independence and improve the quality of your life.

It is important to note that should you become unhappy with the quality of services you receive from a provider, you have the right to choose a different provider at any given time. However, please assist your current provider in improving their quality by notifying the management of the provider organization of any concerns or issues you have. You may find that they are eager to meet your needs and can adjust their services accordingly. If you find that this is not the case you can notify them of your decision to change providers, and they will assist you in this process by providing a current list of all providers for your area. Once you identify the provider organization you want to change to, they will meet with you and your new provider to ensure a smooth transition.

Self Determination *for* Texas



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Statewide Resources & References

Information about the Medicaid waivers

http://www.dads.state.tx.us/providers/waiver_comparisons/

Texas Medicaid Perspectives (2007)

<http://www.hhsc.state.tx.us/medicaid/reports/PB6/PinkBookTOC.html>

Know Your Options (DADS Publication, 2/08)

http://www.dads.state.tx.us/news_info/publications/brochures/DADS262_KnowYourOptions.pdf

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