The Health and Human Services Commission (HHSC) proposes, on behalf of the Department of Aging and Disability Services (DADS), amendments to §46.21, concerning reimbursement; §46.41, concerning required services; and §46.45, concerning required notifications, in Chapter 46, Contracting to Provide Assisted Living and Residential Care Services.

BACKGROUND AND PURPOSE

The purpose of the amendments is to implement rule changes necessitated by a project under the direction of HHSC that will replace the state case-mix system for provider payments, which is based on the Texas Index for Level of Effort (TILE) model, with the federal case-mix system, which is based on the Resource Utilization Group (RUG) model. The TILE-to-RUG project implements Texas Health and Safety Code, §242.221 et seq, which requires DADS to use an automated system for nursing facility reimbursement and an assessment form designed by the United States Health Care Financing Administration (now the Centers for Medicare and Medicaid Services). As allowed by Texas Health and Safety Code, §242.221(b), DADS and HHSC have elected to add other components of the state Medicaid program, such as the Community Based Alternatives (CBA) Program, to the automated system of reimbursement and, therefore, to require use of an assessment form similar to the form on which nursing facility residents are assessed. The proposed amendments concern assisted living and residential care services offered under the CBA Program.

The purpose of the amendments is also to replace references to the Texas Department of Human Services and DHS with references to DADS.

SECTION-BY-SECTION SUMMARY

The proposed amendments to §46.21 and §46.45 replace references to procedures under the TILE model with more generic references, such as "level of care." The amendments also change DHS to DADS.

The proposed amendment to §46.41 deletes a sentence in subsection (b)(5) concerning the determination of a TILE score, because this reference will be obsolete with the implementation of the RUG model. The amendment also adjusts the grammatical structure of the rule to provide clarity.
FISCAL NOTE

Gordon Taylor, DADS Chief Financial Officer, has determined that, for the first five years the proposed amendments are in effect, enforcing or administering the amendments does not have foreseeable implications relating to costs or revenues of state or local governments.

SMALL BUSINESS AND MICRO-BUSINESS IMPACT ANALYSIS

DADS has determined that the proposed amendments will have no adverse economic effect on small businesses or micro-businesses, because the amendments impose no new requirements that would cause them to alter their business practices.

PUBLIC BENEFIT AND COSTS

Barry Waller, DADS Assistant Commissioner for Provider Services, has determined that, for each year of the first five years the amendments are in effect, the public benefit expected as a result of enforcing the amendments is that the rules will reflect accurate terminology and provide accurate requirements for providers.

Mr. Waller anticipates that there will not be an economic cost to persons who are required to comply with the amendments. The amendments will not affect a local economy.

TAKINGS IMPACT ASSESSMENT

DADS has determined that this proposal does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Texas Government Code, §2007.043.

PUBLIC COMMENT

Questions about the content of this proposal may be directed to Gilbert Estrada at (512) 438-2578 in DADS’ Provider Services Division. Written comments on the proposal may be submitted to Texas Register Liaison, Legal Services-014, Department of Aging and Disability Services W-615, P.O. Box 149030, Austin, Texas 78714-9030, or street address 701 West 51st St., Austin, TX 78751; faxed to (512) 438-5759; or e-mailed to rulescomments@dads.state.tx.us. To be considered, comments must be submitted no later than 30 days after the date of this issue of the Texas Register. The last day to submit comments falls on a Sunday; therefore, comments must be either (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered to DADS before 5:00 p.m. on DADS’ last working day of the comment period; or (3) faxed or e-mailed by midnight on the last day of the comment period. When faxing or e-mailing comments, please indicate "Comments on Proposed Rule 014" in the subject line.
Legend:

Single Underline = Proposed new language
[Strike through and brackets] = Current language proposed for deletion
Regular print = Current language
(No change.) = No changes are being considered for the designated subdivision.

STATUTORY AUTHORITY

The amendment is proposed under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Health and Safety Code, §242.226, which authorizes the adoption of rules necessary to improve the efficiency of the reimbursement process for the state Medicaid system and maximize the automated reimbursement system's capabilities.

The amendment affects Texas Government Code, §531.0055 and §531.021; Texas Human Resources Code, §161.021; and Texas Health and Safety Code, §242.226.

§46.21. Reimbursement.

(a) The facility must bill for services provided as described in Chapter 49 of this title (relating to Contracting for Community Care Services).
(b) The [Texas] Department of Aging and Disability Services (DADS) will pay for eligible services provided and billed in compliance with this chapter.

(c) A unit of service is one billable day of authorized service delivered to a client.

(d) The facility must agree to accept the unit rate authorized by DADS, plus any applicable room and board payments, as payment in full for services required by DADS.

(e) The unit rate reimbursed by DADS includes any copayment. The combined reimbursement from DADS and the client or the client's representative for the required services described in §46.41 of this chapter (relating to Required Services) must not exceed the unit rate plus room and board specified for each type of setting. The unit rate does not include charges for services described in §46.15 of this chapter (relating to Additional Services and Fees).

(f) The facility must deduct the copayment amount from reimbursement claims submitted to DADS.

(g) The facility must not bill DADS for the day of discharge, unless the discharge is due to the death of the client.

(h) The facility must bill the double occupancy (Residential Care Apartment) rate for clients in the single occupancy (Assisted Living Apartment) setting who request double occupancy.

(i) The facility must bill DADS for the balance of the bedhold charge for any clients whose daily copayment is less than the maximum bedhold charge allowed by DADS.

(1) The facility must determine the client's daily copayment amount by dividing the client's monthly copayment charge by the number of days in the month.

(2) The facility must deduct the client's daily copayment amount from the bedhold rate and submit the claim to DADS.

(3) This subsection does not apply to the Community Based Alternatives (CBA) Assisted Living/Residential Care (AL/RC) Program.

(j) The facility may bill DADS for emergency care provided to clients for:

(1) up to 60 days per authorization for eligible clients; or

(2) five days for a client ineligible for emergency care.
(k) The facility must not bill for services provided before or after the authorized effective dates for CBA AL/RC or Community Care for Aged and Disabled (CCAD) Residential Care (RC) services, as those dates are determined by DADS [DHS].

(l) When the facility requests a level of care [Texas Index of Level of Effort (TILE)] reset, the facility may bill DADS [DHS] at the new payment rate [TILE level] effective the date of the new [TILE] assessment. The facility may request only two level of care [TILE] resets during each calendar year for each CBA client for the following time periods:

1. January through June; and
2. July through December.

(m) CCAD RC services will be reimbursed at the double occupancy rate, regardless of the actual occupancy.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on ____________.

TITLE 40    SOCIAL SERVICES AND ASSISTANCE
PART 1    DEPARTMENT OF AGING AND DISABILITY SERVICES
CHAPTER 46   CONTRACTING TO PROVIDE ASSISTED LIVING AND RESIDENTIAL CARE SERVICES
SUBCHAPTER C  PROVIDER REQUIREMENTS
RULES    §46.41, §46.45

Proposed action:
X  Amendment

STATUTORY AUTHORITY

The amendments are proposed under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code,
§531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Health and Safety Code, §242.226, which authorizes the adoption of rules necessary to improve the efficiency of the reimbursement process for the state Medicaid system and maximize the automated reimbursement system's capabilities.

The amendments affect Texas Government Code, §531.0055 and §531.021; Texas Human Resources Code, §161.021; and Texas Health and Safety Code, §242.226.

§46.41. Required Services.

(a) Service delivery. The facility must provide services according to the service plan completed for the client.

(b) Required services. Services include:

(1) Personal care. The facility must provide or assist with personal care services identified on the service plan completed for the client. Personal care services are activities related to the care of the client's physical health that include at a minimum:

(A) bathing;
(B) dressing;
(C) grooming;
(D) routine hair and skin care;
(E) exercising;
(F) toileting;
(G) medication administration, including injections, except in [This does not apply to] the Community Care for Aged and Disabled (CCAD) Residential Care (RC) Program;
(H) transferring/ambulating, except [This does not apply to clients residing] in a Type A assisted living facility;
(I) twenty-four-hour supervision, which means the facility must:

(i) conduct checks or visits to each client as identified in the client's service plan, to ensure that each client is safe and well; and

(ii) document the checks and visits in the client's file; [The facility must conduct and document in the client file checks or visits to each client to

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ensure that each client is safe and well. The checks or visits must be made as identified on the service plan completed for the client; and]

(J) meal services, which means the facility must:

(i) provide meal services as described in §92.41(m) of this title (relating to Standards for Type A, Type B, and Type E Assisted Living Facilities);

(ii) offer dietary counseling and nutrition education to the client;

(iii) modify food texture, including:

(I) chopping, grinding, and mashing foods for clients who have trouble chewing; and

(II) cutting up food into bite size pieces for clients who have trouble cutting food; and

(iv) assist with eating, including:

(I) assistance with spoon-feeding in instances when the client is temporarily ill;

(II) bread buttering; and

(III) opening containers or pouring liquids for clients with hand deformities, paralysis, or hand tremors.

(2) Home management. The facility must provide or assist with activities related to housekeeping that are essential to the client's health and comfort, including:

(A) changing bed linens;

(B) housecleaning;

(C) laundering;

(D) shopping;

(E) storing purchased items in the client's living unit, including medical supplies delivered to Community Based Alternatives (CBA) Assisted Living/Residential Care (AL/RC) clients; and

(F) washing dishes.
(3) Transportation and escort.

(A) The facility must provide the client with transportation, escort, or both to:

(i) local community areas where a client may purchase items to meet his or her personal needs or conduct personal business according to the facility's published schedule;

(ii) recreational activities, field/community trips according to the facility's published schedule; and

(iii) the nearest available medical provider for medical appointments, therapies, and other medical care.

(B) The facility must make arrangements for other transportation for the client to the medical care provider of the client's choice if the client's medical provider is not the nearest available provider.

(4) Social and recreational activities. The facility must provide a minimum of four scheduled social and recreational activities per week.

(A) Activity requirements. The social and recreational activities must be:

(i) planned to meet the social needs and interests of the clients; and

(ii) listed on a monthly calendar that is posted in plain view at the facility at least one week in advance.

(B) Types of activities. Social and recreational activities include:

(i) activities that require group and client-initiated activities;

(ii) opportunities to interact with other people;

(iii) interaction, cultural enrichment, educational, or recreational activities; and

(iv) other social activities on site or in the community.

(5) Participation in the client assessment. The facility must designate someone who is familiar with the CBA AL/RC client's needs and service plan to participate in [with] the client's assessment by a home and community support services
agency's licensed nurse. [The assessment will determine the Texas Index of Level of Effort (TILE) at both the annual assessment, and a requested re-assessment of the re-TILE.] A facility is not required to designate someone to participate in a client's [Participation in the client] assessment in [does not apply to] the CCAD RC Program.

(6) Emergency care. The facility must provide emergency care as authorized by the case manager.

(A) Emergency care is assisted living services provided to clients while the case manager seeks a permanent living arrangement.

(B) Emergency care services do not apply to the CBA AL/RC program.

§46.45. Required Notifications.

(a) The facility must notify the [Texas] Department of Aging and Disability [Human] Services (DADS) [DHS] when one of the following happens:

(1) significant changes in the client's health and/or condition;
(2) the client temporarily enters an institution;
(3) serious occurrences or emergencies involving the client or facility staff;
(4) the client or the client's representative requests that services end;
(5) the client refuses to comply with the service plan;
(6) the client engages in discrimination in violation of applicable law;
(7) the client or the client's representative fails to pay copayment;
(8) the client uses ten personal leave days in the current calendar year;
(9) the client or the client's representative requests to move to another facility; or
(10) [when] the facility believes that a client's functional needs have changed such that it will impact the client's level of care, if the facility provides [Texas Index of Level of Effort (TILE). This only applies to facilities providing] assisted living services under the Community Based Alternatives (CBA) Assisted Living/Residential Care (AL/RC) Program and participates [that participate] in the attendant compensation rate option.
(b) The facility must notify the client's DADS [DHS] case manager orally or by facsimile about the change no later than one DADS working day [DHS workday] after the change happens. If the facility's first notification is oral, the facility must send written notification to the case manager within five working days of the initial notification.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on _____________.
The Health and Human Services Commission (HHSC) proposes, on behalf of the Department of Aging and Disability Services (DADS), amendments to §48.6003, concerning eligibility criteria, and §48.6006, concerning the individual plan of care (IPC); and proposes the repeal of §48.6099, concerning the provision of services when costs exceed the individual cost limit, in Chapter 48, Community Care for Aged and Disabled, Subchapter J, which is being renamed Community Based Alternatives (CBA) Program.

BACKGROUND AND PURPOSE

The purpose of the amendments and repeal is to implement the 2008-09 General Appropriations Act (Article II, Department of Aging and Disability Services, Rider 45, H.B. 1, 80th Legislature, Regular Session, 2007), concerning waiver program cost limits. Rider 45 places an individual's annual cost limit for CBA Program services at 200 percent of the reimbursement rate that would have been paid for that same individual to receive services in a nursing facility; authorizes DADS, under certain conditions, to use general revenue to pay for services that exceed the cost limit; requires DADS to use general revenue to continue to provide services to a person who was receiving waiver program services, such as CBA Program services, on September 1, 2005, at a cost that exceeded the waiver program's cost limit; and requires DADS to employ utilization management and utilization review practices as necessary to ensure that the appropriate scope and level of services are provided to an individual receiving services through a waiver program.

The amendments are also proposed to update agency names and terminology, to correct cross-references, and to reorganize the structure of the rule for clarity and consistency with other DADS programs operated in accordance with §1915(c) of the federal Social Security Act.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §48.6003 provides a definition for "individual" and replaces the terms "applicant" and "participant" with "individual" to provide consistency throughout the rule. The amendment also replaces two cross-references to nursing facility rules, concerning qualifications for medical necessity determinations, with one cross-reference to a proposed new nursing facility rule (40 TAC §19.2401), concerning qualifications for medical necessity determinations. The proposed new §19.2401 is published elsewhere in this issue of the Texas Register. The amendment to §48.6003 implements Rider 45 provisions by: (1) increasing the cost limit from 100 percent of the
individual's actual nursing facility payment rate to 200 percent of the reimbursement rate that would have been paid for that same individual to receive services in a nursing facility; and (2) providing a cross-reference to 40 TAC §40.1 (proposed as a new section elsewhere in this issue of the Texas Register), which governs the use of general revenue, under certain conditions, to pay for services that exceed the cost limit. The amendment to §48.6003 also revises terminology, updates rule cross-references, and reorganizes the structure of the rule for clarity and consistency with other DADS waiver program rules.

The proposed amendment to §48.6006, concerning the IPC, expands the provisions of the current rule to address the utilization management and review provisions of Rider 45. Subsection (d) of the proposed amendment describes five requirements that CBA Program services in the IPC must meet in order for DADS to approve the IPC. Subsection (e) of the proposed amendment requires the CBA Program provider to submit certain information to DADS that demonstrates that the CBA Program services in the IPC meet the five requirements described in subsection (d). Subsections (f) and (g) of the proposed amendment govern the procedures for utilization review and state that DADS may conduct utilization review at any time and may deny or reduce services if DADS determines that one or more of the CBA Program services in the IPC do not meet the requirements of subsection (d).

The proposed repeal of §48.6099 eliminates a rule governing exceptions to the CBA Program cost limit. The Centers for Medicare and Medicaid Services has indicated that exceptions to the cost limit may not be granted and, therefore, this rule is no longer necessary. The provisions in §48.6099 covering an individual who was receiving CBA Program services on or before September 1, 2005, at a cost that exceeded the individual cost limit of the CBA Program have been revised to comply with Rider 45 and are included in proposed new §40.1, published elsewhere in this issue of the Texas Register.

FISCAL NOTE

Gordon Taylor, DADS Chief Financial Officer, has determined that, for the first five years the proposed amendments and repeal are in effect, enforcing or administering the amendments and repeal does not have foreseeable implications relating to costs or revenues of state or local governments.

SMALL BUSINESS AND MICRO-BUSINESS IMPACT ANALYSIS

DADS has determined that the proposed amendments and repeal will not have an adverse economic effect on small businesses or micro-businesses, because the proposal places no new requirements on small businesses or micro-businesses.

PUBLIC BENEFIT AND COSTS

Barry Waller, DADS Assistant Commissioner for Provider Services, has determined that, for each year of the first five years the amendments and repeal are in effect, the public benefit expected as a result of enforcing the amendments and repeal is that DADS
procedures for addressing situations in which an individual cannot be served within the individual cost limit of a waiver program and whose health and safety cannot be ensured in another available living arrangement will be clarified.

Mr. Waller anticipates that there will not be an economic cost to persons who are required to comply with the amendments and repeal. The amendments and repeal will not affect a local economy.

TAKINGS IMPACT ASSESSMENT

DADS has determined that this proposal does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Texas Government Code, §2007.043.

PUBLIC COMMENT

Questions about the content of this proposal may be directed to Kristi Guilbeaux at (512) 438-2756 in DADS' Provider Services Division. Written comments on the proposal may be submitted to Texas Register Liaison, Legal Services-010, Department of Aging and Disability Services W-615, P.O. Box 149030, Austin, Texas 78714-9030, or street address 701 West 51st St., Austin, TX 78751; faxed to (512) 438-5759; or e-mailed to rulescomments@dads.state.tx.us. To be considered, comments must be submitted no later than 30 days after the date of this issue of the Texas Register. The last day to submit comments falls on a Sunday; therefore, comments must be either (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered to DADS before 5:00 p.m. on DADS' last working day of the comment period; or (3) faxed or e-mailed by midnight on the last day of the comment period. When faxing or e-mailing comments, please indicate "Comments on Proposed Rule 010" in the subject line.
TITLE 40    SOCIAL SERVICES AND ASSISTANCE
PART 1    DEPARTMENT OF AGING AND DISABILITY SERVICES
CHAPTER 48   COMMUNITY CARE FOR AGED AND DISABLED
SUBCHAPTER J  [BEGIN ADDITION] COMMUNITY BASED ALTERNATIVES (CBA) PROGRAM [end addition] [begin deletion]1915(c) MEDICAID HOME AND COMMUNITY BASED WAIVER SERVICES FOR AGED AND DISABLED ADULTS WHO MEET CRITERIA FOR ALTERNATIVES TO NURSING FACILITY CARE [END DELETION]

RULE §48.6003, §48.6006

Proposed action:
X Amendment

STATUTORY AUTHORITY

The amendments are proposed under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; and Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program.

The amendments affect Texas Government Code, §531.0055 and §531.021, and Texas Human Resources Code, §161.021.

(a) In this section, the term "individual" means a person applying for or enrolled in the Community Based Alternatives (CBA) Program, unless the context clearly indicates otherwise.

(b) To be determined eligible by the Department of Aging and Disability Services (DADS) for the CBA Program provided as an alternative to care in a nursing facility, an individual applicant must:

1. be age 21 years of age or older;
2. meet the level-of-care criteria for medical necessity for nursing facility care in accordance with §19.2401 and §19.2409 and §19.2410 of this title (relating to General Qualifications for Medical Necessity Determinations and Criteria Specific to a Medical Necessity Determination);
3. choose the CBA Program as an alternative to nursing facility services, as described in the Code of Federal Regulations, Title 42, §441.302(d);
4. not be enrolled in another Medicaid waiver program approved by the Centers for Medicare and Medicaid Services (CMS) pursuant to §1915(c) of the Social Security Act and operated by DADS choose home and community-based waiver services as an alternative to nursing facility placement based on an informed choice with approval conditional on feasible alternatives available under the waiver in accordance with 42 Code of Federal Regulations §441.302(d)(1);
5. live in a county not included in a Medicaid managed care area; and
6. have an individual plan of care (IPC) with a cost for CBA Program services at or below 200 percent of the reimbursement rate that would have been paid for that same individual to receive nursing facility services considering all other resources, including resources described in §40.1 of this title (relating to Use of General Revenue for Services Exceeding the Individual Cost Limit of a Waiver Program (for waiver services as specified in §48.6006 of this title (relating to Individual Plan of Care for Waiver Services) whose cost does not exceed 100% of the individual's actual nursing facility payment rate).
(7) have been determined by the Texas Health and Human Services Commission to be financially eligible for Medicaid; [end addition]

(6) meet the financial eligibility criteria for waiver services as specified in §48.6007 of this title (relating to Financial Eligibility Criteria); [end deletion]

(8) [end deletion] (7) have ongoing needs for [begin addition] CBA Program waiver [end deletion] services [begin addition] with [end deletion] whose [end deletion] projected costs, as indicated on the [begin addition] IPC [end addition] [begin deletion] Individual Plan of Care [end deletion], [begin addition] that [end addition] do not exceed the [begin addition] following [end deletion] maximum service ceilings [begin deletion] set for those services as listed below [end deletion]:

(A) [begin addition] Adaptive Aids [end addition] and [begin addition] medical supplies [end addition] service category [begin addition] must not [end addition] exceed $10,000 per individual per [begin addition] IPC [end addition] year without approval by [begin addition] DADS [end addition] the waiver manager [end deletion];

(B) minor home modifications service category [begin addition] must not [end addition] exceed [begin addition] a lifetime maximum of $7,500 [end addition] per individual [begin deletion] $7500 [end deletion] per individual without approval by [begin addition] DADS, after which minor home modifications must not exceed $300 per IPC year for maintenance or additional modifications [end addition] the waiver manager [end deletion]; and

(C) respite care [begin addition] must not [end addition] exceed 30 days per individual per [begin addition] IPC [end addition] year without approval by [begin addition] DADS [end addition] the waiver manager [end deletion];

(9) [end addition] (8) receive [begin addition] CBA Program waiver [end deletion] services within 30 days after [begin deletion] waiver [end deletion] eligibility is established;

(10) [end addition] (9) [end deletion] reside [begin deletion] either [end deletion] in [begin addition] the individual's [end addition] his [end deletion] own home [begin addition] ; [end addition]
In addition, (C) an adult foster care home contracted with DADS to provide Community Based Alternatives (CBA) services; (11) not reside in an institutional setting, including a hospital, a nursing facility, an intermediate care facility for persons with mental retardation, or a facility required to be licensed as an assisted living facility but is not licensed; CBA services will not be delivered to residents of hospitals, nursing facilities, ICF-MR facilities, or unlicensed assisted living facilities; and

(12) meet two or more of the criteria for nursing home risk, as specified in the Resident Assessment Instrument-Home Care Assessment for Nursing Home Risk as revised in April 1996 and summarized as follows:

(A) needs assistance with one or more of the activities of dressing, personal hygiene, eating, toilet use, or bathing;

(B) has a functional decline in the past 90 days;

(C) has a history of a fall two or more times in past 180 days;

(D) has a neurological diagnosis of Alzheimer's disease, head trauma, multiple sclerosis, parkinsonism, or dementia; Head Trauma, Multiple Sclerosis, Parkinsonism, or Dementia;

(E) has a history of nursing facility placement within the last five years;

(F) has multiple episodes of urine incontinence daily; or

(G) goes out of one's residence one or fewer days a week.

Enrollment in the CBA Program is limited to the number of individuals approved by the Centers for Medicare and Medicaid Services or the availability of state funding.
An individual is Eligible individuals are to be enrolled from the CBA Program interest list on a "first-come, first-served" basis, except for individuals who meet the following criteria:

(A) an individual who is 21 years of age and:

(i) has been receiving children age 21 who are no longer eligible for the Medically Dependent Children Program (MDCP) services and is no longer eligible for MDCP; or

(ii) has been receiving nursing services through the Texas Health Steps Program and is no longer eligible for Texas Health Steps Program services; or

(B) an individual described in paragraph (3) of this subsection children age 21 who have been receiving nursing services through the Texas Health Steps Program and are no longer eligible.

(2) Except for an individual described in paragraph (1)(A) and (B) of this subsection, DADS suspends enrollment of individuals whose names are on the CBA Program interest list into the CBA Program while program participants exceed funded limits. For purposes of this section, the census is considered to have exceeded funded limits when DADS determines that the combination of existing caseloads and individuals described in paragraph (1)(A) and (1)(B) of this subsection exceed funded limits within the current budget period.

(3) An individual receiving services reimbursed through the Texas Medicaid Nursing Facility Program Individuals residing in a Texas nursing facility who are enrolled in Medicaid will be approved for the CBA Program if the individual requests services while residing in a Texas [begin deletion] a Texas [end deletion] nursing facility and meets all eligibility criteria for the CBA Program. If the individual is discharged from the nursing facility for a community setting before being determined eligible for Medicaid nursing facility services and the individual will be denied immediate enrollment in the CBA Program [begin deletion] Community Care services unless these services are part of an entitlement.
program. Upon inquiry to DADS regarding the possibility of nursing facility placement and upon admission to a nursing facility, DADS must make information on Community Care services, including Medicaid waiver services, available to the individual making the inquiry or being admitted to a nursing facility. Upon inquiry of discharge from a nursing facility, DADS must also make information on Community Care services, including Medicaid waiver services, available to the nursing facility resident.

(c) Participants may be enrolled in only one waiver program at a time.

(d) The nursing facility risk criteria will be applied at the time of the first annual reassessment for current Community Based Alternatives Program participants and at the time of initial enrollment for all new applicants.

(e) An individual transferring from a nursing facility or MDCP is exempt from subsection (b)(12) of this section.

(f) A participant must live in a county not included in a managed care service area and meet all other eligibility requirements to be enrolled in CBA.


(a) In this section, the term “individual” means a person applying for or enrolled in the Community Based Alternatives (CBA) Program, unless the context clearly indicates otherwise.

(b) A CBA Program provider must coordinate with an interdisciplinary team to develop an individual plan of care (IPC) that is based on assessments conducted in accordance with §48.6020 and §48.6022 of this subchapter (relating to Pre-Enrollment Health Assessment; and Community Based Alternatives Annual Reassessment) and that meets the criteria in subsection (d) of this section.

(c) Before providing CBA Program services in accordance with the IPC, the CBA Program provider must obtain approval from the Department of Aging and Disability Services (DADS).

(d) To be approved by DADS, CBA Program services in the IPC must:
(1) be necessary to protect the individual's health and welfare in the community;

(2) supplement rather than replace the individual's natural supports and other non-CBA Program services and supports for which the individual may be eligible;

(3) prevent the individual's admission to an institution;

(4) be the most appropriate type and amount of services to meet the individual's needs; and

(5) be cost effective.

(e) To demonstrate that the CBA Program services in the IPC meet the requirements described in subsection (d) of this section, the CBA Program provider must submit to DADS the following:

(1) an assessment of the individual supporting the CBA Program services recommended by the CBA Program provider; and

(2) documentation that other sources for adaptive aids and medical supplies are unavailable.

(f) DADS conducts utilization review of an IPC and supporting documentation at any time to determine if the CBA Program services specified in the IPC meet the requirements described in subsection (d) of this section.

(1) The CBA Program provider must submit documentation supporting the IPC to DADS as requested by DADS.

(2) If DADS determines that one or more of the CBA Program services specified in the IPC do not meet the requirements described in subsection (d) of this section, DADS denies or reduces the service, modifies the IPC, and sends written notification to the individual and CBA Program provider.

(g) In addition to the utilization review conducted in accordance with subsection (f) of this section, DADS may conduct utilization reviews of CBA Program providers and CBA Program services based on utilization patterns and trends.[end addition]

[beginden deletion] (a) Waiver clients must have an individual plan of care for waiver services developed by the interdisciplinary team as described in the waiver request. The individual plan of care must specify the type of waiver services required to support the individual in the community, the units of waiver services, and their frequency.

[beginden deletion] (b) The individual plan of care must be signed and dated by the interdisciplinary team prior to implementation. The interdisciplinary team must certify in writing that the
waiver services are necessary as an alternative to institutionalization and appropriate to meet the needs of the individual in the community.

[(e) The individual plan of care must be approved by the Texas Department of Human Services (DHS) and updated by the interdisciplinary team at least annually. [end deletion]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on ____________.

TITLE 40  SOCIAL SERVICES AND ASSISTANCE
PART 1  DEPARTMENT OF AGING AND DISABILITY SERVICES
CHAPTER 48  COMMUNITY CARE FOR AGED AND DISABLED
SUBCHAPTER J  1915(c) MEDICAID HOME AND COMMUNITY-BASED WAIVER SERVICES FOR AGED AND DISABLED ADULTS WHO MEET CRITERIA FOR ALTERNATIVES TO NURSING FACILITY CARE
RULE  §48.6099

Proposed action:
\underline{X} Repeal

STATUTORY AUTHORITY

The repeal is proposed under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; and Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program.

The repeal affects Texas Government Code, §531.0055 and §531.021, and Texas Human Resources Code, §161.021.

\underline{— (a) The Department of Aging and Disability Services (DADS) does not provide Community-Based Alternatives (CBA) services to an individual if the cost of providing}
The Health and Human Services Commission (HHSC) proposes, on behalf of the Department of Aging and Disability Services (DADS), amendments to §48.6021, concerning delay of pre-enrollment home health assessment; §48.6022, concerning Community Based Alternatives (CBA) annual reassessment; and §48.6078, concerning billable units, in Chapter 48, Community Care for Aged and Disabled, Subchapter J, which is being renamed Community Based Alternatives (CBA) Program.

BACKGROUND AND PURPOSE

The purpose of the amendments is, in part, to implement rule changes necessitated by a project under the direction of HHSC that will replace the state case-mix system for provider payments, which is based on the Texas Index for Level of Effort (TILE) model, with the federal case-mix system, which is based on the Resource Utilization Group (RUG) model. The TILE-to-RUG project implements Texas Health and Safety Code, §242.221 et seq, which requires DADS to use an automated system for nursing facility reimbursement and an assessment form designed by the United States Health Care Financing Administration (now the Centers for Medicare and Medicaid Services). As allowed by Texas Health and Safety Code, §242.221(b), DADS and HHSC have elected to add other components of the state Medicaid program, such as the CBA Program, to the automated system of reimbursement and, therefore, to require use of an assessment form similar to the form on which nursing facility residents are assessed. As a result, DADS will replace its Client Assessment, Review and Evaluation (CARE) form (also known as Form 3652) with an assessment based on the federal Minimum Data Set (MDS) assessment for making medical necessity determinations and calculating the RUG. For the purpose of this rule, the community-based assessment is termed the "medical necessity and level of care assessment."

SECTION-BY-SECTION SUMMARY

The proposed amendment to §48.6021 replaces a reference to the CARE form with a more generic term. The amendment also adjusts the grammatical structure of the rule to provide clarity.

The proposed amendment to §48.6022 replaces a reference to the CARE form with a more generic term. It also updates the time frame for submitting the form and an individual's service plan to reflect current practice.
The proposed amendment to §48.6078 replaces a reference to a procedure under the TILE model with a more generic reference to "level of care."

FISCAL NOTE

Gordon Taylor, DADS Chief Financial Officer, has determined that, for the first five years the proposed amendments are in effect, enforcing or administering the amendments does not have foreseeable implications relating to costs or revenues of state or local governments.

SMALL BUSINESS AND MICRO-BUSINESS IMPACT ANALYSIS

DADS has determined that the proposed amendments will not have an adverse economic effect on small businesses or micro-businesses, because the amendments impose no new requirements that would cause them to alter their business practices.

PUBLIC BENEFIT AND COSTS

Barry Waller, DADS Assistant Commissioner for Provider Services, has determined that, for each year of the first five years the amendments are in effect, the public benefit expected as a result of enforcing the amendments is that DADS rules will provide accurate requirements for CBA providers. The amendment, which requires providers to conduct assessments of individuals served in the community on a form similar to the form on which nursing facility residents are assessed, will allow for better comparison of services in Texas to services in other states and provide for more streamlined and integrated business processes. These improvements will in turn lead to opportunities for improved services for DADS' consumers.

Mr. Waller anticipates that there will not be an economic cost to persons who are required to comply with the amendments. The amendments will not affect a local economy.

TAKINGS IMPACT ASSESSMENT

DADS has determined that this proposal does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Texas Government Code, §2007.043.

PUBLIC COMMENT

Questions about the content of this proposal may be directed to Gilbert Estrada at (512) 438-2578 in DADS' Provider Services Division. Written comments on the proposal may be submitted to Texas Register Liaison, Legal Services-014, Department of Aging and Disability Services W-615, P.O. Box 149030, Austin, Texas 78714-9030, or street address 701 West 51st St., Austin, TX 78751; faxed to (512) 438-5759; or e-mailed to rulescomments@dads.state.tx.us. To be considered, comments must be submitted no later
than 30 days after the date of this issue of the *Texas Register*. The last day to submit comments falls on a Sunday; therefore, comments must be either (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered to DADS before 5:00 p.m. on DADS' last working day of the comment period; or (3) faxed or e-mailed by midnight on the last day of the comment period. When faxing or e-mailing comments, please indicate "Comments on Proposed Rule 014" in the subject line.
Title 40  
Social Services and Assistance  
Part 1  
Department of Aging and Disability Services  
Chapter 48  
Community Care for Aged and Disabled  
Subchapter J  
Community Based Alternatives (CBA) Program  
[1915(c) Medicaid Home and Community-Based Waiver Services for Aged and Disabled Adults Who Meet Criteria for Alternatives to Nursing Facility Care]  
Rule  
§§48.6021, 48.6022, 48.6078

Proposed action:  
X Amendment

Statutory Authority

The amendments are proposed under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Health and Safety Code, §242.226, which authorizes the adoption of rules necessary to improve the efficiency of the reimbursement process for the state Medicaid system and maximize the automated reimbursement system's capabilities.

The amendments affect Texas Government Code, §531.0055 and §531.021; Texas Human Resources Code, §161.021; and Texas Health and Safety Code, §242.226.

§48.6021. Delay of Pre-Enrollment Home Health Assessment.

(a) A home and community support services agency (HCSSA) must [The only valid reasons for the Home and Community Support Services (HCSS) agency to not] complete the pre-enrollment home health assessment within the time period described in
§48.6020 of this chapter (relating to Pre-Enrollment Home Health Assessment), unless [14 days for routine applicants or by the negotiated date for priority applicants are that]:

(1) the decision to initiate Medicare home health services is pending; or

(2) there is a delay in getting the medical necessity and level of care assessment [Client Assessment, Review, and Evaluation form] signed by the physician.

(b) The HCSSA [HCSS agency] must notify the case manager of a delay in obtaining the physician's signature which would prevent the HCSSA [HCSS agency] from meeting the time frame for completion of the pre-enrollment home health assessment as follows [by]:

(1) For priority referrals, the HCSSA must orally notify [verbally notifying] the case manager no later than 24 hours before the negotiated assessment completion date [if it is a priority referral,] of the delay in obtaining the physician's signature and submit a [The agency must submit written documentation on the] Case Information form to the case manager within two working days after [Texas Department of Human Services (DHS) workdays of] the oral [verbal] notification, documenting the reason for the delay [; and]

(2) For routine referrals, the HCSSA must submit [submitting] the Case Information form documenting the reason for the delay to the case manager no later than 24 hours before the end of the 14-day time frame allowed [for routine referrals and documenting the reason for the delay].

§48.6022. Community Based Alternatives Annual Reassessment.

The home and community support services [Home and Community Support Services] agency must complete and return the Individual Service Plan (ISP) attachments and the medical necessity and level of care assessment [Client Assessment, Review, and Evaluation form] to the case manager's office during the second [between the fifth and the 20th day of the fourth] month before the month the ISP expires [expiration of the individual service plan (ISP)], according to reassessment due dates listed in Appendix XIX of the Community Based Alternatives Provider Manual [Community Based Alternatives manual] (CBA Reassessment Packet Due Dates).

§48.6078. Billable Units.

The following activities may be billed as Community Based Alternatives (CBA) services by a home and community support services agency [Home and Community Support Services agencies]:

(1) Nursing services:

(A) direct participant contact;

(B) participation on the interdisciplinary team (IDT);
(C) time spent in delegating, training, and supervising personal care attendants, Adult Foster Care providers, and provider substitutes in the delivery of nursing tasks that have been delegated;

(D) time spent in providing nursing tasks that had been delegated to an attendant in order to prevent a service break, if no attendant can be found;

(E) time spent in training family members, neighbors, and other informal support providers to provide needed nursing or personal care tasks;

(F) time spent performing the annual reassessment or level of care resets which include actual participant contact and documentation of assessment forms and care plan;

(G) time spent performing assessments and developing written specifications for adaptive aids; and

(H) follow-up orientation visit following delivery of adaptive aids.

(2) Specialized therapy services (occupational therapy, physical therapy, and speech pathology):

(A) direct participant contact;

(B) development of written bid specifications;

(C) follow-up/orientation visit following delivery of adaptive aid; and

(D) participation on the IDT.

(3) Personal assistance services:

(A) direct participant contact to provide personal care and nursing tasks that have been delegated; and

(B) participation on the IDT.

(4) Billable items for medical supplies include the invoice cost, including freight charges and sales tax, of the medical supply and the requisition fee.

(5) Billable items for minor home modifications include the invoice cost of labor, materials, sales tax, actual cost of specification development up to $200, actual cost of inspection up to $150, and the requisition fee.

(6) Billable items for adaptive aids include the invoice cost of the item, including freight charges and sales tax, actual cost of development of written bid specifications for
computer assistive technology, environmental controls and augmentative communication
devices, and the follow-up/orientation visit by the professional knowledgeable of these
items, up to $500 of the cost of the item, and the requisition fee.

(7) In-Home Respite Care--relief of the unpaid primary caregiver.

This agency hereby certifies that the proposal has been reviewed by legal counsel and
found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on ____________.
waiver services are necessary as an alternative to institutionalization and appropriate to meet the needs of the individual in the community.

[(e) The individual plan of care must be approved by the Texas Department of Human Services (DHS) and updated by the interdisciplinary team at least annually. [end deletion]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on ____________.

TITLE 40   SOCIAL SERVICES AND ASSISTANCE
PART 1    DEPARTMENT OF AGING AND DISABILITY SERVICES
CHAPTER 48   COMMUNITY CARE FOR AGED AND DISABLED
SUBCHAPTER J  1915(c) MEDICAID HOME AND COMMUNITY-BASED WAIVER SERVICES FOR AGED AND DISABLED ADULTS WHO MEET CRITERIA FOR ALTERNATIVES TO NURSING FACILITY CARE

RULE    §48.6099

Proposed action:
X   Repeal

STATUTORY AUTHORITY

The repeal is proposed under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; and Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program.

The repeal affects Texas Government Code, §531.0055 and §531.021, and Texas Human Resources Code, §161.021.

— (a) The Department of Aging and Disability Services (DADS) does not provide Community Based Alternatives (CBA) services to an individual if the cost of providing
those services exceeds the individual cost limit specified in §48.6003(a)(5) of this chapter (relating to Client Eligibility Criteria), except:

(1) DADS continues to provide CBA services to an individual who was receiving those services on September 1, 2005, at a cost that exceeded the individual cost limit, if continuation of those services:

(A) is necessary for the individual to live in the most integrated setting appropriate to the individual’s needs; and

(B) does not affect DADS’ compliance with the federal cost-effectiveness and efficiency requirements under United States Code (U.S.C.), Title 42, §1396n(b) and (c)(2)(D); or

(2) DADS continues to provide CBA services to an individual who is ineligible to receive those services under this subsection if:

(A) the cost of providing those services over a 12-month period, excluding the cost of minor home modifications and adaptive aids, does not exceed 133.3% of the individual cost limit; and

(B) continuation of those services does not affect DADS’ compliance with the federal cost-effectiveness and efficiency requirements under 42 U.S.C. §1396n(b) and (c)(2)(D).

(b) The DADS commissioner may exempt an individual receiving CBA services from the cost limit described in subsection (a)(2)(A) of this section.

(c) An individual receiving services through the Medically Dependent Children Program is covered by the provisions in this section when the individual applies for transition to the CBA Program at age 21.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on ___________.
The Health and Human Services Commission (HHSC) proposes, on behalf of the Department of Aging and Disability Services (DADS), amendments to §50.4, concerning eligibility criteria; §50.10, concerning additional eligibility criteria related to level of care; and §50.16, concerning the individual service plan (ISP); and proposes the repeal of §50.48, concerning utilization review; and §50.50, concerning the provision of services when costs exceed the individual cost limit, in Chapter 50, §1915(c) Consolidated Waiver Program.

BACKGROUND AND PURPOSE

The purpose of the amendments is, in part, to implement the 2008-09 General Appropriations Act (Article II, Department of Aging and Disability Services, Rider 45, H.B. 1, 80th Legislature, Regular Session, 2007), concerning waiver program cost limits. Rider 45 places an individual's annual cost limit for Consolidated Waiver Program (CWP) services at, as applicable: (1) 200 percent of the estimated annualized per capita cost of providing services in an intermediate care facility for persons with mental retardation (ICF/MR); (2) 50 percent of the reimbursement rate that would have been paid for that same individual under age 21 to receive services in a nursing facility; or (3) 200 percent of the reimbursement rate that would have been paid for that same individual age 21 or over to receive services in a nursing facility. However, a recent communication from the Centers for Medicare and Medicaid Services states that the waiver cannot have cost limits that vary depending upon a person’s age. Therefore, this proposal uses the higher of the two cost limits described in (2) and (3). Rider 45 also authorizes DADS, under certain conditions, to use general revenue to pay for services that exceed the cost limit; requires DADS to use general revenue to continue to provide services to a person who was receiving waiver program services, such as CWP services, on September 1, 2005, at a cost that exceeded the waiver program's cost limit; and requires DADS to employ utilization management and utilization review practices as necessary to ensure that the appropriate scope and level of services are provided to an individual receiving services through a waiver program.

The purpose of the amendments and repeal is also to implement rule changes necessitated by a project under the direction of HHSC that will replace the state case-mix system for provider payments, which is based on the Texas Index for Level of Effort (TILE) model, with the federal case-mix system, which is based on the Resource Utilization Group (RUG) model. The transition to the RUG model affects the Texas Nursing Facility Program, as well as community-based waiver programs, including CWP, which serve individuals who have a determination of medical necessity for nursing facility care.
Furthermore, the amendments are proposed to update agency names and terminology, to correct cross-references, and to reorganize the structure of the rules for clarity and consistency with other DADS programs operated in accordance with §1915(c) of the federal Social Security Act.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §50.4 deletes references to the TILE payment rate and establishes the new cost limits for CWP services. The amendment also: (1) provides a cross-reference to 40 TAC §40.1 (proposed as a new section elsewhere in this issue of the Texas Register), which governs the use of general revenue, under certain conditions, to pay for services that exceed the cost limit; (2) replaces references to the Texas Department of Human Services or DHS with references to the Department of Aging and Disability Services or DADS; (3) revises a reference to TDMHMR (the former Texas Department of Mental Health and Mental Retardation); (4) deletes references to slot allocations; and (5) updates the rule cross-references for Level of Care I and Level of Care VIII criteria.

The proposed amendment to §50.10 deletes a reference to the cost limit for individuals under age 21 in subsection (a)(2), because the cost limit is now referenced in the proposed amendment to §50.4. The proposed amendment also updates terminology to reflect current usage and updates the rule cross-reference for Level of Care VIII criteria.

The proposed amendment to §50.16, concerning the ISP, expands the provisions of the current rule to address the utilization management and review provisions of Rider 45. Subsection (d) of the proposed amendment describes five requirements that CWP services in the ISP must meet in order for DADS to approve the ISP. Subsection (e) of the proposed amendment requires the CWP provider to submit certain information to DADS that demonstrates that the CWP services in the ISP meet the five requirements described in subsection (d). Subsections (f) and (g) of the proposed amendment govern the procedures for utilization review and state that DADS may conduct utilization review at any time and may deny or reduce services if DADS determines that one or more of the CWP services in the ISP do not meet the requirements of subsection (d).

The proposed repeal of §50.48 eliminates a reference to the TILE rate and allows for the placement of utilization review requirements in the proposed amendment to §50.16.

The proposed repeal of §50.50 eliminates a rule governing exceptions to the CWP cost limit. The Centers for Medicare and Medicaid Services has indicated that exceptions to the cost limit may not be granted and, therefore, this rule is no longer necessary. The provisions in §50.50 covering an individual who was receiving CWP services on or before September 1, 2005, at a cost that exceeded the CWP individual cost limit have been revised to comply with Rider 45 and are included in proposed new §40.1, published elsewhere in this issue of the Texas Register.
FISCAL NOTE

Gordon Taylor, DADS Chief Financial Officer, has determined that, for the first five years the proposed amendments and repeal are in effect, enforcing or administering the amendments and repeal does not have foreseeable implications relating to costs or revenues of state or local governments.

SMALL BUSINESS AND MICRO-BUSINESS IMPACT ANALYSIS

DADS has determined that the proposed amendments and repeal will not have an adverse economic effect on small businesses or micro-businesses, because the proposal places no new requirements on small businesses or micro-businesses.

PUBLIC BENEFIT AND COSTS

Barry Waller, DADS Assistant Commissioner for Provider Services, has determined that, for each year of the first five years the amendments and repeal are in effect, the public benefit expected as a result of enforcing the amendments and repeal is that DADS procedures for addressing situations in which an individual cannot be served within the individual cost limit of a waiver program and whose health and safety cannot be ensured in another available living arrangement will be clarified.

Mr. Waller anticipates that there will not be an economic cost to persons who are required to comply with the amendments and repeal. The amendments and repeal will not affect a local economy.

TAKINGS IMPACT ASSESSMENT

DADS has determined that this proposal does not restrict or limit an owner’s right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Texas Government Code, §2007.043.

PUBLIC COMMENT

Questions about the content of this proposal may be directed to Kristi Guilbeaux at (512) 438-2756 in DADS' Provider Services Division. Written comments on the proposal may be submitted to Texas Register Liaison, Legal Services-010, Department of Aging and Disability Services W-615, P.O. Box 149030, Austin, Texas 78714-9030, or street address 701 West 51st St., Austin, TX 78751; faxed to (512) 438-5759; or e-mailed to rulescomments@dads.state.tx.us. To be considered, comments must be submitted no later than 30 days after the date of this issue of the Texas Register. The last day to submit comments falls on a Sunday; therefore, comments must be either (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered to DADS before 5:00 p.m. on DADS' last working day of the comment period; or (3) faxed or e-mailed by midnight on the last day of the comment period. When faxing or e-mailing comments, please indicate "Comments on Proposed Rule 010" in the subject line.
STATUTORY AUTHORITY

The amendments are proposed under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; and Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program.

The amendments affect Texas Government Code, §531.0055 and §531.021, and Texas Human Resources Code, §161.021.

§50.4. [begin deletion] Participant [end deletion] Eligibility Criteria.

(a) To be determined eligible by the [begin deletion] Texas [end deletion] Department of [begin addition] Aging and Disability [end addition] [begin deletion] Human [end deletion] Services [begin addition] (DADS) [end addition] [begin deletion] (DHS) [end deletion] for [begin addition] the [end deletion] Consolidated Waiver Program (CWP) [begin deletion] services [end deletion], an applicant or participant must:

(1) live in the pilot area;
(2) have been determined by the Texas Health and Human Services Commission (HHSC) to be financially eligible for Medicaid

(3) not be enrolled in another §1915(c) Medicaid waiver program;

(4) have an individual service plan (ISP) with a cost for CWP services at or below one of the following individual cost limits considering all other resources, including resources described in §40.1 of this title (relating to Use of General Revenues for Services Exceeding the Individual Cost Limit of a Waiver Program); the individual service plan (ISP) for home and community-based services must specify the type of waiver services required to keep an individual in the community, the units of waiver services, and their frequency and duration as defined in §50.16 of this title (relating to Individual Service Plan);

(A) 200 percent of the estimated annualized per capita cost of

(B) 200 percent of the reimbursement rate that would have been paid for that same individual to receive services in a nursing facility;

(5) have an ISP for home and community-based services with an estimated annual cost that does not exceed:

(A) 125% of the average aggregate cost of intermediate care facilities for individuals with mental retardation (ICF/MR) Level I, V, VI, and VIII for individuals who meet the ICF-MR level of care in accordance with §50.8(a)(2) of this title (relating to Individual Level of Care Criteria);

(B) 150% of the individual’s actual Texas Index for Level of Effort (TILE) payment rate for individuals with a nursing facility level of care in accordance with §50.8(a)(1) of this title (relating to Individual Level of Care Criteria);

(6) have been determined by DADS:

(A) to meet the level-of-care criteria as described in §50.8(a)(1) of this chapter (relating to Individual Level of Care Criteria); or
(B) to qualify for:

(i) the ICF/MR Level of Care (LOC) I, as described in §9.238 of this title (relating to Level of Care I Criteria); or

(ii) the ICF/MR LOC VIII, as described in §9.239 of this title (relating to ICF/MR Level of Care VIII Criteria).

(6) have ongoing needs for CWP waiver services with projected costs, as indicated on the ISP, that do not exceed the maximum service ceilings that follow:

(A) adaptive aids and medical supplies service category must not exceed $10,000 per individual per ISP year without approval by DADS with DHS maintaining the right to exception;

(B) minor home modifications service category:

   (i) must not exceed $7,500 per individual seven years until the individual is 21 years of age without approval by DADS; and

   (ii) must not exceed a lifetime maximum of $7,500 per individual without approval by DADS for an individual 21 years of age or older, after which minor home modifications must not exceed $300 per ISP year for maintenance or additional modifications; then the minor home modifications service category cannot exceed $7500 (lifetime maximum) with a maximum of $300 for repairs per ISP year thereafter;

(C) respite care must not exceed 45 days per individual per ISP year without approval by DADS with DHS maintaining the right to exception; and

(D) dental services must not exceed $1,000 per individual per ISP year;
receive CWP waiver services within 30 days after CWP waiver eligibility is determined;

meet the re-evaluation of institutional level-of-care criteria as performed annually by DADS using the same criteria as used initially;

reside in:

(A) the applicant's or participant's own home;

(B) in a licensed assisted living facility contracted with DADS to provide CWP services;

(C) in an adult foster care home contracted with DADS to provide CWP services;

(D) a 24-hour residential habilitation contracted with DADS to provide CWP services;

(E) a family surrogate services setting contracted with DADS to provide CWP services; or

(F) in a foster home that meets the requirements for foster homes in accordance with 40 TAC §700.1501 (relating to Decision on Foster Home Applications); (concerning Foster and Adoptive Home Development). CWP services will not be delivered to residents of hospitals, nursing facilities, ICF-MR facilities, or unlicensed assisted living facilities unless the facility is exempt in accordance with §50.30 of this title (relating to 24 Hour Residential Habilitation) as pertains to provider requirements for 24-hour residential habilitation; and

not reside in an institutional setting, including a hospital, a nursing facility, an ICF/MR, or a facility required to be licensed as an assisted living facility but is not licensed; and
(11) choose CWP waiver services as an alternative to institutional care.

(b) A preadmission level of care assessment expires 120 calendar days from its issuance. For a participant [begin addition] participants who are enrolled in the waiver program [end deletion] within 30 calendar days of discharge from an institution, the current level-of-care assessment may be used for enrollment and is valid until the expiration date on the approved ISP.

(c) Enrollment into this waiver program [begin deletion] is limited to the number of [begin addition] individuals approved by the Centers for Medicare and Medicaid Services (CMS) [end addition] and funded by the State of Texas.

(d) Enrollment in the pilot is restricted to 200 participants with the following slot allocation:

[(1) 50 slots for adults who meet the requirements for nursing facility care from the Community Based Alternatives (CBA) interest list;]

[(2) 50 slots for children who meet the requirements for nursing facility care from the Medically Dependent Children Program (MDCP) interest list;]

[(3) 25 slots for adults with mental retardation who meet the requirements for ICF-MR care level I from the Home and Community Based Services (HCS) interest list;]

[(4) 25 slots for children with mental retardation who meet the requirements for ICF-MR care level I from the HCS interest list;]

[(5) 25 slots for adults with related conditions or developmental disabilities who meet the requirements for ICF-MR care level VIII from the CLASS interest list, with one of these slots specifically targeted to an individual who is deaf-blind with multiple disabilities from the Deaf Blind Multiple Disabilities (DBMD) interest list; and]

[(6) 25 slots for children with related conditions or developmental disabilities who meet the requirements for ICF-MR care level VIII from the CLASS interest list, with one of these slots specifically targeted to an individual who is deaf-blind with multiple disabilities from the DBMD interest list.]

[(e) If the funding for CWP changes, the ratios for slot allocation will remain the same.]

[(f) For purposes of slot allocation, HCS means TDMMR waiver currently operating in the pilot area.]

Page 38 of 87
Section 50.10. Additional Eligibility Criteria Related to Level of Care.

(a) An individual who meets the level-of-care criteria for medical necessity for nursing facility care in accordance with §50.8(a)(1) of this chapter (relating to Individual Level of Care Criteria) must also meet the following requirements:

(1) meet two or more of the criteria for nursing home risk, as specified in the Resident Assessment Instrument Home Care Assessment for Nursing Home Risk as revised in April 1996 in accordance with §48.6003(10)(A-G) of this title (relating to Client Eligibility Criteria Nursing Home Risk), unless the individual is transferring to the Consolidated Waiver Program (CWP) from a nursing facility; or
(B) [begin addition] is [end addition] applying for or receiving §1915(c) waiver services before [begin addition] the individual's [end addition] [begin deletion] their [end deletion] 21st birthday; and

(2) if under 21 years of age [begin addition], [end addition] [begin deletion] :

[begin deletion] (A) the participant must [end deletion] access services through the Comprehensive Care Program [begin deletion] ; and [end deletion]

[begin deletion] (B) yearly Consolidated Waiver Program services are limited to 50% of the cost ceiling in §50.4(a)(5)(B) of this title (relating to Participant Eligibility Criteria) [end deletion].

(b) [begin addition] An individual who meets Level of Care VIII criteria, as described in §9.239 of this title (relating to ICF/MR Level of Care VIII Criteria) [end addition] [begin deletion] Individuals who meet the level of care criteria for an intermediate care facility for the mentally retarded with related conditions (ICF-MR/RC Level VIII) in accordance with §50.8(a)(2)(A) of this title (relating to Individual Level of Care Criteria) [end deletion] and who [begin addition] wishes [end addition] [begin deletion] wish [end deletion] to fill [begin addition] a slot [end addition] [begin deletion] slots [end deletion] in the program designated for people who are [begin addition] deaf blind [end addition] [begin deletion] deaf-blind [end deletion] with multiple disabilities must provide medical documentation that verifies the existence of deaf blindness with multiple disabilities.

§50.16. Individual Service Plan (ISP).

[begin addition] (a) In this section, the term "individual" means a person applying for or enrolled in the Consolidated Waiver Program (CWP), unless the context clearly indicates otherwise.

(b) A CWP provider must coordinate with an interdisciplinary team to develop an individual service plan (ISP) that is based on an assessment of the individual and that meets the criteria in subsection (d) of this section.

(c) Before providing CWP services in accordance with the ISP, a CWP provider must obtain approval from the Department of Aging and Disability Services (DADS).

(d) To be approved by DADS, CWP services in the ISP must:

1) be necessary to protect the individual's health and welfare in the community;
(2) supplement rather than replace the individual's natural supports and other non-CWP services and supports for which the individual may be eligible;

(3) prevent the individual's admission to an institution;

(4) be the most appropriate type and amount of services to meet the individual's needs; and

(5) be cost effective.

(e) To demonstrate that the CWP services in the ISP meet the requirements described in subsection (d) of this section, the CWP provider must submit to DADS the following:

(1) an assessment of the individual supporting the CWP services recommended by the CWP provider; and

(2) documentation that other sources for adaptive aids and medical supplies are unavailable.

(f) DADS conducts utilization review of an ISP and supporting documentation at any time to determine if the CWP services specified in the ISP meet the requirements described in subsection (d) of this section.

(1) The CWP provider must submit documentation supporting the ISP to DADS as requested by DADS.

(2) If DADS determines that one or more of the CWP services specified in the ISP do not meet the requirements described in subsection (d) of this section, DADS denies or reduces the service, modifies the ISP, and sends written notification to the individual and CWP provider.

(g) In addition to the utilization review conducted in accordance with subsection (f) of this section, DADS may conduct utilization reviews of CWP providers and CWP services based on utilization patterns and trends.[end addition]

[begin deletion] (a) Waiver participants must have a person directed individual service plan (ISP) for waiver services developed by the interdisciplinary team (IDT) as described in the waiver request.]

[(b) The IDT members must sign and date the ISP prior to implementation of the plan. The IDT members must certify in writing that the waiver services are necessary as an alternative to institutionalization and appropriate to meet the needs of the individual in the community.]
[The Texas Department of Human Services (DHS) must approve and the IDT must update the ISP at least annually.]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on ____________.

TITLE 40   SOCIAL SERVICES AND ASSISTANCE
PART 1    DEPARTMENT OF AGING AND DISABILITY SERVICES
CHAPTER 50   §1915(c) CONSOLIDATED WAIVER PROGRAM
RULE       §50.48, §50.50

Proposed action:
X  Repeal

STATUTORY AUTHORITY

The repeal is proposed under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; and Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program.

The repeal affects Texas Government Code, §531.0055 and §531.021, and Texas Human Resources Code, §161.021.

[§50.48. Utilization Review.]

(a) The Texas Department of Human Services (DHS) will review a proposed Individual Service Plan (ISP) and supporting documentation specified in §50.16 of this title (relating to Individual Service Plan for Waiver Services) upon receipt of a proposed ISP having a cost that exceeds 100% of:

(1) the Nursing Facility Texas Index for Level of Effort for individuals who meet the level of care criteria for medical necessity for nursing facility care in accordance with §50.8(a)(1) of this title (relating to Individual Level of Care Criteria); or

(2) the estimated annualized average per capita cost for Intermediate Care Facility for Individuals with Mental Retardation (ICF/MR) services for individuals who meet the
level of care criteria for an ICF/MR in accordance with §50.8(a)(2) of this title (relating to Individual Level of Care Criteria).

— (b) DHS will review the proposed ISP to determine if the type and amount of CWP program services specified in the ISP are appropriate and supported by documentation specified in §50.16 of this title (relating to Individual Service Plan). After reviewing the proposed ISP and supporting documentation, DHS may request additional documentation. DHS will review any additional documentation submitted in accordance with its request. DHS may modify an ISP based on its review and approve the proposed ISP or send written notification that the proposed ISP has been approved with modifications, or DHS may deny an applicant CWP services due to the proposed ISP exceeding the cost ceiling as defined in §50.4(a)(5)(A)-(B) of this chapter (relating to Participant Eligibility Criteria).

[§50.50. Providing CWP Services When Costs Exceed the Individual Cost Limit.

— (a) The Department of Aging and Disability Services (DADS) does not provide Consolidated Waiver Program (CWP) services to an individual if the cost of providing those services exceeds the individual cost limit specified in §50.4(a)(5)(A) or (B) of this chapter (relating to Participant Eligibility Criteria), except:

1. DADS continues to provide CWP services to an individual who was receiving those services on September 1, 2005, at a cost that exceeded the individual cost limit, if continuation of those services:

   A. is necessary for the individual to live in the most integrated setting appropriate to the individual's needs; and

   B. does not affect DADS' compliance with the federal cost-effectiveness and efficiency requirements under United States Code (U.S.C.), Title 42, §1396n(b) and (c)(2)(D); or

2. DADS continues to provide CWP services to an individual who is ineligible to receive those services under this subsection if:

   A. the cost of providing those services over a 12-month period, excluding the cost of minor home modifications and adaptive aids, does not exceed 133.3% of the individual cost limit; and

   B. continuation of those services does not affect DADS' compliance with the federal cost-effectiveness and efficiency requirements under 42 U.S.C. §1396n(b) and (c)(2)(D).

— (b) The DADS commissioner may exempt an individual receiving CWP services from the cost limit described in subsection (a)(2)(A) of this section. [end deletion]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on ______. 
The Health and Human Services Commission (HHSC) proposes, on behalf of the Department of Aging and Disability Services (DADS), an amendment to §51.103, concerning definitions, in Chapter 51, Medically Dependent Children Program (MDCP).

BACKGROUND AND PURPOSE

The purpose of the amendment is to implement a rule change necessitated by a project under the direction of HHSC that will replace the state case-mix system for provider payments, which is based on the Texas Index for Level of Effort (TILE) model, with the federal case-mix system, which is based on the Resource Utilization Group (RUG) model. The TILE-to-RUG project implements Texas Health and Safety Code, §242.221 et seq, which requires DADS to use an automated system for nursing facility reimbursement and an assessment form designed by the United States Health Care Financing Administration (now the Centers for Medicare and Medicaid Services). As allowed by Texas Health and Safety Code, §242.221(b), DADS and HHSC have elected to add other components of the state Medicaid program, such as MDCP, to the automated system of reimbursement and, therefore, to require use of an assessment form similar to the form on which nursing facility residents are assessed. The reference in §51.103(13) to an individual's TILE score will not be applicable under the RUG system and, therefore, needs to be revised.

The amendment also updates terminology in response to House Bill 2426, 80th Legislature, Regular Session, 2007, which amended the Texas Occupations Code, Chapter 301, and changed the name of the Board of Nurse Examiners for the State of Texas (BNE) to the Texas Board of Nursing.

SECTION-BY-SECTION SUMMARY

The amendment to §51.103(8) revises the definition of "BNE" so that references in the chapter to the BNE will mean the Texas Board of Nursing. The proposal also amends the definitions in §51.103(30), (35), and (41) to update references to the BNE.

The amendment to §51.103(13) revises the definition of "cost ceiling" to eliminate references to an individual's TILE score and to the specific percentage of the nursing facility reimbursement rate that is associated with an individual's cost ceiling. The percentage was revised in the 2008-09 General Appropriations Act (Article II, Department of Aging and Disability Services, Rider 45, H.B. 1, 80th Legislature, Regular Session, 2007) and is better placed in a section other than the definitions section. An amendment to §51.203, proposed elsewhere in this issue of the Texas Register, includes
the revised percentage of the nursing facility reimbursement rate that is associated with an individual's cost ceiling.

The definition of "TILE" in §51.103(49) is deleted from the section, because it is now an obsolete term and is no longer used in Chapter 51.

FISCAL NOTE

Gordon Taylor, DADS Chief Financial Officer, has determined that, for the first five years the proposed amendment is in effect, enforcing or administering the amendment does not have foreseeable implications relating to costs or revenues of state or local governments.

SMALL BUSINESS AND MICRO-BUSINESS IMPACT ANALYSIS

DADS has determined that the proposed amendment will not have an adverse economic effect on small businesses or micro-businesses, because the amendment imposes no new requirements that would cause them to alter their business practices.

PUBLIC BENEFIT AND COSTS

Barry Waller, DADS Assistant Commissioner for Provider Services, has determined that, for each year of the first five years the amendment is in effect, the public benefit expected as a result of enforcing the amendment is that DADS' rules will reflect accurate terminology and provide accurate information to MDCP providers.

Mr. Waller anticipates that there will not be an economic cost to persons who are required to comply with the amendment. The amendment will not affect a local economy.

TAKINGS IMPACT ASSESSMENT

DADS has determined that this proposal does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Texas Government Code, §2007.043.

PUBLIC COMMENT

Questions about the content of this proposal may be directed to Lynn Cooper at (512) 438-3519 in DADS' Provider Services Division. Written comments on the proposal may be submitted to Texas Register Liaison, Legal Services-013, Department of Aging and Disability Services W-615, P.O. Box 149030, Austin, Texas 78714-9030, or street address 701 West 51st St., Austin, TX 78751; faxed to (512) 438-5759; or e-mailed to rulescomments@dads.state.tx.us. To be considered, comments must be submitted no later than 30 days after the date of this issue of the Texas Register. The last day to submit comments falls on a Sunday; therefore, comments must be either (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered to DADS before
5:00 p.m. on DADS' last working day of the comment period; or (3) faxed or e-mailed by midnight on the last day of the comment period. When faxing or e-mailing comments, please indicate "Comments on Proposed Rule 013" in the subject line.
TITLE 40    SOCIAL SERVICES AND ASSISTANCE
PART 1    DEPARTMENT OF AGING AND DISABILITY SERVICES
CHAPTER 51   MEDICALLY DEPENDENT CHILDREN PROGRAM
SUBCHAPTER A  INTRODUCTION
RULE     §51.103

Proposed action:
X  Amendment

STATUTORY AUTHORITY

The amendment is proposed under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Health and Safety Code, §242.226, which authorizes the adoption of rules necessary to improve the efficiency of the reimbursement process for the state Medicaid system and maximize the automated reimbursement system's capabilities.

The amendment affects Texas Government Code, §531.0055 and §531.021; Texas Human Resources Code, §161.021; and Texas Health and Safety Code, §242.226.

§51.103. Definitions.

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

(1) §1915(c) waiver program--A home or community-based service authorized by §1915(c) of the Social Security Act and approved by the Centers for Medicare and Medicaid Services.
(2) Activities of daily living--Activities that are essential to daily self care, including bathing, dressing, grooming, routine hair and skin care, meal preparation, feeding, exercising, toileting, transfer and ambulation, positioning, range of motion, and assistance with self-administered medications.

(3) Adaptive aid--A device that is needed to treat, rehabilitate, prevent, or compensate for a condition that results in a disability or a loss of function and helps an individual perform the activities of daily living or control the environment in which he lives.

(4) Adjunct support services--Direct care services needed because of an individual's disability that:

(A) help an individual participate in:

(i) child care;

(ii) post-secondary education; or

(iii) independent living; or

(B) support an individual's move to an independent living situation.

(5) Appeal--A request for a hearing to challenge a service suspension, service reduction, service denial, or case closure.

(6) Attendant--An employee of a provider or of an individual who has selected the consumer directed services option who provides direct care to the individual.

(7) Basic child care--Watchful attention and supervision of an individual while the individual's primary caregiver is at work, in job training, or at school.

(8) BNE--Formerly, this referred to the Board of Nurse Examiners for the State of Texas. It now refers to the Texas Board of Nursing.

(9) Case closure--A DADS action that terminates an individual from MDCP services.

(10) Case manager--A DADS employee who is responsible for case management activities for an individual, including eligibility determination, enrollment, assessment and reassessment of the individual's need, service plan development, and intercession on the individual's behalf.

(11) Consumer directed services--A means of service delivery in which an individual or the individual's parent or guardian is the employer of the attendant.

(12) Contract--A written agreement between DADS and a provider to provide MDCP services to an individual in exchange for payment.
(13) Cost ceiling--The maximum dollar amount available to an individual for MDCP services per IPC year[, which is based on 63% of the nursing facility rate associated with the individual's TILE score].

(14) DADS--Department of Aging and Disability Services.

(15) DADS RN--A DADS employee who is an RN and has two years of experience in pediatric nursing.

(16) Day--Any reference to a day means a calendar day, unless otherwise specified in the text. A calendar day includes weekends and holidays.

(17) Delegated task--A task that a practitioner or RN delegates in accordance with state law.

(18) DFPS--Department of Family and Protective Services.

(19) Facility-based respite--Respite services provided to an individual in a licensed hospital or nursing facility.

(20) Family member--A person who is related by blood, by affinity, or by law to an individual.

(21) Foster home--Means a foster home as defined in the Human Resources Code, §42.002.

(22) Guardian--A person appointed as a guardian of the estate or of the person by a court.

(23) HHSC--Texas Health and Human Services Commission.

(24) Host family--A provider with whom an individual lives when the individual's parents are unable to care for him.

(25) Imminent danger--An immediate, real threat to a person's safety.

(26) Individual--A person who has been determined eligible to receive MDCP services.

(27) Interest list--A list of people who have contacted DADS and expressed an interest in MDCP services but have not applied for nor been determined eligible for MDCP services.

(28) IPC--Individual plan of care. A plan that documents the following:
(A) services provided to an individual through both MDCP and third-party resources, and the sources or providers of those services;

(B) medical information about the individual obtained by a DADS RN;

(C) a social assessment of the individual and the individual's family obtained by the case manager;

(D) the projected cost of the MDCP services;

(E) the service initiation date; and

(F) the respite or adjunct support services provider's service schedule.

(29) IPC year--A period not to exceed 365 days that is recorded on the IPC with a beginning and end date.

(30) LVN--Licensed vocational nurse. A person licensed by the Texas Board of Nursing or who holds a license from another state recognized by the Texas Board of Nursing to practice vocational nursing in Texas.

(31) MDCP--Medically Dependent Children Program. A §1915(c) waiver program that provides community-based services to help the primary caregiver care for an individual in the community.

(32) Medical necessity--The medical criteria a person must meet for admission to a Texas nursing facility.

(33) Minor home modification--A physical change to an individual's residence that is needed to prevent institutionalization or to support the most integrated setting for an individual to remain in the community.

(34) Parent--An individual's natural or adoptive parent or the spouse of the natural or adoptive parent.

(35) Practitioner--A physician currently licensed in Texas, Louisiana, Arkansas, Oklahoma, or New Mexico; a physician assistant currently licensed in Texas; or an RN approved by the Texas Board of Nursing to practice as an advanced practice nurse.

(36) Primary caregiver--A person who:

(A) is legally responsible for an individual's routine daily care, provision of food, shelter, clothing, health care, education, nurturing, and supervision; and

(B) provides daily, uncompensated care for the individual.
(37) Provider--An entity that has a contract with DADS to provide MDCP services.

(38) Reckless behavior--Acting with conscious indifference to the consequences.

(39) Residence--The place where an individual lives.

(40) Respite services--Direct care services needed because of an individual's disability that provide a primary caregiver temporary relief from caregiving activities when the primary caregiver would usually perform such activities.

(41) RN--Registered nurse. A person licensed by the Texas Board of Nursing [BNE] or who holds a license from another state recognized by the Texas Board of Nursing [BNE] to practice professional nursing in Texas.

(42) Service authorization form--Document that shows DADS' approval for a provider to deliver MDCP services.

(43) Service initiation date--The first day an individual begins receiving MDCP services.

(44) Service reduction--A temporary or permanent decrease in the number of service hours delivered to an individual.

(45) Service schedule--A schedule for delivering respite or adjunct support services to an individual that is agreed upon and signed by the individual or the individual's parent or guardian. A fixed service schedule specifies certain days, times of day, or time periods for delivery of the services. A variable service schedule specifies the number of authorized hours of services to be delivered per day, per week, or per month, but does not specify certain days, times of day, or time periods for delivery of the services.

(46) Service suspension--A temporary stoppage of MDCP services without loss of program or Medicaid eligibility.

(47) Texas Accessibility Standards--Texas Department of Licensing and Regulation building standards adopted to meet the provisions of Texas Government Code, Chapter 469, and to meet or exceed the construction and alterations requirements of Title III of the Americans with Disabilities Act (42 U.S.C. §§12181-12189).

(48) Third-party resources--Goods and services available to an individual from a source other than MDCP, such as Medicaid home health, Texas Health Steps Comprehensive Care Program, and private insurance.

[(49) TILE--Texas Index for Level of Effort. The system used to identify the intensity of the care needs of a person in a Texas nursing facility and in MDCP.]
(49) Transition assistance services--One-time service provided to a Medicaid-eligible resident of a nursing facility located in Texas to assist the resident in moving from the nursing facility into the community to receive MDCP services.

(50) Working day--Any day except Saturday, Sunday, a state holiday, or a federal holiday.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on ____________.
STANATORY AUTHORITY

The amendment is proposed under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; and Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program.

The amendment affects Texas Government Code, §531.0055 and §531.021, and Texas Human Resources Code, §161.021.

§51.203. Eligibility Requirements.

To be eligible to participate in MDCP, a person must:

(1) live in Texas;

(2) be:

(A) a citizen of the United States (U.S.);
(B) an alien who entered the U.S. before August 22, 1996, who has lived in the U.S. continuously since entry, and who meets the definition of a qualified alien at 8 U.S.C. §1641(b) or (c); or

(C) an alien who entered the U.S. on or after August 22, 1996, who has lived in the U.S. continuously since entry, and who meets the definition of a qualified alien at 8 U.S.C. §1612(b) and §1613;

(3) be under 21 years of age;

(4) meet the financial Medicaid eligibility criteria described in [begin addition] Texas Administrative Code, Title 1, [end addition] [begin deletion] 1 TAC [end deletion] Chapter 358 (relating to Medicaid Eligibility), based on the [begin addition] person's [end addition] income and resources [begin deletion] of the individual [end deletion];

(5) for initial enrollment only, meet at least one of the disability criteria described in §51.205(b) of this chapter (relating to Disability Criteria);

(6) meet medical necessity as described in §51.207 of this chapter (relating to Medical Necessity);

(7) have an IPC [begin addition] with a cost for MDCP services at or below 50 percent of the reimbursement rate that would have been paid for the same individual to receive nursing facility services considering all other resources, including resources described in §40.1 of this title (relating to Use of General Revenue for Services Exceeding the Individual Cost Limit of a Waiver Program) [end addition] [begin deletion] that a practitioner has signed [end deletion]; and

(8) if the person is under 18 years of age, reside:

   (A) with a family member; or

   (B) with a foster family that includes no more than four children unrelated to the individual.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on ____________.
Proposed action:
X  Repeal

STATUTORY AUTHORITY

The repeal is proposed under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; and Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program.

The repeal affects Texas Government Code, §531.0055 and §531.021, and Texas Human Resources Code, §161.021.

[begin deletion] §51.239, Providing MDCP Services When Costs Exceed the Individual Cost Ceiling.

(a) DADS does not provide MDCP services to an individual if the cost of providing those services exceeds the individual cost ceiling specified in §51.103(13) of this chapter (relating to Definitions), except:

(1) DADS continues to provide MDCP services to an individual who was receiving those services on September 1, 2005, at a cost that exceeded the individual cost ceiling, if continuation of those services:

(A) is necessary for the individual to live in the most integrated setting appropriate to the individual's needs; and

(B) does not affect DADS' compliance with the federal cost-effectiveness and efficiency requirements under United States Code (U.S.C.), Title 42, §1396n(b) and (c)(2)(D); or

(2) DADS continues to provide MDCP services to an individual who is ineligible to receive those services under this subsection if:

(A) the cost of providing those services over a 12-month period, excluding the cost of minor home modifications and adaptive aids, does not exceed 133.3% of the individual cost ceiling; and
(B) continuation of those services does not affect DADS’ compliance with the federal cost effectiveness and efficiency requirements under 42 U.S.C. §1396n(b) and (e)(2)(D).

— (b) The DADS commissioner may exempt an individual receiving MDCP services from the cost ceiling described in subsection (a)(2)(A) of this section.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on ____________.

TITLe 40 SOCIAL SERVICES AND ASSISTANCE
PART 1 DEPARTMENT OF AGING AND DISABILITY SERVICES
CHAPTER 51 MEDICALLY DEPENDENT CHILDREN PROGRAM
SUBCHAPTER D PROVIDER REQUIREMENTS
DIVISION 1 CONTRACTING REQUIREMENTS
RULE §51.409

Proposed action:
X New

STATUTORY AUTHORITY

The new section is proposed under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; and Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program.


[begin addition] §51.409. Utilization Review.

DADS may conduct utilization reviews of MDCP providers and MDCP services based on utilization patterns and trends. [end addition]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.
Issued in Austin, Texas, on ____________.
The Health and Human Services Commission (HHSC) proposes, on behalf of the Department of Aging and Disability Services (DADS), an amendment to §60.16, concerning medical necessity assessments, in Chapter 60, Contracting to Provide Programs of All-Inclusive Care for the Elderly (PACE).

BACKGROUND AND PURPOSE

The purpose of the amendment is to implement a rule change necessitated by a project under the direction of HHSC that will replace the state case-mix system for provider payments, which is based on the Texas Index for Level of Effort (TILE) model, with the federal case-mix system, which is based on the Resource Utilization Group (RUG) model. The TILE-to-RUG project implements Texas Health and Safety Code, §242.221 et seq, which requires DADS to use an automated system for nursing facility reimbursement and an assessment form designed by the United States Health Care Financing Administration (now the Centers for Medicare and Medicaid Services). As allowed by Texas Health and Safety Code, §242.221(b), DADS and HHSC have elected to add other components of the state Medicaid program, such as PACE, to the automated system of reimbursement and, therefore, to require use of an assessment form similar to the form on which nursing facility residents are assessed. As a result, DADS will its Client Assessment, Review and Evaluation (CARE) form (also known as Form 3652) with forms based on the federal Minimum Data Set (MDS) assessment for making medical necessity determinations and calculating the RUG. For the purpose of this rule, the community-based assessment is termed "the medical necessity and level of care assessment."

SECTION-BY-SECTION SUMMARY

The amendment replaces references to the CARE form and to the TILE assessment with references to the medical necessity and level of care assessment. It also corrects outdated references to the Texas Department of Human Services (DHS) and replaces them with references to either DADS or to HHSC, as appropriate.

FISCAL NOTE

Gordon Taylor, DADS Chief Financial Officer, has determined that, for the first five years the proposed amendment is in effect, enforcing or administering the amendment does not have foreseeable implications relating to costs or revenues of state or local governments.
SMALL BUSINESS AND MICRO-BUSINESS IMPACT ANALYSIS

DADS has determined that the proposed amendment will not have an adverse economic effect on small businesses or micro-businesses, because the amendment imposes no new requirements that would cause them to alter their business practices.

PUBLIC BENEFIT AND COSTS

Barry Waller, DADS Assistant Commissioner for Provider Services, has determined that, for each year of the first five years the amendment is in effect, the public benefit expected as a result of enforcing the amendment is that DADS rules will provide accurate requirements for PACE providers. The amendment, which requires providers to conduct assessments of individuals served in the community on a form similar to the form on which nursing facility residents are assessed, will allow for better comparison of services in Texas to services in other states and provide for more streamlined and integrated business processes. These improvements will in turn lead to opportunities for improved services for DADS' consumers.

Mr. Waller anticipates that there will not be an economic cost to persons who are required to comply with the amendment. The amendment will not affect a local economy.

TAKINGS IMPACT ASSESSMENT

DADS has determined that this proposal does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Texas Government Code, §2007.043.

PUBLIC COMMENT

Questions about the content of this proposal may be directed to Pam Lovell at (512) 438-2489 in DADS' Provider Services Division. Written comments on the proposal may be submitted to Texas Register Liaison, Legal Services-012, Department of Aging and Disability Services W-615, P.O. Box 149030, Austin, Texas 78714-9030, or street address 701 West 51st St., Austin, TX 78751; faxed to (512) 438-5759; or e-mailed to rulescomments@dads.state.tx.us. To be considered, comments must be submitted no later than 30 days after the date of this issue of the Texas Register. The last day to submit comments falls on a Sunday; therefore, comments must be either (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered to DADS before 5:00 p.m. on DADS' last working day of the comment period; or (3) faxed or e-mailed by midnight on the last day of the comment period. When faxing or e-mailing comments, please indicate "Comments on Proposed Rule 012" in the subject line.
§60.16. Medical Necessity Assessments.

(a) The provider agency must complete a medical necessity and level of care assessment [begin addition] Client Assessment and Review Evaluation (CARE) form [end deletion] based on the client's total needs.

(b) The provider agency must electronically transmit or mail the medical necessity and level of care assessment [end deletion]
addition] [begin deletion] CARE form [end deletion] to the agency with which the Texas [begin addition] Health and Human Services Commission (HHSC) [end addition] [begin deletion] Department of Human Services (DHS) [end deletion] contracts for medical necessity determinations.

(c) The provider agency must enroll any eligible applicant within 60 calendar days [begin addition] after [end addition] [begin deletion] of [end deletion] the date of the [begin addition] medical necessity and level of care assessment [end addition] [begin deletion] CARE form [end deletion].

(d) The provider agency must complete another [begin addition] medical necessity and level of care assessment [end addition] [begin deletion] CARE form [end deletion] and submit it to the agency with which [begin addition] HHSC [end addition] [begin deletion] DHS [end deletion] contracts for medical necessity determinations 12 months after the initial assessment.

1) If the client meets the state's medical necessity criteria and the client has an irreversible or progressive diagnosis, or a terminal illness that could reasonably be expected to result in death in the next six months, and [begin addition] the Department of Aging and Disability Services (DADS) [end addition] [begin deletion] DHS [end deletion] determines that there is no reasonable expectation of improvement or significant change in the client's condition because of severity of a chronic condition or the degree of impairment of functional capacity, [begin addition] DADS [end addition] [begin deletion] DHS [end deletion] will permanently waive the annual recertification requirement and the client may be deemed to be continually eligible for PACE. The [begin addition] medical necessity and level of care assessment [end addition] [begin deletion] CARE form [end deletion] must have sufficient documentation to substantiate the client's prognosis and the client's functional capacity.

2) In addition, if [begin addition] DADS [end addition] [begin deletion] DHS [end deletion] determines that a PACE client no longer meets the medical necessity criteria for nursing facility care, the client may be deemed to continue to be eligible for PACE until the next annual reassessment, if, in the absence of PACE services, it is reasonable to expect that the client would meet the nursing facility medical necessity criteria within the next six months.

(e) The provider agency's licensed nurse must complete the [begin addition] medical necessity and level of care assessment [end addition] [begin deletion] CARE form [end deletion] for the provider agency. The licensed nurse must be registered with the agency with which [begin addition] HHSC [end addition] [begin deletion] DHS [end deletion] contracts for medical necessity determinations as having, within the last two years, received and passed a [begin addition] state-approved [end addition] [begin deletion] Texas Health and Human Services Commission approved [end deletion] training on the [begin addition] medical necessity and level of care assessment [end addition] [begin deletion] Texas Index for Level of Effort (TILE) assessment [end deletion].
This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on ____________.
Proposed action: X Amendment

STATUTORY AUTHORITY

The amendment is proposed under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Health and Safety Code, §242.226, which authorizes the adoption of rules necessary to improve the efficiency of the reimbursement process for the state Medicaid system and maximize the automated reimbursement system's capabilities.

The amendment affects Texas Government Code, §531.0055 and §531.021; Texas Human Resources Code, §161.021; and Texas Health and Safety Code, §242.226.


The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise.
(1) Abuse--Any act, failure to act, or incitement to act done willfully, knowingly, or recklessly through words or physical action which causes or could cause mental or physical injury or harm or death to a resident. This includes verbal, sexual, mental/psychological, or physical abuse, including corporal punishment, involuntary seclusion, or any other actions within this definition.

(A) "Involuntary seclusion"--Separation of a resident from others or from his room against the resident's will or the will of the resident's legal representative. Temporary monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used as a therapeutic intervention as determined by professional staff and consistent with the resident's plan of care.

(B) "Mental/psychological abuse"--Mistreatment within the definition of "abuse" not resulting in physical harm, including, but not limited to, humiliation, harassment, threats of punishment, deprivation, or intimidation.

(C) "Physical abuse"--Physical action within the definition of "abuse," including, but not limited to, hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment.

(D) "Sexual abuse"--Any touching or exposure of the anus, breast, or any part of the genitals of a resident without the voluntary, informed consent of the resident and with the intent to arouse or gratify the sexual desire of any person and includes but is not limited to sexual harassment, sexual coercion, or sexual assault.

(E) "Verbal abuse"--The use of any oral, written, or gestured language that includes disparaging or derogatory terms to a resident or within the resident's hearing distance, regardless of the resident's age, ability to comprehend, or disability.


(3) Activities assessment--See Comprehensive Assessment and Comprehensive Care Plan [of Care].

(4) Activities director--The qualified individual appointed by the facility to direct the activities program as described in §19.702 of this title (relating to Activities).

(5) Addition--The addition of floor space to an institution.

(6) Administrator--Licensed nursing facility administrator.

[begin addition] (7) Admission MDS assessment--An MDS assessment that determines a recipient's initial determination of eligibility for medical necessity for admission into the Texas Medicaid Nursing Facility Program.[end addition]
(7) Admission determination of medical necessity—The state Medicaid claims administrator's decision regarding an individual's need for medical and nursing services upon the individual's entering his entry into a nursing facility or upon his becoming eligible for Medicaid. The admission determination of medical necessity is valid for up to 120 days from the effective date assigned by the Utilization Review Committee.

(8) Affiliate--With respect to a:

(A) partnership, each partner thereof;

(B) corporation, each officer, director, principal stockholder, and subsidiary; and each person with a disclosable interest;

(C) natural person, which includes each:

(i) person's spouse;

(ii) partnership and each partner thereof of which said person or any affiliate of said person is a partner; and

(iii) corporation in which said person is an officer, director, principal stockholder, or person with a disclosable interest.

(9) Agent--An adult to whom authority to make health care decisions is delegated under a durable power of attorney for health care.

(10) Applicant--A person or governmental unit, as those terms are defined in the Health and Safety Code, Chapter 242, applying for a license under that chapter.


(12) Attending physician--A physician, currently licensed by the Texas Medical State Board of Medical Examiners, who is designated by the resident or responsible party as having primary responsibility for the treatment and care of the resident.

(13) Authorized electronic monitoring--The placement of an electronic monitoring device in a resident's room and using the device to make tapes or recordings after making a request to the facility to allow electronic monitoring.

(14) Barrier precautions--Precautions including the use of gloves, masks, gowns, resuscitation equipment, eye protectors, aprons, faceshields, and protective clothing for purposes of infection control.
CARE form--The DADS Client Assessment, Review and Evaluation (CARE) form completed by Medicaid-certified nursing facilities which allows for determination of medical necessity, reimbursement rate, initial level of the Preadmission Screening and Resident Review (PASARR) and the initial medical care determination and reassessment of the 1915(c) waivers.

Care and treatment--Services required to maximize resident independence, personal choice, participation, health, self-care, psychosocial functioning and reasonable safety, all consistent with the preferences of the resident.

Case mix--A method of classifying recipients based upon resource and service needs and paying nursing facilities a per diem rate according to the recipient's classification.

Certification--The determination by DADS that a nursing facility meets all the requirements of the Medicaid and/or Medicare programs.


CMS--Centers for Medicare & Medicaid Services, formerly the Health Care Financing Administration (HCFA).

Complaint--Any allegation received by DADS other than an incident reported by the facility. Such allegations include, but are not limited to, abuse, neglect, exploitation, or violation of state or federal standards.

Completion date--The date an RN assessment coordinator signs an MDS assessment as complete.

Comprehensive assessment--An interdisciplinary description of a resident's needs and capabilities including daily life functions and significant impairments of functional capacity, as described in §19.801(2) of this chapter (relating to Resident Assessment).

Comprehensive care plan--A plan of care prepared by an interdisciplinary team that includes measurable short-term and long-term objectives and timetables to meet the resident's needs developed for each resident after admission. The plan addresses at least the following needs: medical, nursing, rehabilitative, psychosocial, dietary, activity, and resident's rights. The plan includes strategies developed by the team, as described in...
§19.802(b)(2) of this title (relating to Comprehensive Care Plans), consistent with the physician's prescribed plan of care, to assist the resident in eliminating, managing, or alleviating health or psychosocial problems identified through assessment. Planning includes:

(A) goal setting;

(B) establishing priorities for management of care;

(C) making decisions about specific measures to be used to resolve the resident's problems; and/or

(D) assisting in the development of appropriate coping mechanisms.

Controlling person--A person with the ability, acting alone or in concert with others, to directly or indirectly, influence, direct, or cause the direction of the management, expenditure of money, or policies of a nursing facility or other person. A controlling person does not include a person, such as an employee, lender, secured creditor, or landlord, who does not exercise any influence or control, whether formal or actual, over the operation of a facility. A controlling person includes:

(A) a management company, landlord, or other business entity that operates or contracts with others for the operation of a nursing facility;

(B) any person who is a controlling person of a management company or other business entity that operates a nursing facility or that contracts with another person for the operation of a nursing facility; and

(C) any other individual who, because of a personal, familial, or other relationship with the owner, manager, landlord, tenant, or provider of a nursing facility, is in a position of actual control or authority with respect to the nursing facility, without regard to whether the individual is formally named as an owner, manager, director, officer, provider, consultant, contractor, or employee of the facility.

Covert electronic monitoring--The placement and use of an electronic monitoring device that is not open and obvious, and the facility and DADS have not been informed about the device by the resident, by a person who placed the device in the room, or by a person who uses the device.
DADS--The Department of Aging and Disability Services.

Dangerous drugs--Any drug as defined in the Texas Health and Safety Code, Chapter 483.

Dentist--A practitioner licensed by the Texas State Board of Dental Examiners.

Department--Department of Aging and Disability Services.

DHS--Formerly, this term referred to the Texas Department of Human Services; it now refers to DADS, unless the context concerns an administrative hearing. Administrative hearings were formerly the responsibility of DHS; they now are the responsibility of the Texas Health and Human Services Commission (HHSC).

Dietitian--A qualified dietitian is one who is qualified based upon either:

(A) registration by the Commission on Dietetic Registration of the American Dietetic Association; or

(B) licensure, or provisional licensure, by the Texas State Board of Examiners of Dietitians. These individuals must have one year of supervisory experience in dietetic service of a health care facility.

Direct care by licensed nurses--Direct care consonant with the physician's planned regimen of total resident care includes:

(A) assessment of the resident's health care status;

(B) planning for the resident's care;

(C) assignment of duties to achieve the resident's care;

(D) nursing intervention; and

(E) evaluation and change of approaches as necessary.

Distinct part--That portion of a facility certified to participate in the Medicaid Nursing Facility program.
Drug (also referred to as medication)--Any of the following:

(A) any substance recognized as a drug in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of them;

(B) any substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man;

(C) any substance (other than food) intended to affect the structure or any function of the body of man; and

(D) any substance intended for use as a component of any substance specified in subparagraphs (A)-(C) of this definition. It does not include devices or their components, parts, or accessories.

Electronic monitoring device--Video surveillance cameras and audio devices installed in a resident's room, designed to acquire communications or other sounds that occur in the room. An electronic, mechanical, or other device used specifically for the nonconsensual interception of wire or electronic communication is excluded from this definition.

Emergency--A sudden change in a resident's condition requiring immediate medical intervention.

Exploitation--The illegal or improper act or process of a caretaker using the resources of an elderly or disabled person for monetary or personal benefit, profit, or gain.

Exposure (infections)--The direct contact of blood or other potentially infectious materials of one person with the skin or mucous membranes of another person. Other potentially infectious materials include the following human body fluids: semen, vaginal secretions, cerebrospinal fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, and body fluid that is visibly contaminated with blood, and all body fluids when it is difficult or impossible to differentiate between body fluids.

Facility--Unless otherwise indicated, a facility is an institution that provides organized and structured nursing care and service and is subject to licensure under Health and Safety Code, Chapter 242.

(A) For Medicaid, a facility is a nursing facility which meets the requirements of §1919(a)-(d) of the Social Security Act. A facility may not include any institution that is for the care and treatment of mental diseases except for services furnished to individuals
age 65 and over and who are eligible as defined in §19.2500 of this title (relating to Preadmission Screening and Resident Review (PASARR)).

(B) For Medicare and Medicaid purposes (including eligibility, coverage, certification, and payment), the "facility" is always the entity which participates in the program, whether that entity is comprised of all of, or a distinct part of, a larger institution.

(C) "Facility" is also referred to as a nursing home or nursing facility. Depending on context, these terms are used to represent the management, administrator, or other persons or groups involved in the provision of care of the resident; or to represent the physical building, which may consist of one or more floors or one or more units, or which may be a distinct part of a licensed hospital.

[begin deletion] (41) Facility nurse assessor--The licensed nurse in the nursing facility, who completes the Client Assessment, Review and Evaluation (CARE) forms. [end deletion]

[begin deletion] (40) [end addition] [begin deletion] (42) [end deletion] Family representative--An individual appointed by the resident to represent the resident and other family members, by formal or informal arrangement.

[begin addition] (41) [end addition] [begin deletion] (43) [end deletion] Fiduciary agent--An individual who holds in trust another's monies.

[begin addition] (42) [end addition] [begin deletion] (44) [end deletion] Free choice--Unrestricted right to choose a qualified provider of services.

[begin addition] (43) [end addition] [begin deletion] (45) [end deletion] Goals--Long-term: general statements of desired outcomes. Short-term: measurable time-limited, expected results that provide the means to evaluate the resident's progress toward achieving long-term goals.

[begin addition] (46) [end addition] [begin deletion] (4) [end deletion] Governmental unit--A state or a political subdivision of the state, including a county or municipality.

[begin addition] (47) [end addition] [begin deletion] (48) [end deletion] HCFA--Health Care Financing Administration, now the Centers for Medicare & Medicaid Services (CMS).

[begin addition] (48) [end addition] [begin deletion] (49) [end deletion] Health care provider--An individual, including a physician, or facility licensed, certified, or otherwise authorized to administer health care, in the ordinary course of business or professional practice.
Hearing--A contested case hearing held in accordance with the Administrative Procedure Act, Texas Government Code, Chapter 2001, and the formal hearing procedures in 1 TAC Chapter 357, Subchapter I.

HIV--Human Immunodeficiency Virus.

Incident--An abnormal event, including accidents or injury to staff or residents, which is documented in facility reports. An occurrence in which a resident may have been subject to abuse, neglect, or exploitation must also be reported to DADS.

Infection control--A program designed to prevent the transmission of disease and infection in order to provide a safe and sanitary environment.

Inspection--Any on-site visit to or survey of an institution by DADS for the purpose of licensing, monitoring, complaint investigation, architectural review, or similar purpose.

Interdisciplinary care plan--See the definition of "comprehensive care plan."

IV--Intravenous.

Legend drug or prescription drug--Any drug that requires a written or telephonic order of a practitioner before it may be dispensed by a pharmacist, or that may be delivered to a particular resident by a practitioner in the course of the practitioner's practice.

Licensed health professional--A physician; physician assistant; nurse practitioner; physical, speech, or occupational therapist; pharmacist; physical or occupational therapy assistant; registered professional nurse; licensed vocational nurse; licensed dietitian; or licensed social worker.

Licensed nursing home (facility) administrator--A person currently licensed by DADS in accordance with Chapter 18 of this title (relating to Nursing Facility Administrators).

Licensed vocational nurse (LVN)--A nurse who is currently licensed by the Texas Board of Nursing.
Board of Nursing Nurse Examiners for the State of Texas as a licensed vocational nurse.


(59) Life safety features--Fire safety components required by the Life Safety Code, including, but not limited to, building construction, fire alarm systems, smoke detection systems, interior finishes, sizes and thicknesses of doors, exits, emergency electrical systems, and sprinkler systems.

(60) Life support--Use of any technique, therapy, or device to assist in sustaining life. (See §19.419 of this title (relating to Advance Directives and Medical Powers of Attorney)).

(61) Local authorities--Persons, including, but not limited to, local health authority, fire marshal, and building inspector, who may be authorized by state law, county order, or municipal ordinance to perform certain inspections or certifications.

(62) Local health authority--The physician appointed by the governing body of a municipality or the commissioner's court of the county to administer state and local laws relating to public health in the municipality's or county's jurisdiction as defined in Health and Safety Code, §121.021.

(63) Long-term care-regulatory--DADS' Regulatory Services Division, which is responsible for surveying nursing facilities to determine compliance with regulations for licensure and certification for Title XIX participation.

(64) Manager--A person, other than a licensed nursing home administrator, having a contractual relationship to provide management services to a facility.

(65) Management services--Services provided under contract between the owner of a facility and a person to provide for the operation of a facility, including administration, staffing, maintenance, or delivery of resident services. Management services do not include contracts solely for maintenance, laundry, or food service.
(66) MDS--Minimum data set. See Resident Assessment Instrument (RAI).

(67) MDS nurse reviewer--A registered nurse employed by HHSC to monitor the accuracy of the MDS assessment submitted by a Medicaid-certified nursing facility.

(68) Medicaid applicant--A person who requests the determination of eligibility to become a Medicaid recipient.

(69) Medicaid nursing facility vendor payment system--Electronic billing and payment system for reimbursement to nursing facilities for services provided to eligible Medicaid recipients.

(70) Medicaid recipient--A person who meets the eligibility requirements of the Title XIX Medicaid program, is eligible for nursing facility services, and resides in a Medicaid-participating facility.

(71) Medical director--A physician licensed by the Texas Medical Board, who is engaged by the nursing home to assist in and advise regarding the provision of nursing and health care.

(72) Medical necessity (MN)--The determination that a recipient requires the services of licensed nurses in an institutional setting to carry out the physician's planned regimen for total care. A recipient's need for custodial care in a 24-hour institutional setting does not constitute a medical need. A group of health care professionals employed or contracted by the state Medicaid claims administrator contracted with HHSC makes individual determinations of medical necessity regarding nursing facility care. These health care professionals consist of physicians and registered nurses.

(73) Medical necessity assessment--The process by which the applicant's or recipient's medical condition is evaluated to determine the need for nursing facility care based upon information supplied by the nursing facility.

(74) Medical power of attorney--The legal document that designates an agent to make treatment decisions if the individual designator becomes incapable.

(75) Medical-social care plan--See Interdisciplinary Comprehensive Care Plan.
Medically related condition--An organic, debilitating disease or health disorder that requires services provided in a nursing facility, under the supervision of licensed nurses.

Medication aide--A person who holds a current permit issued under the Medication Aide Training Program as described in Chapter 95 of this title (relating to Medication Aides--Program Requirements) and acts under the authority of a person who holds a current license under state law which authorizes the licensee to administer medication.

Minimum data set (MDS)--See Resident Assessment Instrument (RAI).

Misappropriation of funds--The taking, secretion, misapplication, deprivation, transfer, or attempted transfer to any person not entitled to receive any property, real or personal, or anything of value belonging to or under the legal control of a resident without the effective consent of the resident or other appropriate legal authority, or the taking of any action contrary to any duty imposed by federal or state law prescribing conduct relating to the custody or disposition of property of a resident.


Neglect--A deprivation of life's necessities of food, water, or shelter, or a failure of an individual to provide services, treatment, or care to a resident which causes or could cause mental or physical injury, or harm or death to the resident.

NHIC--Formerly, this term referred to the National Heritage Insurance Corporation. It, which was the intermediary for the Texas Medicaid program, it now refers to the state Medicaid claims administrator.

Nonnursing personnel--Persons not assigned to give direct personal care to residents; including administrators, secretaries, activities directors, bookkeepers, cooks, janitors, maids, laundry workers, and yard maintenance workers.

Nurse aide--An individual who provides nursing or nursing-related services to residents in a facility under the supervision of a licensed nurse. This definition does not include an individual who is a licensed health professional, a registered dietitian, or someone who volunteers such services without pay. A nurse aide is not authorized to provide nursing and/or
nursing-related services for which a license or registration is required under state law. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants.

[Nurse aide trainee--An individual who is attending a program teaching nurse aide skills.]

[Nurse practitioner--A person licensed by the Texas Board of Nursing Examiners (BNE) as a registered professional nurse, authorized by the Texas Board of Nursing as an advanced practice nurse in the role of nurse practitioner.]

[Nurse reviewer--A registered professional nurse employed by HHSC to monitor the accuracy of the CARE form assessment data.]

[Nursing assessment--See definition of "comprehensive assessment" and "comprehensive care plan."]

[Nursing care-Service provided by nursing personnel which include, but are not limited to, observation; promotion and maintenance of health; prevention of illness and disability; management of health care during acute and chronic phases of illness; guidance and counseling of individuals and families; and referral to physicians, other health care providers, and community resources when appropriate.]

[Nursing facility/home--An institution that provides organized and structured nursing care and service, and is subject to licensure under Health and Safety Code, Chapter 242. The nursing facility may also be certified to participate in the Medicaid Title XIX program. Depending on context, these terms are used to represent the management, administrator, or other persons or groups involved in the provision of care to the residents; or to represent the physical building, which may consist of one or more floors or one or more units, or which may be a distinct part of a licensed hospital.]

[Nursing facility/home administrator--See the definition of "licensed nursing home (facility) administrator."]

[Nursing personnel--Persons assigned to give direct personal and nursing services to residents, including registered nurses, licensed vocational nurses, nurse aides, orderlies, and medication aides. Unlicensed personnel function under the authority of licensed personnel.]
Objectives--See definition of "goals."

OBRA--Omnibus Budget Reconciliation Act of 1987, which includes provisions relating to nursing home reform, as amended.

Ombudsman--An advocate who is a certified representative, staff member, or volunteer of the DADS Office of the State Long Term Care Ombudsman.

Optometrist--An individual with the profession of examining the eyes for defects of refraction and prescribing lenses for correction who is licensed by the Texas Optometry Board.

Paid feeding assistant--An individual who meets the requirements of §19.1113 of this chapter (relating to Paid Feeding Assistants) and who is paid to feed residents by a facility or who is used under an arrangement with another agency or organization.

PASARR--Preadmission Screening and Resident Review.

Palliative Plan of Care--Appropriate medical and nursing care for residents with advanced and progressive diseases for whom the focus of care is controlling pain and symptoms while maintaining optimum quality of life.

Patient care-related electrical appliance--An electrical appliance that is intended to be used for diagnostic, therapeutic, or monitoring purposes in a patient care area, as defined in Standard 99 of the National Fire Protection Association.

Person--An individual, firm, partnership, corporation, association, joint stock company, limited partnership, limited liability company, or any other legal entity, including a legal successor of those entities.

Person with a disclosable interest--A person with a disclosable interest is any person who owns at least a 5.0% interest in any corporation, partnership, or other business entity that is required to be licensed under Health and Safety Code, Chapter 242. A person with a disclosable interest does not include a bank, savings and loan, savings bank, trust company, building and loan association, credit union, individual loan and thrift company, investment banking firm, or insurance company, unless these entities participate in the management of the facility.
Pharmacist--An individual, licensed by the Texas State Board of Pharmacy to practice pharmacy, who prepares and dispenses medications prescribed by a physician, dentist, or podiatrist.

Physical restraint--See Restraints (physical).

Physician--A doctor of medicine or osteopathy currently licensed by the Texas Medical State Board of Medical Examiners.

Physician assistant (PA)--

(A) A graduate of a physician assistant training program who is accredited by the Committee on Allied Health Education and Accreditation of the Council on Medical Education of the American Medical Association; or

(B) A person who has passed the examination given by the National Commission on Certification of Physician Assistants. According to federal requirements (42 CFR §491.2) a physician assistant is a person who meets the applicable state requirements governing the qualifications for assistant to primary care physicians, and who meets at least one of the following conditions:

(i) is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians; or

(ii) has satisfactorily completed a program for preparing physician assistants that:

(I) was at least one academic year in length;

(II) consisted of supervised clinical practice and at least four months (in the aggregate) of classroom instruction directed toward preparing students to deliver health care; and

(III) was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation; or

(C) A person who has satisfactorily completed a formal educational program for preparing physician assistants who does not meet the requirements of paragraph (d)(2), 42 CFR §491.2, and has been assisting primary care physicians for a total of 12 months during the 18-month period immediately preceding July 14, 1978.
Podiatrist--A practitioner whose profession encompasses the care and treatment of feet who is licensed by the Texas State Board of Podiatric Medical Examiners.

Poison--Any substance that federal or state regulations require the manufacturer to label as a poison and is to be used externally by the consumer from the original manufacturer's container. Drugs to be taken internally that contain the manufacturer's poison label, but are dispensed by a pharmacist only by or on the prescription order of a physician, are not considered a poison, unless regulations specifically require poison labeling by the pharmacist.

Practitioner--A physician, podiatrist, dentist, or an advanced practice nurse or physician assistant to whom a physician has delegated authority to sign a prescription order, when relating to pharmacy services.

Preadmission medical necessity determination--The determination of need for nursing facility care before the individual's admission into the nursing facility. This determination is valid until admission into a nursing facility or up to 30 days from the effective date.

PRN (pro re nata)--As needed.

Provider--The individual or legal business entity that is contractually responsible for providing Medicaid services under an agreement with DADS.

Psychoactive drugs--Drugs prescribed to control mood, mental status, or behavior.

Qualified surveyor--An employee of DADS who has completed state and federal training on the survey process and passed a federal standardized exam.

Quality assessment and assurance committee--A group of health care professionals in a facility who develop and implement appropriate action to identify and rectify substandard care and deficient facility practice.

Quality-of-care monitor--A registered nurse, pharmacist, or dietitian employed by DADS who is trained and experienced in long-term care facility regulation, standards of practice in long-term care, and evaluation of resident care, and functions independently of DADS' Regulatory Services Division.
Recipient--Any individual residing in a Medicaid certified facility or a Medicaid certified distinct part of a facility whose daily vendor rate is paid by Medicaid.

Registered nurse (RN)--An individual currently licensed by the Texas Board of Nursing for the State of Texas as a Registered Nurse in the State of Texas.

Reimbursement methodology--The method by which HHSC determines nursing facility per diem rates.

Remodeling--The construction, removal, or relocation of walls and partitions, the construction of foundations, floors, or ceiling-roof assemblies, the expanding or altering of safety systems (including, but not limited to, sprinkler, fire alarm, and emergency systems) or the conversion of space in a facility to a different use.

Renovation--The restoration to a former better state by cleaning, repairing, or rebuilding, including, but not limited to, routine maintenance, repairs, equipment replacement, painting.

Representative payee--A person designated by the Social Security Administration to receive and disburse benefits, act in the best interest of the beneficiary, and ensure that benefits will be used according to the beneficiary's needs.

Resident--Any individual residing in a nursing facility.

Resident assessment instrument (RAI)--An assessment tool used to conduct comprehensive, accurate, standardized, and reproducible assessments of each resident's functional capacity as specified by the Secretary of the U.S. Department of Health and Human Services. At a minimum, this instrument must consist of the Minimum Data Set (MDS) core elements as specified by the Centers for Medicare & Medicaid Services (CMS); utilization guidelines; and Resident Assessment Protocols (RAPS).

Responsible party--An individual authorized by the resident to act for him as an official delegate or agent. Responsible party is usually a family member or relative, but may be a legal guardian or other individual. Authorization may be in writing or may be given orally.
Restraint hold--

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

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

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

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

Restraints (chemical)--Psychoactive drugs administered for the purposes of discipline, or convenience, and not required to treat the resident's medical symptoms.

Restraints (physical)--Any manual method, or physical or mechanical device, material or equipment attached, or adjacent to the resident's body, that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. The term includes a restraint hold.

RN assessment coordinator--A registered nurse who signs and certifies a comprehensive assessment of a resident's needs, using the RAI, including the MDS, as specified by DADS.

RUG--Resource Utilization Group. A categorization method, consisting of 34 categories based on the MDS, that is used to determine a recipient's service and care requirements and to determine the daily rate DADS pays a nursing facility for services provided to the recipient.

Seclusion--See the definition of "involuntary seclusion" in paragraph (1)(A) of this section.

Secretary--Secretary of the U.S. Department of Health and Human Services.

Services required on a regular basis--Services which are provided at fixed or recurring intervals and are needed so frequently that it would be impractical to provide the services in a home or family setting. Services required on a regular basis include continuous or periodic nursing observation, assessment, and intervention in all areas of resident care.
SNF--A skilled nursing facility or distinct part of a facility that participates in the Medicare program. SNF requirements apply when a certified facility is billing Medicare for a resident's per diem rate.

Social Security Administration--Federal agency for administration of social security benefits. Local social security administration offices take applications for Medicare, assist beneficiaries file claims, and provide information about the Medicare program.

Social worker--A qualified social worker is an individual who is licensed, or provisionally licensed, by the Texas State Board of Social Work Examiners as prescribed by the Texas Occupations Code, Chapter 505, and who has at least:

(A) a bachelor's degree in social work; or

(B) similar professional qualifications, which include a minimum educational requirement of a bachelor's degree and one year experience met by employment providing social services in a health care setting.

Standards--The minimum conditions, requirements, and criteria established in this chapter with which an institution must comply to be licensed under this chapter.

State Medicaid claims administrator--The entity under contract with HHSC to process Medicaid claims in Texas.

State plan--A formal plan for the medical assistance program, submitted to CMS, in which the State of Texas agrees to administer the program in accordance with the provisions of the State Plan, the requirements of Titles XVIII and XIX, and all applicable federal regulations and other official issuances of the U.S. Department of Health and Human Services.

State survey agency--DADS is the agency, which through contractual agreement with CMS is responsible for Title XIX (Medicaid) survey and certification of nursing facilities.

Supervising physician--A physician who assumes responsibility and legal liability for services rendered by a physician assistant (PA) and has been approved by the Texas Medical Board to supervise services rendered by specific PAs. A supervising physician may also be a physician who provides general supervision of a nurse practitioner providing services in a nursing facility.
Supervision--General supervision, unless otherwise identified.

Supervision (direct)--Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity within his sphere of competence. If the person being supervised does not meet assistant-level qualifications specified in this chapter and in federal regulations, the supervisor must be on the premises and directly supervising.

Supervision (general)--Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity within his sphere of competence. The person being supervised must have access to the licensed and/or qualified person providing the supervision.

Supervision (intermittent)--Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity within his sphere of competence, with initial direction and periodic inspection of the actual act of accomplishing the function or activity. The person being supervised must have access to the licensed and/or qualified person providing the supervision.

TDMHMR--Formerly, this term referred to the Texas Department of Mental Health and Mental Retardation; it now refers to DADS.

Texas Register--A publication of the Texas Register Publications Section of the Office of the Secretary of State that contains emergency, proposed, withdrawn, and adopted rules issued by Texas state agencies. The Texas Register was established by the Administrative Procedure and Texas Register Act of 1975.

Therapeutic diet--A diet ordered by a physician as part of treatment for a disease or clinical condition, in order to eliminate, decrease, or increase certain substances in the diet or to provide food which has been altered to make it easier for the resident to eat.

Therapy week--A seven-day period beginning the first day rehabilitation therapy or restorative nursing care is given. All subsequent therapy weeks for a particular individual will begin on that day of the week.

Threatened violation--A situation that, unless immediate steps are taken to correct, may cause injury or harm to a resident's health and safety.
TILE—Texas Index for Level of Effort; an index of 11 categories plus a default that consists of relative resource utilization groups. The index determines where a nursing facility client fits based upon service and care requirements. It determines the daily rate to be paid on behalf of the client.

TILE 202 restorative nursing—Nursing care and practices, based on a plan of care developed by the restorative team, designed to maintain or improve on goals achieved during physical or occupational therapy. Examples of TILE 202 restorative nursing include training and skill practice in self feeding, bed mobility, transfers, ambulation, dressing or grooming, and active range of motion.

TILE error—Inaccuracies in a CARE form assessment of a Medicaid recipient that result in an incorrect TILE classification.

Title II—Federal Old-Age, Survivors, and Disability Insurance Benefits of the Social Security Act.

Title XVI—Supplemental Security Income (SSI) of the Social Security Act.

Title XVIII—Medicare provisions of the Social Security Act.

Title XIX—Medicaid provisions of the Social Security Act.

Total health status—Includes functional status, medical care, nursing care, nutritional status, rehabilitation and restorative potential, activities potential, cognitive status, oral health status, psychosocial status, and sensory and physical impairments.

UAR—HHSC's Utilization and Assessment Review Section.

Uniform data set—See Resident Assessment Instrument (RAI).

Universal precautions—The use of barrier and other precautions by long-term care facility employees and/or contract agents to prevent the spread of blood-borne diseases.

Utilization review committee—The group of health care professionals contracted by HHSC to make individual determinations of medical necessity regarding nursing facility care. The Utilization Review Committee consists of physicians and registered nurses.
Vendor payment—Payment made by DADS on a daily-rate basis for services delivered to recipients in Medicaid-certified nursing facilities. Vendor payment is based on the nursing facility's approved-to-pay claim processed by the state Medicaid claims administrator. The Nursing Facility Billing Statement, subject to adjustments and corrections, is prepared from information submitted by the nursing facility, which is currently on file in the computer system as of the billing date. Vendor payment is made at periodic intervals, but not less than once per month for services rendered during the previous billing cycle.

Working day—Any 24-hour period, Monday through Friday, excluding state and federal holidays.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on ____________.

TITLE 40 SOCIAL SERVICES AND ASSISTANCE
PART 1 DEPARTMENT OF AGING AND DISABILITY SERVICES
CHAPTER 19 NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION
SUBCHAPTER M PHYSICIAN SERVICES
RULE §19.1210

Proposed action:
X Amendment

STATUTORY AUTHORITY

The amendment is proposed under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Health and Safety Code, §242.226, which authorizes the adoption of rules necessary to improve the efficiency of the reimbursement process for the state Medicaid system and maximize the automated reimbursement system's capabilities.
on the date that an individual's financial resources are exhausted, the potential recipient must have a valid medical necessity (MN) determination.

— (1) If a recipient is found to be otherwise eligible for vendor payments for all or part of the three months prior to the date of his application for Medicaid assistance, Texas Department of Human Services (DHS) Medicaid eligibility staff will notify facility staff. Facility staff should submit a request for MN determination form (CARE) for the retroactive period.

— (2) If an applicant meets all other eligibility criteria for three months prior coverage, DHS makes retroactive vendor payments according to the assigned Texas Index for Level of Effort (TILE) level for the period indicated on the CARE form submitted for retroactive coverage.

— (3) DHS makes retroactive vendor payments for only that period of time during which physician certification, plan of care, and medical necessity requirements are met. After establishment of any retroactive medical necessity, verification may be done to show that the applicant's record includes the physician's certification, recertification, and plans of care, and that the plans were reviewed as required during the applicable period(s). The effective date of the new MN determination for the retroactive period of eligibility is the first day of the earliest month in which the applicant qualified for a medical necessity determination. If the recipient has paid for the retroactive time period, the facility must reimburse him the vendor portion that DHS paid.

§19.2409. General Qualifications for At-Risk Assessments and Medical Necessity Determinations.

(a) To be eligible for the Medicaid (Title XIX) Long-term Care program, an individual must meet two or more of the following criteria for nursing facility risk, as specified in the Resident Assessment Instrument Home Care Assessment for Nursing Home Risk, as revised in April 1996 and summarized as follows:

(1) needs assistance with one or more of the activities of dressing, personal hygiene, eating, toilet use, or bathing;
(2) has a functional decline in the past 90 days;
(3) has a history of a fall two or more times in past 180 days;
(4) has a neurological diagnosis of Alzheimer's, head trauma, multiple sclerosis, Parkinsonism, or dementia;
(5) has a history of nursing facility placement within the last five years;
(6) has multiple episodes of urine incontinence daily; or
(7) goes out of one's residence one or fewer days a week.

(b) Medical necessity (MN) is the prerequisite for participation in the Medicaid (Title XIX) Long-term Care program. This section contains the general qualifications for an MN determination. To verify that medical necessity exists, an individual must meet the conditions described in paragraphs (1) and (2) of this subsection.

(1) The individual must demonstrate a medical disorder or disease or both, with a related impairment that:
(A) limits his ability to recognize problems, changes in his condition, and the need for or side effects of prescribed medications;
(B) is of sufficient seriousness that his needs exceed the routine care which may be given by an untrained person; and
(C) requires nurses' supervision, assessment, planning, and intervention that are available only in an institution.

(2) The individual must require medical/nursing services that:

(A) are ordered by and remain under the supervision of a physician;

(B) are dependent upon the individual's documented medical, physical, and/or functional disorders, conditions, or impairments;

(C) require the skills of registered or licensed vocational nurses;

(D) are provided either directly by or under the supervision of licensed nurses in an institutional setting; and

(E) are required on a regular basis.

§19.2410. Criteria Specific to a Medical Necessity Determination.

(a) Specific criteria are also used to determine if the individual has medical necessity requiring nursing facility care. The Texas Department of Human Services (DHS) recognizes, however, that these criteria are not all-inclusive. The applicant's or the recipient's condition may be so complex that only the professional medical judgment of Utilization Review Committee physicians will be the deciding factor.

(b) For an applicant or a recipient to qualify for nursing facility care, the recipient's medical problems and health care needs are, at a minimum, such that he requires institutional care under the supervision of a physician. An applicant or a recipient must need services for which a registered nurse's or licensed vocational nurse's supervision is required on a daily and/or routine basis. Services which could qualify an individual for a medical necessity determination include but are not limited to:

(1) routine monitoring of an individual in stable condition to determine responses to the treatment plan and to detect problems requiring the physician's attention and/or a change in the plan of care;

(2) administration of intramuscular (IM) medications and observation of the individual's response and side effects;

(3) administration and adjustment of medication for pain and monitoring of result and side effects;

(4) administration of insulin to a diabetic individual whose condition is stable but who is unable to self-administer insulin because of physical, medical, or mental reasons;

(5) routine oxygen administration after a regimen of therapy has been established and/or therapy can be done by the individual with nursing supervision;

(6) routine oral suctioning;

(7) tracheostomy care when an individual's condition is stable, but he is unable to care for his tracheostomy;

(8) routine IPPB therapy after a regimen of therapy has been established and/or therapy can be done by the individual with nursing supervision;

(9) routine maintenance of an indwelling catheter system;

(10) routine care of stoma and surrounding skin in the presence of a colostomy or ileostomy and routine care of a suprapubic catheter;

(11) decubitus care involving superficial, noninfected lesions and preventive measures when an individual has a physical illness which makes him susceptible to decubiti formation;
—— (12) bowel and bladder control training and maintenance after a successful program has been established;
—— (13) care of an individual with an amputation or a fracture requiring routine care of a stylized condition and reinforcement of an established rehabilitation plan; and
—— (14) rehabilitative/restorative care, passive range-of-motion (ROM) exercises and positioning, care and assistance in application of braces/prosthetic devices or reinforcement of maintenance rehabilitative procedures.[end deletion]

§19.2413. Reconsideration of Medical Necessity (MN) Determination and Effective Dates.
When a facility provides care for a recipient for a period of time not covered by an effective medical necessity determination at admission or completion of Texas Nursing Facility Client Assessment, Review, and Evaluation (CARE) forms between reviews, the Texas Department of Human Services (DHS) will reconsider the effective dates.
— (1) Recipients eligible for reconsideration of effective dates must have the following, prior to the submission of a request for reconsideration:
—— (A) financial eligibility established;
—— (B) admission to the Medicaid Nursing Facility Vendor Payment System on DHS's Resident Transaction Notice form; and
—— (C) a medical necessity determination using a CARE form with a Purpose Code 2.
— (2) Requests for reconsideration require the completion of a CARE form based on the recipient's status in the facility during the four weeks immediately preceding the first date for which payment is to be recovered, with the exception of the instances noted in §19.1812 (1) of this title (relating to Case Mix Classification System).
— (3) Requests for reconsideration for periods of time already denied a medical necessity determination by the Utilization Review Committee (URC) will not be accepted.
— (4) The URC will only accept a request up to 12 months following the last day that service was provided.
— (5) The URC will notify the facility of the results of the reconsideration within 45 days. The facility may initiate an appeal, when reconsideration is denied, by submitting a request in writing as outlined in Chapter 79 of this title (relating to Legal Services). The facility must initiate the appeal within ten workdays of receipt of notification that a reconsideration was denied.
— (6) The facility may neither charge nor take any other recourse against Medicaid recipients, their family members, or their representatives for any claim denied or reduced because of the facility's failure to comply with any DHS rule, regulation, or procedure pertaining to reimbursement.[end deletion]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on ____________.