

**Level-Of-Need Determinations:
The right to challenge denials,
reductions, and terminations of
LON services**

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COMMISSIONER
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To: Home and Community-Based Services (HCS) Provider
Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) Provider

Subject: Information Letter No. 08-86
Written Notification to an Individual or Legally Authorized Representative (LAR) of the Denial of a Level of Need (LON) Assignment

The purpose of this letter is to advise you that effective July 15, 2008, the Texas Department of Aging and Disability Services (DADS) will send written notification to an individual receiving HCS or ICF/MR services or their legally authorized representative (LAR) when DADS denies a LON assignment for the individual. This notification will be sent to the individual or LAR at the same time the program provider is notified of the denial. As part of this notification process to the individual or LAR, the individual or LAR will be advised that he or she may contact the program provider to discuss the program provider's option of requesting a reconsideration or administrative hearing regarding the denial of the LON. Furthermore, the individual or LAR will be advised that he or she may give the program provider any documentation or other information regarding the denial of the LON. Please discuss your intent to request a reconsideration or administrative hearing with the individual or LAR who inquires about a denial of a LON. In addition, please consider any documentation or other information given to you by the individual or LAR in making such a decision.

Home and Community Based Services Program Individual Plan of Care (IPC) Cost Ceiling

If an individual's Level of Need (LON) is:	Then the 200% IPC cost ceiling is:
PERVASIVE PLUS	\$302,979.20
PERVASIVE	\$168,177.40
EXTENSIVE	\$157,934.28
LIMITED	\$157,934.28
INTERMITTENT	\$157,934.28

Right to a Fair Hearing Under State and Federal Law

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 357 HEARINGS
SUBCHAPTER A UNIFORM FAIR HEARING RULES FOR THE MEDICAID,
TANF AND FOOD STAMP PROGRAMS
RULE §357.1 AUTHORITY AND RIGHT TO APPEAL

(a) HHS System Authority.

(1) The statutes creating the Health and Human Services (HHS) System Agency grants HHS authority to issue rules and regulations for administering the programs for which it has legal responsibility. These standards for fair hearings apply to the TANF and food stamp programs and all Medicaid-funded services.

(2) HHSC Appeals Division is responsible for:

- (A) publishing fair hearing rules;
- (B) receiving fair hearings appeal requests;
- (C) conducting impartial fair hearings; and
- (D) issuing legally binding decisions.

(b) Right to Appeal

(1) HHSC provides an opportunity for a fair hearing to clients of Medicaid-funded services, TANF, and food stamp programs. A client of one of these programs has the right to appeal:

- (A) an agency action to reduce, suspend, terminate, delay, or deny benefits;
- (B) a decision to transfer or discharge a client from a skilled nursing facility or nursing facility;
- (D) an adverse determination made by an HHS System Agency or its designee with regard to the preadmission screening and annual resident review (PASARR) and
- (E) the denial of a prior authorization request.

- Written notice and the right to request a fair hearing is required by federal law (42 U.S.C. sec.1396(a)(3) and federal regulations (42 C.F.R. secs. 431.220) when the state agency does the following:
 - Denies eligibility;
 - Does not act upon a service request with reasonable promptness; or
 - When the individual believes the agency has taken an action erroneously

Notice Must be Adequate

- Notice to recipients reducing or denying a particular LON or terminating individuals from a Medicaid waiver program (e.g. HCS) must include the following:
 - reasons or grounds for the action
 - citation to specific statutory section supporting the reduction, termination or denial
 - notice of recipient or applicant's right to appeal

Right or No Right to a Fair Hearing

Right to a Fair Hearing-

- Home and Community-based Services Program (HCS): 200 percent of the reimbursement rate that would have been paid for the individual to receive services in an ICF/MR or 200 percent of the estimated annualized per capita cost for ICF/MR services, which is ever greater Cite.

No Right to a Fair Hearing-

- Use of General Revenue Funds (GR) for Services.
- DADS can use GR funds to pay for services over the 200 percent cost cap when it determines:
 - (a) the person's health and safety cannot be protected within the cost cap and
 - (b) there is no other available living arrangement in which the person's health & safety can be protected as evidenced by
 - (i) an assessment by clinical staff from DADS; and
 - (ii) supporting documentation, including the person's medical records.

Changes To the Law Affecting Person with Chronic Disabilities

- * eligible recipients are entitled to receive up to 200 percent of the estimated annualized per capita costs;
- * annualized per capita costs for HCS and CLASS waiver programs are based on ICF-MR rates and CBA/STAR PLUS it is based on a medical level of need (also known as the TILE rate).

Changes To the Law Affecting Person with Chronic Disabilities

- Rider 45 Also Authorizes Care Costs That Exceed 200 Percent
 - * Rider 45 authorizes care costs in excess of 200 percent of either the ICF-MR rate or the nursing facility rate;
 - * In other words, individuals living at home may continue to get their medical needs met at home when health and safety requires additional services;

Changes To the Law Affecting Person with Chronic Disabilities

- Rider 45 Also Authorizes Care Costs That Exceed 200 Percent – continued
 - * Department of Aging and Disability Services (DADS) clinical staff consisting of a doctor and/or nurse does its own evaluation;
 - * DADS clinical staff evaluation must find that your home is the only appropriate setting;

Changes To the Law Affecting Person with Chronic Disabilities

- Rider 45 Authorizes Care Costs That Exceed 200 percent – continued
 - * DADS clinical staff not only does a personal evaluation but reviews medical and service records;
 - * For individuals whose care needs exceed 200 percent DADS utilizes only state dollars (i.e. there are no federal dollars);