



**Implementation of Acute
Care Services and Long-
Term Services and
Supports System Redesign
for Individuals with an
Intellectual or
Developmental Disability**

**As Required by
Texas Government Code, Section
534.054**

**Texas Health and Human Services
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Executive Summary

The annual report on the Implementation of Acute Care Services and Long-Term Services and Supports (LTSS) System Redesign for Individuals with an Intellectual or Developmental Disability (IDD) is submitted in compliance with Texas Government Code Section 534.054.

Chapter 534 directs the Health and Human Services Commission (HHSC) to design and implement an acute care and LTSS system for individuals with IDD to improve outcomes; improve access to quality, person-centered, efficient, and cost-effective services; and implement a capitated, managed care delivery system and the federal Community First Choice Option (CFC). Chapter 534 also created the IDD System Redesign Advisory Committee (IDD SRAC) to advise HHSC in the development and implementation of the system redesign.

Over the past eight years, HHSC has made substantial progress on the IDD system redesign. Milestones achieved to date are outlined below and more information is provided in Appendix B: Historical IDD System Redesign Implementation Activities.

- Between 2014-2016, HHSC completed the transition of all eligible recipients¹ of Medicaid IDD waiver programs and community-based intermediate care facilities for individuals with intellectual disabilities (ICF/IID) from Medicaid fee-for-service (FFS) to capitated managed care programs (STAR+PLUS and STAR Kids) for all acute care services.
- Since 2014 and ongoing, HHSC has increased and enhanced community support services to promote independence and prevent institutionalization of individuals with IDD through the Money Follows the Person Demonstration.
- In 2015, HHSC implemented the CFC option, a Medicaid State Plan benefit, to increase access to services for individuals with IDD, particularly those currently on interest lists for IDD waiver programs.
- In early 2019, HHSC completed and published evaluations to inform managed care transitions and provide information to legislators and stakeholders.
- In 2019, HHSC deployed a new no-wrong-door complaints process to funnel most member complaints to the Office of the Ombudsman; implemented complaint standardization across HHSC and Managed Care Organizations

¹ Individuals who are dually eligible for both Medicare and Medicaid were excluded from the acute care transition.

(MCOs); and revised MCO reporting requirements from quarterly to monthly to aid in early issue detection.

In 2019, the legislature outlined a new key priority of the IDD system redesign. House Bill (H.B.) 4533, 86th Legislature, Regular Session, 2019, amends Government Code Chapter 534 and requires HHSC to establish a pilot program in STAR+PLUS prior to the transition of LTSS to managed care for individuals with IDD. H.B. 4533 also establishes the STAR+PLUS Pilot Program Workgroup (SPPPW) to advise HHSC in collaboration with the IDD SRAC in developing, operating and evaluating the pilot program. STAR+PLUS Pilot Program milestones to date include:

- Development of a workplan and workgroups comprised of cross-agency state staff to inform pilot program development.
- Collaboration with IDD SRAC and SPPPW to develop key elements of the pilot program design including, but not limited to, eligibility criteria, services, a needs-based assessment tool, and providers.
- Completion of a dental study required by H.B. 4533 to inform dental benefits for pilot program participants.
- Collaboration with Centers for Medicare and Medicaid Services (CMS) regarding federal authority and operation of the pilot program.
- Authority through 2020-2021 General Appropriations Act, 87th Legislature, Regular Session, 2021 (Article II, HHSC, Rider 25) to fund pilot program technology changes, evaluation, and HHSC staffing required for the pilot program implementation on September 1, 2023.

In the coming year, HHSC will continue pilot program development in collaboration with the IDD SRAC and SPPPW; and will continue to monitor the acute care transition to managed care and utilization of CFC services in collaboration with the IDD SRAC.

Introduction

Texas Government Code, Section 534.054 requires HHSC, in coordination with the IDD SRAC, to report annually to the Legislature on the implementation of the IDD system redesign. The report must include:

- An assessment of the system redesign implementation, including information regarding the provision of acute care services and LTSS to individuals with IDD under Medicaid and the effects of the redesign on its goals as set forth in Section 534.051, Government Code; and
- Recommendations regarding implementation of, and improvements to, the system redesign, including recommendations regarding appropriate statutory changes to facilitate implementation.

Further, Section 534.112, added by H.B. 4533, requires HHSC, in collaboration with the IDD SRAC and SPPPW, to report by September 1, 2026, an analysis and evaluation of the STAR+PLUS Pilot Program (pilot) and recommendations for improvement. The pilot will implement by September 1, 2023 and operate for at least two years. The pilot evaluation report will be included as part of the annual report required by Section 534.054 and must include:

- An assessment of the effect of the pilot on elements of the system such as access and quality, person-centeredness, integration, employment, appeals, self-direction, and attendant workforce;
- Benefits of providing STAR+PLUS Medicaid managed care services to persons based on functional needs as required in the pilot including feedback based on the personal experiences of pilot participants (e.g., individuals and families served and providers);
- Recommendations about a system of programs and services for consideration by the Legislature, including recommendations for needed statutory changes and whether to transition the pilot to a statewide program under STAR+PLUS;
- An analysis of the experience and outcomes of the following systems changes:
 - ▶ Comprehensive assessment instrument under Section 533A.0335, Texas Government Code,
 - ▶ 21st Century Cures Act,²

² <https://www.congress.gov/114/plaws/publ255/PLAW-114publ255.pdf>

- ▶ Implementation of Home and Community-Based Services (HCBS) settings rules,³
- ▶ Provision of basic attendant and habilitation services required under Section 534.152, Texas Government Code (CFC).

³ <https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider>

Background

Texas Government Code, Section 534.051 directs HHSC to design and implement an acute care and LTSS system for individuals with IDD to support the following goals:

- Provide Medicaid services to more individuals in a cost-efficient manner by providing the type and amount of services most appropriate to the individuals' needs;
- Improve individuals' access to services and supports by ensuring that the individuals receive information about all available programs and services, including employment and least restrictive housing assistance, and how to apply for the programs and services;
- Improve the assessment of individuals' needs and available supports, including the assessment of individuals' functional needs;
- Promote person-centered planning (PCP), self-direction, self-determination, community inclusion, and customized, integrated, competitive employment;
- Promote individualized budgeting based on an assessment of individuals' needs and PCP;
- Promote integrated service coordination of acute care services and LTSS;
- Improve acute care and LTSS outcomes, including reducing unnecessary institutionalization and potentially preventable events;
- Promote high-quality care;
- Provide fair hearing and appeals processes in accordance with applicable federal law;
- Ensure the availability of a local safety net provider and local safety net services;
- Promote independent service coordination and independent ombudsmen services; and
- Ensure that individuals with the most significant needs are appropriately served in the community and that processes are in place to prevent inappropriate institutionalization of individuals.⁴

⁴ <https://statutes.capitol.texas.gov/Docs/GV/htm/GV.534.htm#534.051>

H.B. 4533, 86th Legislature, Regular Session, 2019, amends Government Code Chapter 534 and outlines two stages for the transition of LTSS. Stage one⁵ directs the following activities related to the pilot:

- Development and implementation of a pilot by September 1, 2023 through the STAR+PLUS Medicaid managed care program for individuals with an IDD, traumatic brain injury (TBI) or similar functional need to test person-centered managed care strategies and improvements based on capitation;
- Establishment of a SPPPW to assist with developing and advising HHSC on the operation of the pilot;
- Coordination and collaboration throughout development and implementation of the pilot with the IDD SRAC and the SPPPW; and
- A dental evaluation to determine the most cost-effective dental services for pilot participants.

Stage two⁶ includes development and implementation of a plan to transition all or a portion of services provided through community-based ICF/IID or a Medicaid waiver program to a Medicaid managed care model.

The results of stage one will be used to inform stage two. The program transitions in stage two are staggered beginning with Texas Home Living (TxHmL) by September 1, 2027, Community Living Assistance and Support Services (CLASS) by September 1, 2029, and non-residential Home and Community-based Services (HCS) and Deaf-Blind with Multiple Disabilities (DBMD) services by September 1, 2031.

HHSC must conduct a second pilot to test the feasibility and cost efficiency of transitioning HCS and DBMD residential services and community-based ICF/IID services to managed care.

⁵ Texas Government Code, Chapter 534, SUBCHAPTER C:
<https://statutes.capitol.texas.gov/Docs/GV/htm/GV.534.htm>

⁶ Texas Government Code, Chapter 534, SUBCHAPTER E:
<https://statutes.capitol.texas.gov/Docs/GV/htm/GV.534.htm>

Implementation Activities

For an overview of past implementation activities, see Appendix B: Historical IDD System Redesign Implementation Activities.

STAR+PLUS Pilot Program

H.B. 4533 establishes the SPPPW to advise HHSC in collaboration with the IDD SRAC in developing, operating and evaluating the pilot program. Over the past year HHSC worked with internal workgroups comprised of multiple departments across HHSC, cross-agency staff, and the IDD SRAC and SPPPW to design key elements of the pilot program. HHSC's implementation and planning efforts to date for the pilot include:

- Development of needs-based eligibility criteria and pilot target groups.
- Development of the potential pilot service array and service descriptions. HHSC is exploring the cost of potential pilot services and developing rates.
- Pursuing use of the International Resident Assessment Instrument Intellectual Disability (InterRAI ID) as the pilot functional needs-based assessment.
- Pursuing use of the My Life Plan as the person-centered framework for the pilot.
- Determining roles and responsibilities for the MCO, provider and LIDDAs in the pilot.
- Deciding to work with Texas's External Quality Review Organization to conduct the pre- and post-pilot evaluations.
- Pursuing an 1115 waiver amendment using the parameters similar to the 1915(i)-authority based on communications with CMS and statutory direction for the pilot.
 - ▶ Selecting the Bexar service area as the primary service area in which to operate the STAR+PLUS Pilot Program. HHSC has also identified two backup service areas if unforeseen circumstances prevent operation in the Bexar service area that are prioritized in the following order: MRSA Northeast and Tarrant.

IT Modernization

An exceptional item for IT modernization was funded during the 86th Legislative session to support the future transition of the IDD waiver programs into managed care. The first phase of this transition is currently underway with a focus on migrating the HCS and TxHmL program forms and claims processing function from the legacy mainframe system to modern web-based systems. An implementation date and details about changes for HCS and TxHmL programs will be announced in future articles on the Texas Medicaid & Healthcare Partnership (TMHP) website.

A modernized reporting framework has been designed and developed in the TMHP Long Term Care Online Portal that will incorporate the use of a dashboard concept, alerts and standard reports for providers, state staff and local intellectual and developmental disability authorities (LIDDAs). The new web-based, service-oriented systems are utilizing the same technology platforms as other Medicaid management information system (MMIS) systems. Utilizing the existing MMIS will position the IDD waiver programs for eventual transition of individuals to managed care.

Effects on the System

Complaints, Appeals, and Fair Hearings

Complaints, appeals, and state fair hearings data provide information about access to and quality of acute care services following the transition of acute care services to managed care. Complaints are currently filed by contacting a member's MCO, or the HHSC Office of the Ombudsman.

Complaints Data Trending and Analysis Initiative

HHSC has identified opportunities to improve the member and provider managed care complaints process and data collection for all members including members who have IDD. A cross divisional workgroup was formed in July 2018 to address this effort. Activities are in line with the 85th Legislative Session, Rider 61 report recommendations regarding strengthening oversight of the Texas Medicaid program. Changes are also aligned with the 86th Legislative Session, H.B. 4533 requirements on grievances.

The project streamlined the member and provider complaint process; standardized definitions and categorizations of complaints within HHSC and MCOs; improved data analysis to efficiently recognize patterns and promote early issue resolution; and provided greater transparency about complaints.

HHSC reviewed and improved the member complaints process with a no-wrong-door approach to ensure timely assistance. Complaints received by HHSC are now funneled to the Office of the Ombudsman so that every complaint is recorded accurately and reconciled consistently.

Accomplishments related to the complaints data trending and analysis initiative include:

- Documented the HHS member managed care complaints process, identifying entry points and opportunities to streamline.
- Deployed a new no-wrong-door complaints process. This involves funneling the majority of member complaints to the Office of the Ombudsman.
- Published the Office of the Ombudsman quarterly complaints report to the HHS website.

- Implemented complaint category standardization across HHSC and MCOs.
- Revised MCO reporting requirements from quarterly to monthly to aid in early issue detection.
- Executed contract changes related to complaints definitions.
 - ▶ This includes clarifications that complaints resolved within 24 hours of contact are still considered complaints.
- Deployed client-facing changes to the new member complaints process including a client communication plan. The plan includes:
 - ▶ How to submit a complaint to the Office of the Ombudsman.
 - ▶ Where to seek follow up information on a complaint.
 - ▶ The resolution process and associated timelines.
- Deployed provider-facing changes to the provider managed care complaints process.
- An upcoming project milestone is to post complaints data to the HHSC website.

Requirements for MCOs

STAR+PLUS, STAR Kids, and STAR Health MCOs must maintain a system for receiving, tracking, responding to, reviewing, reporting, and resolving complaints regarding services, processes, procedures, and staff. Individuals enrolled in STAR+PLUS, STAR Kids, and STAR Health, or their legally authorized representative (LAR), may file a complaint with their MCO if they are dissatisfied with a matter other than an adverse benefit determination taken by the MCO.⁷ Individuals in STAR+PLUS, STAR Kids, and STAR Health, or their LAR, may file an appeal with their MCO if they are dissatisfied with an adverse benefit determination taken by the MCO.

⁷ An adverse benefit determination means: the denial or limited authorization of a member or provider requested services, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized service; the denial in whole or in part of payment for service; the failure to provide services in a timely manner as determined by the State; the failure of an MCO to act within the timeframes set forth in the contract and 42 C.F.R. §438.408(b); for a resident of a rural area with only one MCO, the denial of a Medicaid members' request to obtain services outside of the Network; or the denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Complaint means an expression of dissatisfaction expressed by a complainant, orally or in writing to the MCO, about any matter related to the MCO other than an adverse benefit determination. Complaint has the same meaning as grievance, as provided by 42 C.F.R. § 438.400(b). Possible subjects for complaints include the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member’s rights regardless of whether remedial action is requested. Complaint includes the member’s right to dispute an extension of time (if allowed by law) proposed by the MCO to make an authorization decision.

Table 1 below shows the average monthly number of individuals in an IDD waiver or ICF/IID compared to the number of complaints received in state fiscal year 2020 by managed care program.

Table 1. Average Monthly Number of Individuals in an IDD Waiver or ICF/IID Receiving Services in STAR+PLUS, STAR Kids, and STAR Health and Complaints Received by MCOs from these Members in Fiscal Year 2020 regarding Acute Care.

Managed Care Program	Average Monthly Number of Individuals Receiving Services who were in an IDD Waiver or ICF/IID	Number of Complaints Received by Members in an IDD Waiver or ICF/IID in Fiscal Year 2020
STAR+PLUS	16,778	98
STAR Kids	4,392	41
STAR Health	139	2
Total	21,309	141

The top three reasons for complaints from members in an IDD waiver or ICF/IID in fiscal year 2020 were quality of care or services, billing issues, and accessibility/availability of services. All reasons for complaints in fiscal year 2020 from members in an IDD waiver are listed below.

- Quality of care or services
- Billing issues
- Accessibility/availability of services
- Eligibility
- Durable medical equipment (DME)
- Quality of service provider
- Plan administration
- Prescription/pharmacy
- Prior authorization

- Transportation

A complainant’s oral or written dissatisfaction with an adverse benefit determination is considered a request for an MCO internal appeal. Table 2 identifies the number of MCO internal appeals upheld, overturned, or withdrawn for people enrolled in an IDD waiver or community-based ICF/IID program by MCO program.

Table 2. Number of MCO Internal Appeals Upheld, Overturned, or Withdrawn for Recipients in an IDD Waiver or ICF/IID Enrolled in STAR+PLUS, STAR Kids, and STAR Health in Fiscal Year 2020

Program	Total Number of Appeals Filed	Number of Appeals Upheld by MCO ⁸	Number of Appeals Overturned by MCO ⁹	Number of Appeals Withdrawn by Member
STAR+PLUS	232	117	105	10
STAR Kids	264	178	181	6
STAR Health	10	6	4	0
Total	506	301	290	16

Only after exhausting the MCO internal appeals process may STAR+PLUS, STAR Kids, and STAR Health members, or their LAR, request a State Fair Hearing by HHSC.

The top three reasons for State Fair Hearings in fiscal year 2020 for members enrolled in an IDD waiver or ICF/IID related to reduction or denial of DME, Private Duty Nursing, and therapy. All reasons for State Fair Hearings in 2020 for members enrolled in an IDD waiver related to reduction or denial of services and supports are listed below.

- DME
- Therapy – Treatment
- Private Duty Nursing
- Transportation
- Genetic Testing
- Prior Authorization
- Pharmacy

⁸ Indicates that the MCO investigated, reviewed, and ruled in favor of the adverse benefit determination taken by the MCO.

⁹ Indicates that the MCO investigated, reviewed, and overturned the adverse benefit determination taken by the MCO.

Office of the Ombudsman

The Office of the Ombudsman received 36 complaints, four substantiated¹⁰ and 32 unsubstantiated¹¹ or unable to substantiate in fiscal year 2020 for STAR+PLUS, STAR Kids, and STAR Health members enrolled in an IDD waiver and community-based ICF/IID program. Access to care and quality of care were the primary general complaint categories. All general complaint categories and sub-categories (contact reasons) received are listed below.

- Access to Care
- Claims/Payment
- Customer Service
- Member Enrollment
- Member Health and Safety
- Policies/Procedures
- Prescription Services
- Quality of Care
- Therapy

¹⁰ Substantiated complaint--A complaint for which research clearly indicates HHS policy was violated or HHS expectations were not met.

¹¹ Unsubstantiated complaint--A complaint for which research clearly indicates HHS policy was not violated or HHS expectations were met.

Initiatives to Improve Access and Outcomes

Person-Centered Planning

Federal rules for Medicaid HCBS, including CFC, require person-centered service planning, also referred to as person-centered planning (PCP). Using a PCP process, a service plan and objectives are developed based on a person's preferences, strengths, and clinical and support needs. Person-centeredness balances what is important for the person's health and safety with what is important to the person for their well-being and quality of life. Person-centered service planning considers non-clinical concepts such as self-determination, dignity, community inclusion, and the belief that every person is the expert in their own life, has the potential for a personally defined high quality life, and can meaningfully contribute to society.

To comply with federal and state regulations, HHSC requires people who facilitate person-centered service plans for CFC and HCBS to complete training within six months of hire. The state and its partners, including LIDDAs, The University of Texas Center for Disability Studies, and The Learning Community for Person-Centered Practices, have been working to build the infrastructure to successfully comply by training more certified Person-Centered Thinking (PCT) trainers.

- HHSC has been working to certify PCT trainers and develop mentor trainers to increase capacity throughout the system. To date, nearly 20 PCT trainers and several mentor trainers have been certified, both state employees and community partners.
- The MFPD grant funded an initiative to certify six People Planning Together (PPT) co-facilitators who receive services for IDD. PPT co-facilitators with lived experience partner with a PCT trainer to train people with IDD to create their own person-centered plans and better communicate and work with service providers.
- As of May 4, 2021, 9,591 people, including people from other states, had successfully completed the online PCP Training that launched in February 2017. The free training is accessible at: [HHS Learning Portal: Log in to the site \(texas.gov\)](https://www.hhs.texas.gov/learning-portal).
- In March 2019, HHSC was awarded one of 15 three-year technical assistance grants by the National Center on Advancement of Person-Centered Practices and Systems (NCAPPS) to align policy and practice across the state for all populations across the lifespan. As part of the project plan, HHSC established

a PCP Steering Committee and the draft of a strategic plan to ensure person-centered thinking, planning, and practice occurs throughout the HHSC system. By December 2022, HHSC will have created a PCP organization and system to include the My Life Plan framework and accompanying tools, guidance, rules, policies and procedures, including adaptations for use with all HHSC populations.

- In 2021, as part of the NCAPPS project, HHSC kicked off a series of trainings for mid- to high-level HHSC leadership, with a panel of national experts focused on teaching person-centered practices to assist in the organization becoming more person-centered. HHS also developed a video for the department of human resources to add to the agency's new employee training. The sixteen-minute video can be viewed at <https://youtu.be/CII81TjIEdM>.

IDD Assessment Tool Pilot

Texas Health and Safety Code, Section 533A.0335 directs HHSC to develop and implement a comprehensive assessment instrument and resource allocation process to ensure individuals with IDD receive the type, intensity, and range of appropriate and available services to meet their functional needs. The IDD assessment tool pilot project focused on individuals receiving services under IDD Medicaid waivers, community-based ICFs/IID, and State Supported Living Centers (SSLCs). Initial planning activities for the pilot included:

- Research into nationally recognized comprehensive assessment instruments for individuals with IDD;
- Completion of an external stakeholder survey;
- Interviews with other states about assessment instruments; and
- Solicitation of input from the IDD SRAC and its Assessment Subcommittee.

HHSC selected the InterRAI ID Assessment System to pilot with a sample population to determine appropriateness for use in Texas. The IDD assessment tool pilot project will test and evaluate the tool in three phases across Texas IDD waiver programs:

- Phase 1 began in spring 2017 and included automating and piloting InterRAI with a volunteer sample. Phase 1 was completed on August 31, 2017.
- Phase 2 included the evaluation and comparison of the InterRAI with the currently used assessment, the Inventory for Client and Agency Planning

(ICAP). Phase 2 was completed in December 2018, with the final report received in late February 2019.

- Phase 3 involves the development of a resource allocation algorithm, and statewide rollout of the InterRAI ID assessment instrument. Currently, HHSC is in the process of exploring funding opportunities to develop the resource allocation algorithm.

HCBS Services Settings Requirements

In March 2014, CMS issued a regulation governing settings in which HCBS are provided. The federal regulations support individuals' rights to:

- Privacy, dignity, and respect;
- Community integration;
- Competitive employment; and
- Individual choice concerning daily activities, physical environment, and social interaction.

States must comply with these rules by March 2023, which includes a one-year extension due to the COVID-19 pandemic.

The regulation sets forth a heightened scrutiny process, through which states must submit informational packets for certain settings to demonstrate to CMS that the settings meet federal HCBS criteria.

States are required to submit a Statewide Transition Plan (STP) to CMS for approval. The STP provides assurances of compliance or sets forth the actions that the state will take to bring HCBS programs into compliance. HHSC is revising the STP for submission based on feedback from CMS. HHSC anticipates submission of the revised STP by Fall 2021.

Transition of Day Habilitation Services

As part of HHSC's plan to achieve compliance with the HCBS settings regulation, HHSC will replace day habilitation services with a more integrated service. Day habilitation is currently offered in a congregate setting generally without supports for community integration or person-centered activities. It is available in HCS, TxHmL, and DBMD waiver programs. Approximately 19,000 people on average received day habilitation services each month in 2019.

HHSC initially received direction from the Texas Legislature in 2019 to develop a plan to replace current day habilitation services in waiver programs for individuals with IDD with more integrated services (2020-21 General Appropriations Act, H.B. 1, 86th Legislature, Regular Session, 2019 - Article II, HHSC, Rider 21). HHSC submitted a day habilitation transition plan to state leadership in December 2020, which included plans to replace current day habilitation services in IDD waiver programs with Individualized Skills and Socialization (ISS) – a new, more integrated service that maximizes participation and integration of individuals with IDD in the community.

In 2021, to help achieve this goal, the Texas Legislature awarded HHSC authority to transfer funds in Goal A of the budget for the implementation of ISS, contingent on providers submitting community engagement plans to HHSC (2022-23 General Appropriations Act, Senate Bill (S.B.) 1, 87th Legislature, Regular Session, 2021- Article II, HHSC, Rider 23). The legislature also appropriated approximately \$1.7 million to fund an ISS provider registry, to help ensure ongoing monitoring and oversight of ISS providers.

As outlined in the Transition of Day Habilitation Services plan, HHSC is currently undertaking efforts to replace day habilitation with ISS, which will include an on-site (center-based) component and an off-site (community-based) component. ISS will also include lower staff ratios to allow staff to provide more individual attention to program participants both on-site and off-site. Lower ratios also permit the development of more personalized habilitative activities and optimize a participants' initiative, autonomy, and independence in making life choices.

IDD Strategic Plan

Texas identified the need to develop a Statewide IDD Strategic Plan to unify state agency leaders and stakeholders to identify and prioritize goals and make improvements in the IDD system. The framework used to develop the IDD Strategic Plan is modeled after the successful coordination and unified approach of the Texas Statewide Behavioral Health Strategic Plan.

HHSC, in collaboration with state agency leaders and stakeholders, developed and published the Foundation of the Statewide IDD Strategic Plan in February 2019. The foundational plan includes the following:

- Overview of the IDD population, a history of services and supports, and prevalence data;
- Statewide IDD survey and stakeholder input results; and

- IDD Program Inventory.

During the second phase of the process, stakeholders further explored community needs and collaborated to develop a comprehensive, multi-sectoral strategic plan. The comprehensive plan will be published in 2021 and includes the following:

- Updated overview of the IDD population;
- New statewide survey and stakeholder input results; and
- Vision, mission, goals, objectives, and strategies to make short- and long-term improvements in IDD-related services, supports, systems, and policies.

The third phase will include implementation and monitoring of the plan.

Promoting Independence and Preventing Institutionalization

Money Follows the Person Demonstration

MFPD is a federal demonstration project designed to increase the use of HCBS services and to reduce the use of institutional-based services.¹² The Consolidated Appropriations Act, 2021, Section 204, extends funding for the MFPD program at \$450 million per fiscal year, for all MFPD states, beginning December 19, 2020 through federal fiscal year 2023.

In addition to extending MFPD, the Act makes the following program improvements to change the criteria for eligible individual qualifications:

- Decrease the institutional residency period from 90 days to 60 days; and
- Count as part of the institutional residency requirement any days that an individual resides in an institution and admitted solely for purpose of receiving short-term rehabilitative services.

These changes are expected to increase the number of eligible participants.

The most recent notice of award, dated April 1, 2021, extends Texas's MFPD funding and the program through September 30, 2025.

Many of the MFPD-funded projects in Texas designed to promote independence for individuals with IDD are outlined in Texas's *Promoting Independence Plan*,¹³ in response to the U.S. Supreme Court ruling in *Olmstead v. Zimring*. Some of the projects are highlighted below.

MFPD-funded projects include:

- Integrated and competitive employment initiatives, including regional trainings sharing Employment First (EF) principles, employment recruitment and employment coordinators, an EF website, web-based trainings, and videos and brochure promoting hiring people with disabilities.

¹²<https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/promoting-independence/money-follows-person-demonstration-project>

¹³ [2020 Revised Texas Promoting Independence Plan](#)

- Transition Support Teams help community providers and LIDDAs deliver adequate support to individuals with significant medical, behavioral, and psychiatric challenges transitioning from institutional settings or who are at risk of admission to an institution. Eight LIDDAs and community provider consultative support teams provide educational activities and materials, technical assistance, and consultative case reviews.
- The LIDDA Enhanced Community Coordination (ECC) service coordinators provide intense monitoring and flexible support to individuals to support success in the community. The ECC service coordinator ensures individuals are linked to critical services and receive person-centered services for up to one year following a transition or diversion. From September 1, 2019, through August 31, 2020, 2,452 people received enhanced community coordination.
- MFPD funds transition specialists and a continuity of services specialist at the SSLCs who provide training to SSLC staff, residents, LARs, and family members about the community relocation process and planning. They also serve as a resource for personal support teams to help identify services and supports for individuals in the community, to identify obstacles to community transition, and to develop strategies to mitigate barriers. The continuity of services specialist monitors the final community living discharge plan and post-move support to assure quality and make suggestions for improvement.
- Texas contracted in 2017 with University of Texas Health Science Center at San Antonio (to develop web-based training modules to educate health care practitioners on best practices in treating individuals with IDD and behavioral health needs. Initial topics included trauma-informed care, the importance of interdisciplinary teamwork, and communicating with people with IDD and co-occurring behavioral health needs. This project has also developed and delivered mental health first aid training targeting LTSS providers, online training regarding substance use disorders for LTSS providers, integrated approaches for healthcare professionals working with people with IDD, continuing education credits for a variety of disciplines, and trauma-informed care module for employees of intermediate care facilities (ICFs).
- The Affordable Housing Partnership is a new collaboration between HHSC and the Texas State Affordable Housing Corporation (TSAHC) to provide capital subsidies to developers to build or rehabilitate housing units as affordable, accessible and integrated housing units within Dallas and Travis Counties for qualified individuals receiving or eligible for Medicaid LTSS in the community. It is anticipated the project will result in 30 new units for individuals with disabilities. Priority for available units will be designated for individuals

transitioning into their communities from nursing facilities or ICFs/IID. HHSC and TSAHC will work in partnership to implement and administer the AHP to increase the availability of affordable, accessible and integrated housing for older adults and people with disabilities.

- The Section 811 Project Rental Assistance (PRA) Program is a project-based, federally-funded program that allows state housing finance agencies and state Medicaid agency partners create rental assistance opportunities for persons with extremely low incomes who have a disability and are eligible to receive services and supports. MFPD funding support this housing effort. Texas' Section 811 PRA operates in select areas of the state and serves the following target populations:
 - ▶ Persons with disabilities exiting institutions (e.g., nursing facilities and ICF/IID), who are eligible to receive LTSS through a Medicaid waiver;
 - ▶ persons with SMI who are eligible to receive services through HHSC; and
 - ▶ Youth or young adults with disabilities exiting Department of Family and Protective Services (DFPS) foster care.

Crisis Intervention and Crisis Respite Services

Initially, the 84th Legislature, Regular Session, 2015 allocated \$18.6 million, which increased by \$10 million over subsequent sessions. A total of \$28.6 million was allocated to provide crisis intervention and crisis respite support to individuals with IDD who have behavioral health or mental health support needs. All 39 LIDDAs statewide provide crisis intervention and crisis respite services to support individuals to maintain independent lives in the community, and to avoid unnecessary institutionalization. From September 1, 2019, to August 31, 2020:

- 4,180 individuals were provided therapeutic supports for successful community integration through crisis intervention services,
- 759 individuals were diverted from institutionalization or hospitalization by receiving crisis respite services:
 - ▶ 690 of which utilized IDD Crisis Respite; and
 - ▶ 69 utilized Mental Health Crisis Respite services.

IDD System Redesign Advisory Committee

The IDD SRAC collaborates with HHSC on the IDD acute care and LTSS system redesign by providing recommendations and identifying areas for improvement. The advisory committee consists of 26 members representing communities of interest as identified in Texas Government Code, Section 534.053. IDD SRAC subcommittees include:

- Transition to Managed Care
- Day Habilitation and Employment Services
- System Adequacy

The IDD SRAC meets quarterly and subcommittees meet bi-monthly. However, due to their focus on the development of recommendations for the pilot, the IDD SRAC met monthly for both full committee meetings and subcommittee meetings from May 2020 through November 2020. The IDD SRAC resumed quarterly meeting in January 2021.

Since passage of H.B. 4533, IDD SRAC members worked with HHSC to organize requirements for the pilot and prioritize subcommittee work based on the project timeline. The IDD SRAC also partnered with the SPPPW to coordinate recommendations and work collaboratively to inform the pilot program.

Many IDD SRAC recommendations require a multi-year focus due to required funding and the complexity of policy and system changes recommended (see Appendix A: IDD SRAC Recommendations). During fiscal year 2021, in addition to work on the pilot, the IDD SRAC worked to enhance and build upon recommendations for suggested improvements to the service system (whether provided under FFS or managed care) for legislative and HHSC consideration. The recommendations address a host of suggested service improvements to:

- Simplify access to dental services;
- Improve the IDD assessment process;
- Monitor quality of acute care services and LTSS;
- Access behavioral supports for people with complex needs;
- Increase utilization and coordination of CFC services;
- Improve access to employment services; and
- Prepare for/respond to future public health emergencies (PHE) and disasters.

Challenges and Areas for Further Consideration

HHSC and stakeholders have identified opportunities to improve the current system of services and supports for people with IDD. Many of these challenges and considerations are being prioritized by IDD SRAC subcommittees for the upcoming year. Some of them may require funding or staff resources to implement.

Transition of IDD LTSS to Managed Care

H.B. 4533 provided additional time to transition IDD LTSS to managed care and a structure for robust stakeholder engagement through the IDD SRAC and SPPPW. HHSC will work with stakeholders to ensure challenges are addressed through development and implementation of the STAR+PLUS Pilot Program and subsequent transitions of IDD LTSS to managed care. HHSC continues to work with stakeholders to assess and account for any potential considerations related to COVID-19 and its impact on the pilot and IDD LTSS transition.

Person-Centered Practices

A better understanding of the PCP mindset and process by providers, family members, policymakers, and other significant players in the IDD system can help achieve more person-centered outcomes for people receiving Medicaid waiver services. The current PPT initiative, among other systemic improvements that will be a part of the NCAPPS Technical Assistance activities, is expected to continue to address challenges and provide tools and education. Efforts in 2021 include training PPT to be plan facilitators to assist their peer partners.

Quality Metrics

Further work is needed to identify quality metrics to best measure outcomes of initiatives serving individuals with IDD. The IDD SRAC drafted recommendations on ways to review, analyze and monitor quality metrics for consideration.

The STAR+PLUS Pilot Program provides an opportunity to focus on quality metrics. STAR+PLUS Pilot Program requires identification and tracking of measurable goals using national core indicators, the National Quality Forum LTSS measures, and other appropriate Consumer Assessment of Healthcare Providers and Systems measures. HHSC and the SPPPW Quality Subcommittee collaborate on this effort.

Attendant Workforce

A successful community-based long-term support system is contingent upon a stable and trained workforce. According to the U.S. Bureau of Labor Statistics, personal care aides (PCAs) and home health aides forecasted to be the third and fourth fastest growing occupations in the country from 2016 to 2026 with ten-year projected growth rates of 47 percent and 39 percent, respectively. Meanwhile, as the Baby Boomer generation and informal caregivers age, the number of Americans requiring long-term care is projected to more than double by 2050, creating greater demand for paid attendant services in the coming decades. As of May 2019, Texas employed 300,820 PCAs, the second largest statewide number in the country.¹⁴ While demand for direct care workers both in Texas and nationwide continues to increase substantially, long-term service and support employers are already struggling to hire and retain direct care workers.

The 2020-21 General Appropriations Act, H.B. 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 157) directs HHSC to develop strategies to recruit, retain, and ensure adequate access to the services of community attendants. The work of Rider 157 resulted in the Community Attendant Workforce Strategic Plan¹⁵ for retention and recruitment of community attendants.

CFC

To ensure everyone entitled to receive CFC services is able to access them, HHSC is considering the following options to increase the accessibility and utilization of CFC services for those who qualify, including:

- Offering additional training to MCOs and providers on how to assess for, provide and bill for CFC;
- Developing a plan to target and assess individuals with IDD currently on an IDD waiver interest list;
- Introducing habilitation training for providers who have not previously provided services for individuals with IDD.

¹⁴ <https://phinational.org/policy-research/workforce-data-center/> last modified August 30, 2019.

¹⁵ <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/rider-157-ca-workforce-dev-strat-plan-nov-2020.pdf>

Social Determinants of Health

Social determinants of health (SDOH) are non-medical factors that can influence overall health and the ability to access healthcare and services. Homelessness, lack of transportation, unemployment, food insecurity, and other socioeconomic, environmental causes can pose challenges to obtaining needed medical services and LTSS. Individuals with IDD often face greater challenges when psychological and social needs are unmet. HHSC has agency-wide projects underway to identify the prevalence of SDOH factors among its Texas Medicaid and Children's Health Insurance Program (CHIP) program participants. The agency is developing policy recommendations to improve health outcomes for Texans, including solutions to SDOH barriers preventing adequate access to health care and LTSS.

HHSC is partnering with MCOs, local agencies, and state and national organizations to review existing evidence-based practices around value-based payment models, quality measures, program effectiveness and funding sources for developing SDOH programs in Texas Medicaid and CHIP. Considerations include the use of SDOH survey tools that providers and MCOs can use to screen for barriers to accessing health care; collaboration with community agencies to address these social needs; and an increased focus on aging populations and regions where additional resources to address SDOH factors are most needed.

COVID-19

In March 2020, after the emergence of coronavirus disease (COVID-19) was identified as a PHE, HHSC and all its partners as well as the Texans receiving services through the health care delivery system were profoundly challenged. In a few weeks, HHSC initiated and secured a number of system changes and flexibilities to allow for safer delivery of services, such as allowing virtual assessments and service coordination, telehealth delivery of some LTSS, and allowing family members to provide services in lieu of staff coming into the home from the outside. HHSC coordinated with public health and state emergency officials and MCOs to create a process to obtain personal protective equipment (PPE) for people using the consumer directed services (CDS) option, and, when vaccines became available, collaborated with providers, transportation providers, and MCOs to promote avenues for vaccine administration to people living in facilities, homebound, or lacking access to transportation. HHSC pivoted to a largely remote workforce, and provided for virtual, rather than in-person stakeholder engagement activities.

As the pandemic matures, new variants of the virus emerge, and people attempt to find a path to normalcy, HHSC and its partners continue to extend some

flexibilities, end others, and seek to make others permanent. H.B. 4, 87th Texas Legislature, requires HHSC to assess the clinical and cost-effectiveness of making many of the telehealth, telemedicine, and virtual options developed during the pandemic available permanently. HHSC is developing implementation plans for H.B. 4 and assessing other pandemic flexibilities to determine if they are appropriate for permanent implementation.

Conclusion

HHSC has made significant progress on the IDD system redesign. The past year has heavily focused on the development of the pilot in collaboration with the IDD SRAC and SPPW. Opportunities exist for systemic improvement, as outlined in the previous section and appendices of this report, and as expressed by members of the IDD SRAC and other stakeholders. HHSC is committed to continuing to work with stakeholders to improve programs and services for Texans with IDD.

Recent Milestones

- In 2019, HHSC deployed a new no-wrong-door complaints process to funnel the majority of member complaints to the Office of the Ombudsman; implemented complaint standardization across HHSC and MCOs; and revised MCO reporting requirements from quarterly to monthly to aid in early issue detection.
- From 2019 to 2021, HHSC developed a workplan; created workgroups comprised of cross-agency state staff to inform pilot program development; collaborated with the IDD SRAC and SPPPW to inform the pilot program design including eligibility criteria, services, and providers; and received transfer authority to fund critical infrastructure to prepare for the September 1, 2023 pilot implementation.

Next Steps

HHSC will complete the following steps to:

- Continue efforts to design, implement and evaluate the pilot program, including coordination with the IDD SRAC and SPPPW.
- Post data reports including revised member and provider managed care complaints data.
- Collaborate with the IDD SRAC to assess access to IDD services and supports, and review outcomes related to transitioning acute care services to managed care and implementing CFC.
- Monitor new methods for obtaining CFC non-waiver utilization data and consider options to improve the accessibility and utilization of CFC services.

List of Acronyms

Acronym	Full Name
CDS	Consumer-Directed Services
CFC	Community First Choice Option
C.F.R.	Code of Federal Regulations
CLASS	Community Living Assistance and Support Services
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus disease 2019
DADS	Department of Aging and Disability Services
DBMD	Deaf Blind with Multiple Disabilities
DFPS	Department of Family and Protective Services
DID	Determination of Intellectual Disability
DME	Durable Medical Equipment
DSA	Direct Service Agency
DSHS	Department of State Health Services
EA	Employment Assistance
ECC	Enhanced Community Coordination
EF	Employment First
EQRO	External Quality Review Organization
FFS	Fee-for-service
FMAP	Federal Medical Assistance Percentage
H.B. 4533	House Bill 4533
HCBS	Home and Community-Based Services
HCS	Home and Community-based Services
HHSC	Health and Human Services Commission
ICF	Intermediate Care Facility
ICF/IID	Intermediate Care Facility for an Individual with an Intellectual Disability
IDD	Intellectual and Developmental Disabilities
IDD SRAC	Intellectual and Developmental Disabilities System Redesign Advisory Committee
InterRAI ID	International Resident Assessment Instrument Intellectual Disability Assessment
ITP	Individual Transportation Participant
LAR	Legally Authorized Representative
LIDDA	Local Intellectual and Developmental Disability Authority
LON	Level of Need
LTSS	Long-Term Services and Supports
MCO	Managed Care Organization
MDCP	Medically Dependent Children Program
MMIS	Medicaid Management Information System
NCAPPS	National Center on Advancement of Person-Centered Practices and Systems
NEMT	Non-Emergency Medical Transportation
PCP	Person-Centered Planning

Acronym	Full Name
PCT	Person-Centered Thinking
PHE	Public Health Emergency
SDOH	Social Determinants of Health
SE	Supported Employment
PPE	Personal Protective Equipment
PPT	People Planning Together
SPPPW	STAR+PLUS Pilot Program Workgroup
SSI	Supplemental Security Income
SSLC	State Supported Living Center
STP	Statewide Transition Plan
TBI	Traumatic Brain Injury
TMHP	Texas Medicaid & Healthcare Partnership
TWC	Texas Workforce Commission
TxHmL	Texas Home Living

Appendix A: IDD System Redesign Advisory Committee Recommendations¹⁶

Transition to Managed Care Subcommittee

Identify Eligibility and Enrollment Criteria for the STAR+PLUS Pilot

Background

In 2019, the Texas Legislature directed HHSC to develop a STAR+PLUS Pilot program to test person-centered strategies and improvements for people with IDD through managed care. The legislation, now codified in Texas Government Code Chapter 534, Subchapter C, requires HHSC to coordinate and collaborate with the IDD SRAC and a new SPPPW when designing pilot criteria.

People with IDD and related conditions receive most HCBS LTSS through 1915(c) IDD waiver programs or ICF/IID. These services are carved out of managed care and administered through traditional FFS Medicaid. The STAR+PLUS Pilot will test the delivery of LTSS through a single, coordinated managed care system. A comprehensive evaluation of the pilot will help inform the state's plan to transition LTSS services from IDD waivers and ICF/IIDs to managed care.

Per legislative direction, eligibility and enrollment criteria for the STAR+PLUS Pilot must, at a minimum, include adults in STAR+PLUS with:

- IDD who are not enrolled in a 1915(c) IDD waiver or ICF/IID
- TBI that occurred after age 21
- Similar functional needs, without regard to age of onset or diagnosis

Over the past two years, HHSC worked extensively with the IDD SRAC, SPPPW, and stakeholders to develop STAR+PLUS Pilot Program criteria. These activities led to the development of the following IDD SRAC recommendations.

Recommendations

1. HHSC should determine STAR+PLUS Pilot eligibility by needs-based criteria. To qualify for the pilot, a person must meet all of the following requirements:

¹⁶ Recommendations were drafted and adopted by the IDD SRAC. HHSC made minor non-substantive edits to address formatting and grammar.

- A. Be a Medicaid-eligible adult 21 years of age or older who is enrolled in STAR+PLUS
 - B. Meet criteria for a target group (see recommendation #2 below)
 - C. Demonstrate a need for at least one pilot service
 - D. Have substantial functional limitations in three or more areas of the following major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.
2. Recommended target groups should include:

Table 1. STAR+PLUS Pilot Target Groups

Target Group	Criteria
Group A	People who have a diagnosis: <ul style="list-style-type: none"> ● Intellectual disability (ID) ● Autism ● TBI ● Acquired brain injury ● On the Texas HHSC Approved Diagnostic Codes for Persons with Related Conditions List
Group B	People with “similar functional needs” as Group A, without regard to age of onset or diagnosis. HHSC should determine which individuals have similar functional needs based on eligibility for or use of state plan LTSS, including: <ul style="list-style-type: none"> ● Personal assistance services (PAS) ● Day activity and health services ● CFC services
Group C	People enrolled in STAR+PLUS HCBS with a diagnosis listed in Group A who could benefit from pilot services not available through STAR+PLUS HCBS

- 3. Enrollment should be open for a limited time to ensure a statistically viable and consistent population.
- 4. HHSC will automatically enroll STAR+PLUS Pilot eligible persons in the pilot but give them the ability to opt out.
- 5. HHSC should develop informational materials to help pilot participants make an informed choice to stay in the pilot or opt out.
- 6. HHSC should allow pilot participants to transition to a 1915(c) IDD waiver if their slots become available during pilot operation.

Identify Benefits for the STAR+PLUS Pilot

Background

Texas Government Code § 534.1045 includes a list of required STAR+PLUS Pilot benefits. In general, STAR+PLUS MCOs must offer participants the same benefits as members enrolled in STAR+PLUS HCBS, plus additional LTSS services designed to meet the needs of the pilot population. HHSC has the flexibility to include other non-residential LTSS as appropriate and dental services if cost effective. Over the past two years, HHSC worked extensively with the IDD SRAC, SPPPW, and stakeholders to develop STAR+PLUS Pilot Program benefits. Below are the recommendations for benefits to be included in the IDD SRAC recommendations.

Recommendations

1. The IDD SRAC recommended the following benefits be included in the STAR+PLUS Pilot. The services include current STAR+PLUS HCBS benefits, current STAR+PLUS State plan LTSS services and new services allowed under statute (Chapter 534, Sec. 534.104(a)(6) Government Code) and approved by the IDD SRAC for considerations. These include the following:
 - Current State Plan LTSS Services - Reference Section: 1143.1.2 Long-term Services and Support Listing
 - ▶ Day Activity & Health Services
 - ▶ PAS
 - ▶ CFC (PAS; Emergency Response Services; Support Management; Habilitation)
 - Current STAR+PLUS HCBS Services - Reference Section: 1143.2 Services Available to STAR+PLUS Home and Community Based Services Program Members
 - ▶ Adaptive Aids & Medical Supplies
 - ▶ Adult Foster Care adding modification
 - ▶ Assisted Living
 - ▶ Audiology (Limited)
 - ▶ Auditory Integration Training/Auditory Enhancement Training
 - ▶ Cognitive Rehabilitation Therapy
 - ▶ Dental Treatment
 - ▶ Emergency Response (for Medicaid Assistance Only (MAO) members)

- ▶ Employment Assistance (EA) with modifications career planning
- ▶ Financial Management Services
- ▶ Home Delivered Meals
- ▶ Minor Home Modifications
- ▶ Nursing Services
- ▶ Occupational Therapy
- ▶ PAS (for MAO members)
- ▶ Protective Supervision
- ▶ Physical Therapy
- ▶ Respite
- ▶ Speech
- ▶ Support Consultation
- ▶ Supported Employment (SE) Services
- ▶ Transition Assistance Services
- New HCBS Services for STAR+PLUS Pilot referenced in statute
 - ▶ Behavioral Support Services
 - ▶ Behavioral Health Crisis Intervention Service
 - ▶ Enhanced Behavioral Supports
 - ◇ Enhanced In-Home Respite Services
 - ◇ Enhanced Out of Home Respite Services
 - ◇ Behavioral Support Specialty Services
 - ◇ Individual/Family /Caregiver Coaching to include training, education and Peer Supports
 - ◇ Peer Supports
 - ▶ IDD Enhanced Extended Substance Use Disorder Services (SUDS)
 - ▶ Community support transportation
 - ▶ Day Habilitation
 - ▶ Enhanced Medical Supports
 - ▶ Innovative Technology including remote monitoring
- New Recommendations allowed under statute and approved by the IDD SRAC - HCBS Services
 - ▶ Community Integrations Supports

- ▶ See Enhanced BH and SUDS above
 - ▶ Specialized Therapies – Massage; Recreational; Music; Art; Aquatic; Hippotherapy; Therapeutic Horseback Riding.
 - ▶ Dietary Services
 - ▶ Intervener/interpreter
2. HHSC should explore various options to cover STAR+PLUS pilot services, including under 1115 waiver, 1915(i) state plan, and 1915(b)(3)-like authority.

Simplify Accessing Dental Services

Background

Each program that provides services to persons with IDD under Texas Medicaid has unique and different requirements for accessing dental through the Medicaid waiver for adults with IDD.

Table 2. Requirements for Accessing Dental Services by Waiver or Program

Waiver or ICF/IID Program	Benefit Limit	Unique Rules
HCS	\$2,000	Specific dental limit. Built into initial and renewal plan of care based on need.
TxHmL	\$1,000	Specific dental limit. Built into initial and renewal plan of care based on need.
CLASS	\$10,000	Combined with adaptive aids. Approvals required and not built into initial or renewal plan of care.
DBMD	\$2,500 & \$2,000 for Dental Sedation	Approvals required and not built into initial or renewal plan of care.
ICF/IID	Traditional Medicaid	Discussed at the annual staffing and recommendations for 3 months, 6 months or annual dental care based on need. There are follow-up meetings and appointments based on what was recommended in the staffing.
STAR+PLUS	\$5,000	Specific dental limit. Built into initial and renewal plan of care.

As reflected above, current HHSC rules apply different requirements to the IDD waivers and ICF/IIDs related to accessing dental services. With the addition of anesthesia for some dental procedures now being covered under Medicaid managed care, coordinating and accessing dental services has become more complicated, thus needing clarification and clear guidance from HHSC. This includes explaining how a

dental value-added benefit impacts limits and processes in each of the programs. To streamline the requirements and to allow easy access to dental services for this population, the IDD SRAC has the following recommendations.

Recommendations

1. For each HCBS waiver, include in the person's yearly plan of care the amount of services needed for dental for the year. Educate participants about the change.
2. For TxHmL and HCS, HHSC should expand the approved list of covered Adaptive Aids to include dentures and implants with prior approval from HHSC and reflect the benefit change in all waiver renewals.
3. Allow for the utilization of dental benefits across two service plan years.
4. As part of the development of the plan of care, HHSC will not ask for information on how much primary insurance will pay prior to services being rendered. However, once the claim has occurred, the dentist will include the amount paid by primary dental to assure there is no overpaid amount from Medicaid.
5. If using an anesthesiologist, the anesthesiologist and/or the facility will be paid by acute Medicaid or Medicaid managed care. The health plan must allow for an out of network anesthesiologist and facility to allow access to dental services. Clear guidance including coding for services is needed to describe facilities allowed to bill including the dental office, outpatient facilities, and inpatient facilities. Clear guidance is also needed when the dentist as part of the dentist's license applies anesthesiology services.
6. For any prior authorizations needed for dental services reviewed by HHSC, HHSC will provide a response within three business days of receipt of the treatment plan.
7. If the dental procedure exceeds the approved amount in the initial budget for the individual, due to the dentist finding the need for additional dental treatment while the individual is under anesthesia, the excess amount will be reviewed after the procedure is complete and approved if determined medically necessary without requiring the individual receiving the services to return for another procedure under anesthesia. This will be paid for by the MCO if it falls under the acute care dental benefit or through the Medicaid waiver dental services benefit. Need to educate individuals, families and providers.
8. Some services related to a disability shall be deemed medically necessary/functional necessity, rather than cosmetic, such as chipped teeth in a person who bites, has feeding challenges or other complications related to

the functional necessary dental procedures typically defined as cosmetic. Education is needed with dentist to clarify the policy.

9. HHSC should align policies across HCBS programs to allow for ease in access to dental services that promote access and not restrict access. The policies should be easily understandable for consumers and families.
10. HHSC and the IDD SRAC shall work to build access to services for this population by working with dental schools across Texas.
11. HHSC and the IDD SRAC shall develop methods to address accessing services through sedation early for a child through such strategies as Practice without Pressure to save Medicaid future dollars and result in better outcomes for the member. Possible LAR recommendations. (flag for broader population)
12. Review impact of H.B. 2658 or similar legislation from the 87th Texas legislative session adding dental benefits for persons in STAR+PLUS. Determine change in policy and impact on wavier benefits. Included in impact is use of dental provider under state plan versus dental provider in wavier or private insurance.

Education on Transportation Benefits

Background

HHSC has made changes to the nonemergency medical transportation benefit for persons with disabilities. There is very little information on how to access nonemergency medical transportation for persons on Medicaid. The IDD SRAC received several inquiries from persons with disabilities on how to access nonemergency medical transportation, changes to the guidelines on nonemergency medical transportation and how to receive reimbursement when nonemergency medical transportation is provided through a private car.

HHSC now has contracts with Medicaid managed care to provide services for transportation. As a result of this change further guidance for the program information was needed to ensure persons with disabilities can still access the nonemergency medical transportation benefit. Therefore, the IDD SRAC recommended the following.

Recommendations

1. Update current HHSC brochure that provides a clear understandable information to persons with IDD on how to access nonemergency medical transportation.

2. Provide information on how to access Non-Emergency Medical Transportation (NEMT) access within 48 hours. Allow same day access to NEMT mileage reimbursement benefits, which were allowed prior to June 1, 2021.
3. Distribute the brochure to the public through websites, sharing with organizations to distribute to their members and through mailings. In addition, provide brochure at annual service planning meetings and contacts with service coordinators and case managers (completed, awaiting distribution).
4. Monitor call center hold times for NEMT to assure access to Medicaid transportation benefit and report to HHSC. Consider longer times for access to call centers. Access to on-line scheduling and communication. Transportation system needs to be accessible as all information and scheduling needs to be in accessible format.
5. In the brochure:
 - A. Provide information on who to contact and their contact information;
 - B. Inform persons with disabilities on how to set up a ride;
 - C. Provide information on how to be reimbursed when using a personal car; and
 - D. Answer FAQs identified by the committee.
6. Standardize and simplify NEMT applications for Individual Transportation Participants (ITP), who provide mileage-reimbursement transportation services to Medicaid recipients. The applications and requirements for ITPs should be the same across all Medicaid programs and MCOs to reduce barriers for Medicaid recipients who use NEMT mileage reimbursement benefits.
7. Require TMHP and MCOs to automatically transfer NEMT data for ITP drivers when Medicaid recipients change MCOs or switch to or from an MCO to Traditional Medicaid to avoid delays in access to NEMT mileage reimbursement services for Medicaid recipients. ITP drivers should not be required to complete new ITP applications if they have already been approved as ITP drivers by another MCO or by Traditional Medicaid, to reduce barriers for Medicaid recipients who use NEMT mileage reimbursement benefits.

Monitor Quality on Acute and LTSS Benefits

Background

At this time, HHSC is not able to review and analyze quality metrics specific to the total population of individuals with IDD in the STAR Health, STAR Kids and STAR+PLUS programs. We strongly recommend HHSC and the MCOs work together to create a flag within relevant data systems to allow for tracking of quality and other metrics specific to individuals with IDD.

People with IDD are supported through a variety of managed care and non- managed care programs. Without a code, risk group, or other flag identifying an individual as a person with IDD in the data systems, data for individuals with IDD cannot be disaggregated from totals. At this time, individuals with IDD are unable to be disaggregated from total populations within STAR Health, STAR Kids, and STAR+PLUS acute care services and from STAR+PLUS HCBS LTSS services. HHSC, in collaboration with the MCOs, is able to pull metrics specific to a single sub-set of individuals with IDD, those who are currently supported through an IDD waiver. The other populations of people with IDD supported in managed care, including those not currently supported on an IDD waiver and those currently receiving STAR+PLUS HCBS Waiver services are not flagged.

General Appropriations Act, S.B. 1, 85th Legislature, Regular Session, 2017, Article II, Health and Human Services Commission, Rider 51 (formerly Rider 194) directs HHSC to develop community integration measures for STAR+PLUS and STAR Kids programs.

At present, this rider specifically applies to STAR+PLUS HCBS and to the STAR Kids Medically Dependent Children Program (MDCP).

It is anticipated that the scope of this project will likely expand if more programs, such as IDD Medicaid waivers and Intermediate Care Facilities for individuals with IDD, are carved into managed care.

The Rider 51 – Community Integration Measures project is designed to gather data to assess the STAR+PLUS HCBS and STAR Kids MDCP program compliance with federal HCBS rules concerning community integration in areas such as: community participation, community presence, well- being, and recovery. HHSC is working with stakeholders to identify measures and establish methods of data collection. With stakeholder agreement, HHSC will collect data for measure reporting and publish final data on these measure on the HHSC website annually.

This process is currently conceptualized in two phases:

- Phase I will utilize currently available data streams and data elements from data sources available to the state as of January 2019.
- Phase II will expand upon Phase I measures to include measures derived from data elements that will become available after January 2019.

These phases are somewhat distinct and yet the analysis is being conducted somewhat in tandem, to the extent that is possible.

Progress to Date

- The state put forth two sets of draft measures to stakeholders based on currently available data. Stakeholders have not been satisfied with these measures and recommend the state utilize results of National Core Indicators surveys.
- The state believes the use of the National Core Indicator surveys to be within scope and is continuing to research this possibility.
- A new set of measures went out to stakeholders for review in mid-May 2019, to be followed up by a face-to-face meeting in July. Stakeholders were pleased the new set of measures included National Core Indicator survey results, but recommend further refinement. The draft measures rely on National Core Indicators – Aging and Disabilities (NCI-AD); stakeholders recommend the additional use of National Core Indicators-Adults with IDD.

Recommendations

1. Create a system that is public and data-informed by developing mechanisms for recurring data collection and review of acute and LTSS data, what is used, what is needed, gaps, and implement evaluation of the data. Data must include aggregate information such as:
 - ▶ Review plans of care based on individual identified needs and desires.
 - ▶ Compare what was on plan, provided or not provided and why and overall service utilization.
 - ▶ Identify services provided by one or more than one or different providers, such as behavior supports, PT, OT, which may be provided by non-licensed individuals that reinforce therapy according to the plan of care.
 - ▶ Within the IDD system including ICF/IID, 1915(c) waivers and the STAR+PLUS waiver publish deficiencies of the results of the survey results, complaints and resolutions, similar to the quality reporting system on a quarterly basis. Examine other states for meaningful measures.
2. Incorporate the pilot program performance measures or other quality measures identified in the pilot.
 - A. HHSC shall coordinate and consult with SRAC on a study for regulatory requirements for residential group homes and other residential settings where individuals with IDD receive services.
 - B. Identify people with private insurance coverage and dual Medicaid/Medicare through electronic means. Reports shall differentiate satisfaction and outcomes between those with other coverage and those solely with Medicaid only coverage through the EQRO annual survey. Since Texas does

not allow Medicaid recipients with private insurance to “opt out” of MCO enrollment, require changes to survey design to allow respondents to provide separate responses for satisfaction and outcomes for members with private insurance or Medicaid/Medicare coverage vs Medicaid coverage.

3. Establish and publish a dashboard to track data elements on the HHSC website
 - ▶ Implement recurring data collection, assessment, review, action plan, and public reporting of results and expenditures related to publicly funded services in coordination with the IDD Strategic Plan development and implementation.
 - ▶ Ensure that state leaders have accurate, reliable data to use in development of policy and critical decisions that impact people with IDD. Expand data collection for people who have private insurance or Medicare to improve access to improve evaluation and decision making.
 - ▶ Examine data results for missing data to identify persons without data for key acute care indicators such as annual check-ups, vaccines, etc. Present findings by entity (MCO only, private insurance and MCO, and dual Medicare/Medicaid) and investigate how the persons are accessing services whether acute care was received through out-of-network providers and the effect or potential effect on their health. Based on the findings assess whether additional assistance or oversight from the MCO Service Coordinator is needed to ensure access to needed acute care services, identify health care risks and improve the person's health.
4. Establish IDD population tracking codes within managed care.
5. Continue to seek and monitor IDD data on acute care, targeted case management/service coordination and LTSS quality measures using encounter data from Medicaid MCOs and other entities providing targeted case management/service coordination and LTSS using state data and National Core Indicators to obtain participant experience. In addition to NCI-AD, measures should include sufficient NCI IDD measures.
6. Evaluate and consider OPTUM recommendations for measurements and Utilization Management Review team information/data.
7. Ensure the committee will receive and review the results quarterly with HHSC to determine if the data are valid and can be used as baseline data for the future. The committee will continue to work with HHSC to refine the measures; and determine targeted case management/service coordination and LTSS measures that should be added and used to identify and address opportunities for improvement assessment and evaluation processes for people with IDD. The system should:

- A. Determine people’s satisfaction and the flexibility of the system to meet their changing needs;
- B. Increase frequency of reviews throughout the year to ensure progress toward desired outcomes and preferences of the people using services and flexibility to make changes as needed;
- C. Increase number of people who choose or help decide their daily schedule;
- D. Increase number of people who use self-directed supports and participate in how to use supports budget, hiring, and services;
- E. Increase number of people and families who report high quality services;
- F. Increase number of people and families who report a high quality of life; and
- G. Decrease the number of people experiencing transitions to higher levels of care due to unmet needs (e.g., ER, hospitals, jails, NF, SSLCs and other institutions).

Identify and Develop Acute Health Care Initiatives

Background

Identify and develop health initiatives that address acute care health needs common to individuals with IDD. Individuals with IDD, as a group, are living longer and need the opportunity to age well; however, certain health conditions are common to individuals with IDD and could be reduced or managed if initiatives are developed to build capacity to maintain optimal health and avoid ER, hospital and institutional LTSS.

According to a November 2017 Policy Data Brief Titled Health and Healthcare Access among Adults with Autism Spectrum Disorder (ASD) and Intellectual Disability (ID) by the Lurie Institute for Disability Policy, adults with ASD and ID reported poorer general health than the general adult population of the United States. About 29 percent or 2,390 surveyed using National Core Indicators (NCI) with individuals who receive state developmental disability services reported at least one chronic health condition such as diabetes, hypertension or high cholesterol. More than half of the respondents to their survey reported at least one diagnosis of mental illness/psychiatric condition (anxiety disorders, mood disorders, schizophrenia, etc.). Among those, three out of five took medication to treat those conditions and 24 percent who reported taking medications have no diagnosis on file. Most had access to primary care doctors, annual health exams, dental care and vision care. However, access to different types of preventive health screenings were uneven. Among women ages 21 to 65, 70 percent had a mammogram within the past two years, while 18

percent never had one. Among adults (men and women) ages 50 and above, 27 percent had never received a colon cancer screening.

Recommendations

1. Expand quality-based outcome and process measures to include health care concerns impacting individuals with IDD such as obesity (due to medications), recovery based mental health services for individuals with IDD and co-occurring mental illness, diabetes, respiratory disorders, early onset Alzheimer's/dementia, heart disease, health literacy for self-care and decision making.
2. Improve access to preventive health services and access to timely and accurate psychiatric diagnoses and appropriate treatments.
3. Expand MCO provider networks to include both private and non-profit providers to prevent MCO members from having to go outside Medicaid to get health care services covered by Medicaid, and create a mechanism to collect claims and health care outcomes data from outside Medicaid when the individual uses non-Medicaid health care due to lack of access or due to coverage by primary insurance or Medicare benefits.
4. Ensure that S.B. 1207 regarding coordination of benefits, which was passed in the 2019 Legislative session, is implemented as written to allow Medicaid members to access Medicaid benefits for in network and out of network provider for copays, coinsurance and deductibles. Ensure that Medicaid members are informed or educated about the revised coordination of benefits policy.
5. When Medicaid is the secondary insurer, ensure that Medicaid covers what the primary insurance does not cover, such as co-pays. Implement education and outreach to ensure Medicaid beneficiaries are aware to changes to be implemented due to recent legislation, including people on the Health Insurance Premium Payment (HIPP) Program who need coordination of benefits.
6. Encourage additional enrollments of private health care systems and private providers into Medicaid and Medicaid managed care to expand MCO provider networks.
7. To encourage health and wellness that may result in reduction of obesity rates, which are not always due to low physical activity levels, develop and implement easily understandable, targeted health promotion policies and practices that focus on nutrition, healthy lifestyle and diet.
8. Analyze data and, if needed, expand data collection to include access, availability, experience, utilization, and the results of health care activities

(outcomes) and patient perception of care including use of NCI health and wellness data for individuals with ASD, ID and other developmental disabilities in order to identify health care initiatives. Provide separate results for persons with private insurance and those with dual Medicaid/Medicare coverage.

9. Use MCO encounters and other HHSC data regarding hospitalizations, ER visits and other physical and behavioral health related factors that may lead to institutionalization in nursing facilities, ICF/IID, SSLCs, State Hospitals and other long-term care institutions information to identify and address health initiatives to prevent admissions and facilitate returning to the community for individuals with IDD.
10. Track and report quarterly to SRAC the number and type and health related reasons for admissions, the number of discharges of individuals with IDD, including where they were admitted from, whether they had access to health care or community services by program, length of stay and where they were discharged to by program.
11. Implement certain innovative practices learned during the COVID PHE that increased timely access to services and are agreed to by the individual. Survey individuals and families to understand the impact of COVID and COVID policies during the PHE.
12. Services defined during the pilot program benefit design process should be incorporated into current waivers.
13. Consider use of focused telemedicine for urgent care and behavioral health needs for persons with IDD performed by physicians experienced with the population.

Develop and Implement a Regional Partnership

Background

Funding is needed to develop and implement a regional partnership throughout Texas for LIDDA, MCOs, providers and persons with IDD to better coordinate services and support for persons with IDD, to develop local solutions, strong collaborative partnerships resulting in better health outcomes for persons with IDD.

Persons with IDD may experience barriers to living successfully in the community, to include finding services, receiving coordinated care, understanding benefits, developing a plan for the future, and have opportunities to live and to work in the most integrated environment. The IDD SRAC recommends that Texas HHSC develop regional

partnerships throughout the state of Texas. Again, the goal is to have better outcomes for persons with IDD.

Recommendations

1. Develop and implement a regional partnership throughout Texas for LIDDA, Medicaid MCOs, TEA, the Texas Workforce Commission (TWC), comprehensive providers and persons with IDD, and families to better coordinate services and supports for persons with IDD, to develop local solutions, and to develop strong partnerships resulting in better outcomes for persons with IDD.
2. Explore options for leadership roles to develop and operationalize regional partnerships including persons with lived experience.
3. Initiate regional partnerships prior to the STAR+PLUS Pilot Program to best support the goals of the pilot.
4. Increase coordination and collaboration between MCOs, local providers and state agencies (e.g. TEA, HHSC, DSHS, LIDDAs, TWC, and DFPS) to ensure appropriate and timely transition to adult services including competitive and integrated employment.
5. Pursue public-private partnerships to develop cross-system collaborations and innovative funding options to offer people with disabilities meaningful access to the same opportunities as their peers without disabilities.
6. Increase use of the regional education service centers' statewide networks to develop and provide innovative leadership development, training, and support for education for both professionals and families.
7. Increase regional and statewide resources and personnel to develop and implement inclusive competitive and integrated employment programs for students.

Improve the IDD Assessment Process

Background

At this time, much of the IDD service delivery system relies on an individual's assigned Level of Need (LON) to determine resource allocation for the individual, including staffing ratios in certain services. Many individuals with IDD in Texas are assessed for their LON using the ICAP.

Like any tool, the ICAP has strengths and weaknesses. After years of experience with the ICAP, stakeholders identify strengths as its relative speed and ease of administration. The ICAP can be performed by non-clinical staff, allowing for LIDDA case managers who are familiar with clients and experienced with PCP to administer

the tool. Weaknesses include the ICAP's focus on recent behavior to the exclusion of past history and traumatic events. The striations within the tool are limited to only four generally available LONs (five including the highest, LON 9, which is rarely assigned and not available for medical or physical needs). The four commonly assigned LONs are too broad to account for the tremendous variations in abilities and needs from person to person and to capture differences in a single individual's needs in different settings (e.g. an individual may have much higher needs when in a crowded, unpredictable community setting such as a shopping mall than in a familiar, controlled setting such as a day habilitation site). Require inclusion of PCP and trauma informed care in the assessment process regardless of which tool is used.

In recognition of these and other challenges, S.B. 7 (2013) directed the Department of Aging and Disability Services (DADS)/HHSC to develop and implement a comprehensive, functional assessment instrument for individuals with IDD to ensure each individual receives the type, intensity, and range of services appropriate and available. In April 2015, legacy DADS determined it would pilot the InterRAI ID.

Over the summer of 2017, HHSC used an outside vendor to conduct assessments using the InterRAI ID assessment on voluntary pilot participants. Participants were selected from among individuals receiving services through HCS, TxHmL, CLASS, DBMD, ICF/IIDs, and SSLCs. HHSC sought a sample of no fewer than 1,368 individuals aged 18 or older and drew from rural and urban areas, specifically Lakes Regional, MHMR Tarrant, Metrocare Services, and LifePath Systems' LIDDA Service Areas, along with Denton and Mexia SSLCs.

Recognizing the anticipated timeline for completion of the InterRAI Pilot is 2022, with an indefinite period of time needed after completion of the pilot to develop a resource allocation algorithm if HHSC chooses to implement the InterRAI, the IDD SRAC strongly recommends HHSC work on dual tracks, to improve and modify use of the ICAP at present, while also preparing for the future where the InterRAI may be in place.

Recommendations

As the State moves forward with statutorily directed changes to the assessment, the IDD SRAC recommends improving assessment tool(s), processes and planning for needs:

1. Implement person-centered, individualized and comprehensive training and assessments;
 - ▶ Support comprehensive and accurate assessment of functional, medical, psychiatric, behavioral, physical, and aging needs in all settings and that results in receiving appropriate services regardless of settings.

- ▶ Allow and encourage using a variety of evidence-based, empirically valid tools as necessary to accurately identify needs.
2. Expand or enhance assessment tools and resource algorithms that account for high support needs and changes in conditions across the life continuum of the individual, whether physical, medical, or behavioral.
 - ▶ Ensure high quality services that align resources with assessed needs and preferences (adjust rates that support quality).
 3. Across programs and settings, develop and implement flexibility in service planning and resource allocation based on assessed needs, including for, but not limited to, individuals transitioning to community settings from institutional settings who may need higher levels of support during periods of transition.
 4. Ensure continuity and integrity of services for transitions across programs, settings and changes in needs.
 5. Acknowledgment of the important role an individual's natural supports can play and a willingness to Provide justified family support services, such as additional respite or in-home supports, at the level necessary to support an individual to remain at home.
 6. Ensure individuals receive the amount, type and duration of services needed without requiring natural supports beyond those voluntarily provided.
 7. Increase and improve training for assessment personnel to ensure assessments and staff appropriately address cultural, language, communication, learning differences, and needs of children and adults and their families.
 8. Increase access to board certified behavior analysts to identify and provide timely and appropriate functional behavior assessments and behavior intervention plans.
 9. Increase and enhance mental health screening to obtain baseline information and identify needs including trauma informed care strategies.
 10. During any system redesign that implements new or modified assessments, ensure people maintain their services with no significant reductions.
 11. Maintain continuity and level of care when an individual moves across service or geographic areas.
 12. Coordinate with and include joint recommendations from the pilot program workgroup for assessment recommendations to be utilized in the pilot.

Additionally, the IDD SRAC recommends HHSC take the following actions to address immediate issues with the current assessment process:

1. Modify ICAP scoring requirements to allow for assignment of LON 9 to individuals without a behavior management plan in place if other evidence justifies assignment of LON 9 for a period of 12 months.
2. Automatically assign at least a LON 6 for a period of at least 12 months to all individuals transitioning from institutional settings (already in place for individuals transitioning from SSLCs, but not in place for individuals transitioning from Nursing Facilities and other settings) and aging out from Comprehensive Care Program (CCP) skilled nursing.
3. Adjust the ICAP and other assessment tools to better account for high support needs, including physical, behavioral, and medical needs that enable the assignment of an appropriate LON, including LON 9 for medical and physical needs, not just behavioral.
4. Review adequacy and accuracy of current assessment processes for STAR+PLUS HCBS, CLASS and DBMD.
5. Streamline Determination of Intellectual Disability (DID) and Related Conditions (ID/RC) processes and study how other states complete this determination, such as not requiring repeating the DID or ID/RC at the current frequency unless requested by the individual or LAR.
6. Allow telehealth and telemedicine and other technology, unless contraindicated and when agreed to by the individual and LAR, to prevent delays in enrollment, prior authorizations, reassessments and renewal of Individual Plans of Care (IPCs).

Day Habilitation and Employment Services Subcommittee

Identify Employment and/or Meaningful Day Goals

Background

There is currently no standardization in person-centered service planning across programs. Employment, and meaningful day activity goals are not consistently addressed in assessment tools across programs. In addition, the external assessment conducted by HHSC in compliance with the federal HCBS regulation indicated that exploring and obtaining employment is an interest of a significant number of individuals receiving HCS services and employment goals should be addressed to implement S.B. 1226- the EF legislation of 2013.

Recommendations

1. Require a person-centered plan for all individuals that addresses competitive, integrated employment and other meaningful day activity goals.
 - A. Include self-advocates in the discovery process by the development of a Peer Support Model benefit to assist individuals in identifying their meaningful day.
 - a. PPT- Learning Community
 - b. Opportunities for individual and group learning
 - c. Exploring how to support families and friends to understand the value and possibilities of employment.
 - B. Review and develop recommendations to ensure that assessment and service planning questions are meaningful to individuals.
 - C. The service planning discovery tool currently in development should include a specific module on employment.
2. Require that ALL LTSS providers including case managers, service coordinators, day habilitation providers and direct service agencies (DSAs) complete training in the principles of EF, employment services, steps to become an Employment Services Provider (ESP) with TTWC, the development and implementation of an Employment Plan, work incentives and other resources to maintain benefits while working and the transition of services from TWC to LTSS/waivers.
 - A. Improve electronic communication channels between TWC and LTSS providers and MCOs.
 - B. Require HHSC staff and LTSS providers to be trained in the implementation of what is required from TWC-VRS to obtain employment services to ensure it is never a barrier to pursuing employment goals.
 - C. Provide training that is affordable, accessible and available across Texas for all IDD LTSS providers and day habilitation providers to become successful Employment Services Providers (as the ESPs in TWC) in order to have a "pool" of providers for EA and SE services and to easily transition employment services from TWC to the waiver services.
 - D. Require TWC staff to notify HHSC staff when there is an ESP contract open enrollment period. HHSC will inform TWC who their contact person is. HHSC staff then will distribute this information to all LTSS providers and encourage them to enroll as ESPs.
 - E. Encourage HHSC staff and LTSS providers to register to receive notifications on TWC website to be informed of information related to vocational rehab.
 - F. Allow ESPs contract open enrollment to be available year-round.

- G. Examine the current state contracts for training providers of EA and SE to reduce the overall time required for them to qualify as a credentialed provider.
3. Include TWC Employment Service Providers in the service planning to ensure participants have an Employment plan coordinated with TWC or other employment supports and include this plan in the participants individual plan of care in their waiver for individuals desiring to seek or maintain employment. This recommendation is included in My Life Plan.
 4. Promote awareness of employment supports through all means: case management, service coordination, PCP, assessments, reviews, etc.
 5. Require all TWC Vocational Rehab counselors to receive training from HHSC regarding EF principles, waiver employment program services and the process to transition employment services from TWC to long term services and supports/waivers.
 6. Explore HHSC regulatory staff reviewing for compliance to Department of Labor standards for all sheltered based employment services paying less than minimum wages.
 7. Explore additional strategies to increase competitive integrated employment as per the Texas EF policy including utilization of transitioning from the use of 14c waiver certificates.
 8. Increase additional strategies that lead to skill development to increase competitive employment.

Increase Utilization of Employment Services

Background

Despite the passage of S.B. 1226 EF legislation of 2013 that establishes competitive, integrated employment as the primary goal and priority for citizens using publicly funded services, and the availability of Social Security Administrations (SSA) initiatives, work incentives and the Ticket to Work program, these employment services remain underutilized nationally and in Texas, particularly for individuals with IDD. In addition, Texas Medicaid waiver employment services of EA and SE are grossly underutilized.

Collaboration and expanded partnerships are needed to promote understanding and use of SSA work Incentives, Vocational Rehabilitation services and Medicaid waiver EA and SE services.

Recommendations

1. Require all LTSS providers to contract with a network of EA and SE providers who meet quality standards to provide SE and EA services in order to meet the needs of the participants, including Employment Service Providers (ESPs). The recommended Quality Standards include:
 - A. The Employment Service Provider must have a discovery process in place that supports the individual to identify their employment capacities, abilities and preferences. EA services used for discovery must reflect one-on-one interaction, business exploration and job training. EA service results in the person transitioning to SE Services.
 - B. For all individuals receiving EA services, individual employment plans must be reviewed by the service planning team every six months to discuss and remove any barriers to competitive, integrated employment.
 - C. The Employment Service Provider must have a SE plan in place that includes employment placement, systematic instruction, fading of direct employment supports at the job site and long-term services.
 - D. SE services matches the individual to a job that reflects their employment capacities, abilities and preferences to a full or part-time job in the community paying minimum wage or better.
2. Develop and facilitate regularly scheduled regional and/or local collaboration on employment issues, including state agencies that provide employment services (MCOs, LIDDAs, DSAs, TWC, Texas Education Agency and HHSC which will develop (1) a joint plan for identification of federal and state funding and resources to promote competitive integrated employment, (2) a joint phase-out plan that transitions individuals with disabilities out of subminimum wage and segregated work environments, (3) annual goals for increasing the numbers of persons with disabilities employed in competitive integrated employment and (4) a requirement for each agency to develop a system for collecting and aggregating data that follows Workforce Innovation and Opportunity Act requirements and is reported to the HHSC EF designated staff annually (this recommendation also requires TEA and TWC participation).
3. Require contractors and subcontractors to comply with EF policies by ensuring the primary goal is competitive integrated employment as outlined in the Government Code, 531.02447.
4. Expand the definition of EA services to include providing a person-centered, comprehensive employment plan with support services needed. This could be similar to the Employment Plan used by TWC. This service would aid waiver program participants to obtain, or advance in, competitive employment or self-employment. It is a focused, time limited service engaging a participant in

identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state's minimum wage. Include transportation between the participant's place of residence and the site where career planning is delivered as a component part of career planning services. The cost of this transportation is included in the rate paid to providers of career planning services and the state would include a statement to that effect in the service definition.

5. Establish a centralized source of resources for employment related services and supports including information regarding continued Medicaid eligibility.
6. Support implementation of EF initiatives by having HHSC to measure employment outcomes.
7. Promote competitive, integrated employment by developing and expanding existing educational campaigns and other initiatives to increase awareness of work incentives and provide accurate employment information for pilot participants.
8. Add SSA benefits counseling as a service in all LTSS waivers to promote competitive, integrated employment by not only increasing awareness of work incentives and providing accurate information, but by also assisting with, applying for and implementing work incentives that allow individuals who work to continue their Medicaid eligibility. The SSA benefits counseling will be provided by certified social security benefits counselors or those who are Work Incentive Practitioner-Credentialed. This will ensure participants understand that their Medicaid waiver pilot benefits will be preserved after obtaining employment.
 - A. Increase the number of certified social security benefits counselors by providing the necessary training in SS benefits. Currently there are less than 30 state certified benefits counselors in Texas.
9. Require and allow billing in the IDD waivers for EA providers to be present with an individual when a SE staff is being trained to ensure the transition from EA to SE is successful.
10. Establish a higher EA and SE reimbursement rate, in all waivers, for participants who have higher support needs, such as medical and/or behavioral supports, who require staff to have a higher skill set of training.
11. Establish a transportation benefit to allow flexibility to include the use of taxis, bus passes and ride shares and allow this to be billable through EA and SE services when it is employment related transportation.

Improve Community Access through Home and Community Based Services Regulations

Background

Currently, individuals with IDD receiving day habilitation services do not have full access to the greater community through their HCBS services. Service delivery design and reimbursement rates are barriers to individualized, integrated community participation, making person-centered plans and implementation plans hard to fully implement.

Individuals, regardless of where they live, who receive day habilitation services get the services primarily in facility settings with no or limited access to the community during day habilitation services.

Recommendations

1. Pilot or phase in an hourly community integration service available to individuals regardless of their residential arrangement.
2. Develop and promote pooling of day services dollars to participate in shared interests in the community for up to three individuals to provide staff and transportation.
3. Provide funds to incentivize or reward creative service models that increase flexibility and support individualized, person-centered, lifespan goals to assist the state to come into compliance with HCBS requirements. (For instance: competitive/integrated employment, integrated retirement, community recreation, volunteering, or other activities identified as meaningful by the individual).
4. Incentivize waiver providers (DSAs-direct service providers) and day habilitation providers to become employment providers (such as ESPs in TWC).
5. Seek input from stakeholders in various settings with varying services to increase awareness of barriers to community inclusion.
6. Fully implement the services proposed by the IDD SRAC supported workgroups to allow for choice of meaningful day providers and day activities across settings in order to comply with the federal HCBS regulations.
7. Allow for flexibility of transportation services to support community participation activities.
8. Individuals in residential services should have increased flexibility and options for how they spend their daytime hours.

9. Develop an emergency/disaster plan to include stakeholder input in the event of disruption of services. Include post disaster emergency response evaluation data.

System Adequacy Subcommittee

Access to Services

Background

Timely access to IDD Medicaid-waivers and other waivers serving persons with IDD is limited and interest lists are extremely long, and in many cases, people wait more than fourteen years. As of June 1, 2021, the IDD Medicaid-waiver interest list included the following number of persons on the list: 75,556 for CLASS; 1099 for DBMD; 108,298 for HCS; 94,718 for TxHmL; 18,361 for STAR+PLUS Waiver; and 8,231 for MDCP.³⁷

It is Texas policy that children belong with families. The Texas Legislature funds waivers to support children and adults by diverting funds from admissions to facilities, or transitioning from facilities, as part of its commitment to the Olmstead decision and the Texas Promoting Independence Plan. In 2021, the 87th Legislature funded new waivers slots for 1,549 persons on the interest lists to enroll during the 2022-23 biennium. However, the 86th and 87th Legislatures did not appropriate funds for Promoting Independence waiver slots, which are slots to prevent unnecessary institutionalization. With no Promoting Independence slots, HHSC uses attrition slots for persons seeking diversion from admission to an institution or wanting to transition from institutions to the community during the 2020-21 biennium, and again in the 2022–23 biennium. Attrition slots are created when previously funded HCS slots are permanently discharged by an individual after enrollment.

The tables below outline the Texas Legislature historical funding for HCS and TxHmL waiver services, interest list reduction for HCS, and HHSC appropriation & attrition for HCS waiver slot utilization for the 2020-21 biennium.

A foundational IDD Strategic Plan was developed and provided additional perspective and recommendations to increase and improve access to community services, which will further enhance the service delivery system. The five-year IDD Strategic Plan is pending approval and publication.

³⁷ <https://hhsportal.hhs.state.tx.us/wpsv2/myportal/csil>

Table 1. HCS Targeted Group Appropriated Slots by Biennium

HCS Targeted Group	Purpose	FY 2014-15	FY 2016-17	FY 2018-19	FY 2020-21	FY 2022-23
Crisis Diversion ¹⁷	To prevent institutionalization/crisis	300	400	0	0	0
Nursing Facility Diversion ¹⁸	For persons with IDD diverted from nursing facility admission	150	600	150	0	0
Nursing Facility Transition	For persons with IDD moving from nursing facilities	360	700	150	0	0
Child Protective Services Aging Out	For children aging out of foster care	192	216	110	0	0
Nursing Facility Transition for Children ¹⁹	For children moving from nursing facilities	0	20	0	0	0
Large or medium ICF/IIDs	For persons moving out of an ICF/IID, including an SSLC	400	500	325	0	0
DFPS General Residential Operation (GROs)	For children moving out of a DFPS GRO	25	25	0	0	0
State Hospital (MDU)	For persons moving out of state hospitals	0	120	0	0	0
HCS Interest List Reduction	Statewide interest list reduction	1,324	2,134	0	1,320	542
TxHmL Interest List Reduction	Statewide interest list reduction	3,000 ²⁰	0	0	0	471
Total		5,451	4,295	735	1320	1,013

¹⁷ Crisis Diversion was known as SSLC Diversion in FY14-15 and FY16-17.

¹⁸ FY14-15 HHSC (Prior to Transformation DADS) used resource allocations to designate 150 slots for the purpose of diverting admission to nursing facilities.

¹⁹ None specified in appropriations, but HHSC historically provides about 20 slots per biennium to help transition children from nursing facilities.

²⁰ FY14-15 HHSC (Prior to Transformation DADS) used resource allocation to designate 125 slots for the purpose of diverting admission to nursing facilities via the TxHmL waiver.

Table 2. CLASS, DBMD, MDCP & STAR+PLUS HCBS Appropriated Slots by Biennium

HCBS Program	Purpose	FY 2014-15	FY 2016-17	FY 2018-19	FY 2020-21	FY 2022-23
CLASS Interest List Reduction	Statewide interest list reduction	712	752	0	240	381
DBMD Interest List Reduction	Statewide interest list reduction	100	50	0	8	6
MDCP Interest List Reduction	Statewide interest list reduction	120	104	0	60	42
STAR+PLUS HCBS Interest List Reduction	Statewide interest list reduction	490	0	0	0	107
Total		1422	906	0	300	536

Table 3. HCS Attrition Slot Utilization for the 2020-2021 Biennium

Attrition Target Group	Purpose	2020-21 Appropriated Slots	FY 2020-21 Total Released ²¹	FY 2020-21 Total Enrollment	FY 2020-21 Total Pending Enrollment
Crisis Diversion	To prevent institutionalization/crisis	0	385	247	126
Nursing Facility Diversion	For persons with IDD diverted from nursing facility admission	0	138	77	48
Nursing Facility Transition	For persons with IDD moving from nursing facilities	0	186	69	81
Child Protective Services Aging Out	For children aging out of foster care	0	99	66	32
Nursing Facility Transition for Children	For children (age 21 or younger) moving from nursing facilities	0	7	3	4
Large or Medium ICFs/IID	For persons moving out of an ICF/IID, including SSLCs	0	58	41	15
Total		0	873	503	306²²

²¹ Attrition slots require input from HHSC Budget to determine if resources are available and to what capacity for the specified point in time.
6 March 2020 Waiver Slot Enrollment Progress Report

²² Attrition Slot Utilization as reported in March 2021 *Waiver Slot Enrollment Progress Report*

Table 4. HCS Interest List Reduction by Biennium

HCS Interest List -Biennium	Appropriated Slots	Total Released	Total Enrolled
2014-2015	1,154	5,885	3,698
2016-2017²³	2,134	1,793	1,079
2018-2019²⁴	0	0	0
2020-2021	1,320	1,529	459

²³ During fiscal years 2014-2015, HCS slots were overfilled in response to feedback DADS received about not filling slots quickly enough. The impacts of over-releasing names from the interest list resulted in exceeding the end-of the year target and impacted the total enrolled for fiscal years 2016-2017. *Waiver Enrollment Report (March 2017)*.

²⁴ HHSC did not receive appropriations for HCS interest list reduction during fiscal years 2018-2019.

Recommendations

1. Fully fund 10 percent interest list reduction per year. The committee recognizes this does not fully address reasonable promptness or timely access to Medicaid home and community-based waiver services. The committee recommends using additional available federal funding initiatives, as initiatives become available, to better address reasonable promptness.
2. Fully fund sufficient slots for the Promoting Independence Plan as related to transition and diversion waivers for children and adults, ensuring that the Texas Promoting Independence Plan is comprehensive, effective, and timely in meeting demands. Ensure inclusion of initiatives benefiting children, including waivers to support children being diverted or moved from nursing facilities and other institutional settings to community settings.
3. Provide outreach and training on how to access waivers, including the various attrition waiver slots, to the IDD population (persons and families) and those implementing the processes for accessing attrition slots. As LTSS services are carved into managed care over the next decade, eliminate the LTSS interest list for Supplemental Security Income (SSI) recipients who qualify for IDD waiver programs. Consider HCBS waivers under Section 1915(c), 1915(k), or 1915(i) of the federal Social Security Act (42 U.S.C. Section 1396n(c)) in addition to 1115 waivers which may be used to provide HCBS services to persons with IDD who meet eligibility criteria.
4. Implement a no-interest-list policy for eligible MDCP recipients who receive SSI and are enrolled in STAR Kids or STAR Health managed care programs.
5. Continue the “bridge to the appropriate waiver” policy. When a person comes to the top of an interest list and is found to be ineligible for that specific waiver program, based on disability or medical necessity criteria, the person’s name is moved to the appropriate waiver interest list(s) consistent with their disability or medical necessity criteria. The placement date on the new waiver interest list is the original date that the person was placed on the waiver interest list(s) for which they have been determined to be ineligible. MCOs, LIDDAs, service coordinators and case managers should inform persons of the policy and assist with the process to get onto the appropriate interest list(s).
6. Implement the strategies outlined in HHSC Article II, Rider 19 and Rider 41, H.B. 3720, H.B. 2658, and S.B. 1648, 87th Regular Session, Legislature

requirements regarding Medicaid Waiver Interest lists, to include strategies recommended by the IDD SRAC in coordination and consultation with HHSC. Specifically, require due diligence processes to use all available HHSC service data to access current contact information prior to moving a person to 'inactive' status' on the Interest List.

7. Implement the strategies recommended by the IDD SRAC as outlined in the Medicaid Waiver Programs Interest List Study, Appendix C (Rider 42) to reform the state system for interest list management. Prioritize funding to address gaps in real time information about the needs of individuals currently on waiver interest lists to better understand and manage timely access to services.
8. Implement strategies to reduce the growth rates of the waiver interest list by strengthening the CFC program. Prioritize funding to support sustainable rates for Direct Service Workers, enhance the program service array with the addition of transportation and respite, and increase awareness through a concerted, statewide outreach effort.
9. Include and update as necessary IDD SRAC recommendations that help prevent unnecessary institutionalization and support timely access to services in the most integrated setting into the Texas Promoting Independence Plan.

Strengthen Support for People with More Complex Needs, Including Behavior Supports

Background

Enhanced services, coordination, and monitoring are not available to persons with complex needs across all waivers. Behavior support professionals are in short supply, causing delayed assessment and services, which can lead to more restrictive, out-of-home placements. In addition, some providers have been reluctant or unwilling to take on the liability of serving a person due to the person's medical, physical, or behavior acuity (high needs).

HHSC continues to move forward with supports for persons with medically complex needs through an 1115 Waiver Amendment and through Article II, HHSC Rider 38, 87th Regular Session Legislature. The 1115 STAR+PLUS amendment is pending approval by CMS. The IDD SRAC recommendations for the STAR+PLUS Pilot

program include the development and implementation of enhanced services to better meet the complex needs of persons with IDD. These enhanced services, in addition to fully accessing available services for technical assistance from regional teams, should be considered for persons with IDD in the IDD 1915(c) Medicaid waiver programs.

Recommendations

1. Address barriers for persons with high needs that result in difficulty accessing or maintaining stability in home and community-based programs and services. For example, ensure that provider payments are both justified and sufficient and allow for billing for critical services such as nursing and supervision of non-licensed staff.
2. Establish clear expectations and ensure compliance for providers who delay or deny services to persons with complex or high needs by providing technical assistance and resources for successful services, and by tracking delays and denials.
3. Continue to expand the behavioral, medical, and psychiatric regional teams to serve all waiver programs. Expand the use of evidence-based programs by supporting Local IDD Authorities delivering evidence-based programs to provide training, technical assistance, and ongoing support to other Local IDD Authorities.
4. Establish a Regional Collaborative with participation by IDD provider agencies, MCOs, Local IDD Authorities, community stakeholders, and advocates to develop and implement strategies to better serve persons with complex or high medical, behavioral, physical or psychiatric needs. Implement processes for participating entities to collaborate to identify unmet needs that may lead to crises and identify services to prevent crises.
5. For new HCS waiver enrollments, accept the initial proposed LON from the LIDDA for the first 12 months unless the LON is appealed based on the persons' needs exceeding the LON by the LIDDA. For new CLASS waiver enrollments, establish stratified rates based on the individual's level of care determined by the nursing assessment and/or related-condition eligibility screening.
6. Enhance capacity of crisis respite and long-term stabilization as a measure to prevent hospitalization and/or institutionalization across all waiver programs and in non-waiver services for all persons with IDD.

7. Ensure access to protective supervision/PAS across all waiver programs. Reinstated access to protective supervision in the HCS waiver.
8. Expand due process rights to appeal a LON determination in HCS and level of care determination in CLASS, currently afforded to providers only, to persons and their representatives.
9. Implement a one-year presumption of LON 6 or LON 9 for persons enrolling from all institutional settings or aging out from the CCP skilled nursing, not limited to SSLC transitions. Maintain, at a minimum, the LON of a person transitioning from another waiver or other IDD program for one year.
10. Improve and streamline the SSLC transition process and create successful and timely continuity of necessary supports and services.
11. Modify LON 9 in HCS to address the need for 1:1 staff, beyond aggressive behavior supports and supervision, to include any behavior, or medical or physical need that is life threatening or puts a person at risk of physical harm and requires the same high level of supervision and intervention. Ensure stratified rates in CLASS to address similar needs for 1:1 staff.
12. Create high needs services, such as enhanced behavior supports and enhanced case management, that support advanced direct service professional training, supervision and compensation when supporting persons with high medical, behavioral, physical or psychiatric needs.
13. Create an add-on level or "bump" in CFC services, provided through all waivers, and payment for persons with more complex needs. Consider a rate structure equivalent to that of Residential and Day Habilitation in the HCS Medicaid waiver program. Support a higher rate for persons with higher needs. *Note:* Currently a person with a LON 6 receives a higher rate for the residential and day habilitation services. However, in CFC, the rate is the same regardless of the person's LON. A flat rate that does not recognize individual needs limits the individual/ family's options to obtain services that best meet their needs. Ensure rate enhancement or 'bump' is included for CFC services provided through all waivers and all service models (CDS and Agency options).
14. Add higher level of services with higher total cost allowance for persons with the most complex needs in Medicaid, including in managed care and the STAR+PLUS Pilot program. For example, add a LON 9 for medical needs in the HCS waiver. The increased level may include enhanced rates for Direct Service Workers.

15. Streamline access to General Revenue and other additional funds for those who exceed the cost cap for Medicaid waivers, including in managed care and the STAR+PLUS Pilot Program. To the extent possible use Medicaid Estate Recovery funds.
16. Consider recommendations by the IDD SRAC, in coordination and consultation with HHSC, to meet the requirements of Article II, HHSC Rider 38, 87th Regular Session Legislature regarding a study on the Home and Community-based Services waiver program.

Create Housing Transition Specialist as a Medicaid Waiver Benefit

Background

There is a lack of affordable housing options and no assistance for persons with IDD to find the best housing solution. However, assistance to find appropriate housing may be funded as a Medicaid waiver benefit. One solution is to create a Housing Transition Specialist as a Medicaid waiver benefit to assist consumers and families, case managers, service coordinators and low-income persons with IDD transition and provide housing related services.

The Housing Transition Specialist will educate a potential housing applicant on community living options, property availability, and the application process. The Housing Transition Specialist will assist prospective applicants to apply for housing. The Housing Transition Specialist will maintain relationships with landlords and property managers, assist with the application process and monitor the application process ensuring all documents are submitted to the prospective landlord. The Housing Transition Specialist will work as a member of the person-centered practices team to communicate changes in the housing application progression and to ensure awareness and coordination necessary for supports and services. The Housing Transition Specialist will assist with creative problem solving to resolve landlord/tenant issues and will make referrals to other community resources. The Housing Transition Specialist will help prospective and placed applicants to understand lease and tenant responsibilities, training on how to be a good neighbor, and to ensure the tenant understands how and when to communicate with a landlord. In order to identify safe, affordable, accessible, and integrated community living housing, the Housing Transition Specialist will work with other community housing services and resources. Referrals may be made to Texas

Department of Housing and Community Affairs, the PRA 811 program, Centers for Independent Living, Aging and Disability Resource Center, apartment locator services, and other local or state funded housing resources.

Recommendations

1. Create a Housing Transition Specialist benefit to assist persons with IDD to transition to the most integrated, appropriate housing for the person.
2. Approve funding for Housing Transition Specialist as a Medicaid waiver benefit
3. Address barriers for persons with high needs that result in difficulty accessing and maintaining housing and access to paid caregivers during night hours so participants can live more independently without informal supports.
4. Explore opportunities to establish funding for security deposits and basic furniture/household items for those without resources.
5. Consider creating a Housing Supplement for people seeking to live on their own, but unable to do so due to the cost of living. Explore options for roommate assistance, rental assistance and assistance with resource management. Consider a capped monthly amount to use to cover the difference between the person's benefits and the cost of rent and living expenses. *Note:* The cost would be less than institutionalization. HHSC could pilot the Housing Supplement initially to evaluate the costs/benefits.
6. Remove barriers created by policies preventing HCS and TxHmL waiver caregivers from residing with individuals in the same household not limited to host home/companion care. Ensure policies are clearly communicated to participants.

Navigation Across the Entire IDD Service System

Background

Persons with IDD in Texas migrate across multiple services and service delivery systems over the course of their lifetimes depending on their age, medical needs, availability of services, and changing support needs and preferences. There is insufficient data to best evaluate when and why these migrations occur. The IDD SRAC recommends reviewing the broader IDD system, across community and institutional services, in order to anticipate, plan and implement a more flexible and

sensible system of supports and services whether in managed care or FFS. The February 2019 Foundational IDD Strategic Plan is a start to better understanding the needs, services, gaps in services and timely availability of services. It is also an opportunity to more strategically use data that has historically been fragmented and not part of a strategic, actionable plan. The five-year IDD Strategic Plan will provide additional perspectives and recommendations.

Recommendations

System reform must assist persons with IDD to live full, healthy and participatory lives in the community. Specifically, the system reform must address the needs of persons and families to navigate the IDD and HCBS systems successfully. In addition, the system must be designed to support and implement person-centered practices, consumer choice and consumer direction. Persons with IDD and families should receive the assistance they need to effectively support and advocate on behalf of themselves and other persons with disabilities. The system must be accessible, easily understood and transparent for persons, including information about rights and obligations as well as steps to access needed services.

HHSC should identify and obtain data needed to fully evaluate the migration/transition of persons with IDD across systems, including the reasons and number of transitions, and provide recommendations on the delivery of services to facilitate timely access to the services most appropriate to a person's needs. HHSC should coordinate and consult with the IDD SRAC on the following strategies:

1. Provide comprehensive data at least quarterly to the IDD SRAC and the public regarding the requests for waivers, and enrollments by slot type, and the interest lists by waiver type. In addition, provide data on institutional census, admission and discharge of persons with IDD including SSLCs, ICFs, GROs and Nursing Facilities. Data should include the numbers of persons active and inactive by waiver type on the interest lists, and the numbers of persons inactivated by quarter.
2. Improve Interest List data and tracking across programs, including STAR+PLUS, serving persons with IDD, including the number of persons on the interest list who are receiving institutional services by institutional type and waiver interest list.
3. Provide choice of the most appropriate waiver when a person in an SSLC or other institutional setting is transitioning to the community and would qualify for the DBMD or HCS waiver.

4. Participate in the development of the five-year IDD Strategic Plan and encourage broad stakeholder input.
5. Continue to contribute to the development, implementation and recommendations of the STAR+PLUS Pilot Program for persons with IDD and similar functional needs. Continue to collaborate with the STAR+PLUS Pilot Program Workgroup.
6. In conjunction and coordination with Regional Collaboratives, implement a well-coordinated transition and referral process when persons experience a transition in care. The transition processes should identify problems and explore options through local, state and Medicaid resources. Transitions in care may include changes in caregivers, MCOs, provider agencies or care settings.
7. Fully assess a person with IDD at the time the person applies for assistance to determine all appropriate services for the person under the Medicaid medical assistance program, including both waiver and non-waiver services. In the selection of a standardized assessment, consider adoption of an assessment, or screening tool, that identifies current needs and imminent risks of individuals. Practical options are to modify Form 8577, develop an assessment tool, adopt a fully vetted IDD assessment tool, and/or incorporate existing health and risk assessments used by MCOs.
8. Continue processes to allow a person with a suspected intellectual or developmental disability to register for IDD Interest Lists.
9. Ensuring procedures are operationalized for obtaining authorization for IDD Medicaid waiver services and other non-waiver services under the Medicaid medical assistance program, including procedures for appealing denials of service that take into account physical, intellectual, behavioral and sensory barriers and providing feedback on development of the new Independent Review Organization, including outreach and education.
10. Continue use of HCBS waivers and other alternative programs to meet the support and service needs of persons on Interest Lists for IDD comprehensive waivers.
11. Consider waivers under Section 1915 (c), 1915(k) or 1915(i) of the federal Social Security Act (42 U.S.C. Section 1396n(c) in addition to 1115 waivers which may be used to provide HCBS services to people with IDD who meet eligibility criteria. Access funds through all available federal initiatives, to

include Money Follows the Person and the 10% increase in the Home and Community Based Services Federal Medical Assistance Percentage (FMAP).

12. Implement consistent processes to assist people seeking placement on Interest Lists to receive information about alternate community resources during the routine Interest List contacts. Process should include training requirements for entities responsible for completing the Interest List contacts. In addition, process should require the provision of written information about critical resources, to include Medicaid eligibility, CFC, Texas Home Living program, Money Follows the Person, diversion for at risk people, and local community resources.
13. Ensure compliance with policies that require that a child or youth receiving Medicaid services has access to the most appropriate, comprehensive waiver service as adults, based on that person's needs and preferences, when the person ages out of and loses eligibility for Medicaid State Plan or Medicaid waiver services for children. In addition, processes should ensure that families have access to education and resource information to successfully support their family member transitioning to adult services.
14. Establish the family support necessary to maintain a person's living arrangement with a family for children and, if desired, for adults with ID.
15. Ensure that eligibility requirements, assessments for service needs, and other components of service delivery are comprehensive, accurate, and designed to be fair and equitable for all families, including families with parents who work outside the home, parents who volunteer and parents who are not employed.
16. Provide for a broad array of integrated community service options and a reasonable choice of service providers, consistent with HCBS settings requirements. Improve use and flexibility of CDS options and training for self-advocates to direct their own services when desired.
17. Ensure that the array of integrated community service options allows persons with IDD to experience a "meaningful day." Consider the following definition for "meaningful day."

Meaningful Day (See *And Yet More selection of the Idea Book for It's Official: The Unabridged 3/1/06 Measurable Definition of a Meaningful Day*): Meaningful Day means *individualized* access for individuals with developmental disabilities to support their participation in activities and function of *community life* that are desired and chosen by the general population. The term "day" does not exclusively

denote activities that happen between 9:00 a.m. to 5:00 p.m. on weekdays. This includes: purposeful and meaningful work; substantial and sustained opportunity for *optimal health, self-empowerment and personalized relationships; skill development* and/or maintenance; and social, educational and community inclusion activities that are directly linked to the vision, goals, and desired personal outcomes documented in the individual's Person-centered Support Plan. Successful Meaningful Day supports are measured by whether or not the individual achieves his/her desired outcomes as identified in the individual's Person-centered Support Plan, as documented in daily schedules and progress notes. Meaningful Day activity should help move the individual closer to a specified outcome identified in his/her Person-centered Support Plan.

18. Evaluate the quality and effectiveness of services for persons with IDD, including persons with high support needs. The evaluation should address whether access to crisis services prevented or could have prevented the need to migrate to a more restrictive setting or a different Medicaid waiver.
19. Coordinate, or combine, statutorily required IDD-specific reports to allow for a broad view of the systems' strengths and weaknesses and a more accurate assessment of barriers and gaps to services. Note: There are numerous IDD-specific reports that identify barriers to community, including reports on referrals, provider capacity, affordable community housing, and other services and supports needed to ensure community stability. The data from these various reports needs to be coordinated in a focused assessment of barriers and gaps to services.
20. Monitor the implementation and impact of managed care, new policies and initiatives required by the 87th Texas Legislature.
21. Identify state agency staff to assist persons to understand, maintain, and manage their Medicaid benefits. Implement improvements to ensure a streamlined process for Medicaid eligibility for IDD Waiver applicants.

Increase CFC Utilization and Improve Coordination

Background

As an early step in the IDD System Redesign, on June 1, 2015, Texas became one of the first states in the nation to implement CFC. CFC was implemented as a

Medicaid State Plan benefit, available for children and adults with Medicaid who meet an institutional level of care and have a functional need for services. The main services available in the CFC service array are PAS and Habilitation (HAB). PAS involves assistance with activities of daily living, such as bathing, dressing, and eating, and health related tasks, and instrumental activities of daily living, such as money management, meal planning and preparation, cleaning, cooking, and shopping. HAB involves assisting a person to learn, develop and maintain skills for everyday life activities.

CFC in Texas was designed and implemented as a cost-effective alternative to institutional care. CFC's limited service array was meant to provide services and supports for thousands of Medicaid-eligible children and adults, many of whom are on IDD Interest Lists awaiting a more comprehensive package of services. CFC services could sufficiently meet the needs of some persons on interest lists, thus improving the person's quality of life and maintaining the person in the community, relieving family pressure, and possibly even eliminating the need for a person to remain on the interest list. For persons with more intense needs, CFC could provide a lifeline, keeping the person out of institutional care, while the person awaited a more robust program or waiver.

Unfortunately, the full promise of CFC has not been realized. The uptake rate for CFC (the number of people offered the service who accept) has remained lower than anticipated (according to "CFC Closures FY17" report, presented by HHSC to System Adequacy subcommittee at June 26, 2018 meeting). Stakeholders, including LIDDAs, who serve as the front door to CFC services for persons with IDD, and MCOs, who are responsible for overseeing the delivery of CFC services for many populations, report challenges related to outreach, coordination and data collection. Notably, LIDDAs found through their outreach efforts that many people offered CFC were not interested because the services array (PAS and HAB) did not meet the person's needs. Persons and families noted that the in-home assistance and habilitation available through CFC would be more beneficial when coupled with transportation and respite. Additionally, MCOs and LIDDAs both report problems with the reporting program between MCOs and LIDDAs where progress with assessments, timeframes, and outcomes should be captured.

The 84th Texas Legislature (2015) responded to the low uptake rate and stakeholders' call for a package of services more responsive to the needs of persons with IDD by appropriating approximately \$30 million to add respite and transportation services to the CFC service array. Due to complications, these funds

were never utilized for their intended purpose and the CFC service array remains unchanged.

Stakeholders note other significant difficulties with CFC implementation. Some additional factors include:

1. A lack of CFC direct service providers due to Medicaid reimbursement rates that do not cover the cost of service delivery. LIDDAs report that persons struggle to find a provider willing to provide services at current rates, even when providers in the area are contracted with MCOs to do so. State or MCO action to address network inadequacy is thwarted by a lack of statewide CFC utilization data.
2. HHSC inability to run reports to examine data related to the number of persons who have been authorized for CFC services compared to the number of persons who actually received a CFC service.
3. Workforce, funding, and process challenges to timely assessments.
4. Lack of education on how to provide habilitation to persons with IDD. More emphasis should be given to provide education to attendants doing the day- to- day work with members, so they are successful in helping members learn skills.
5. An inconsistent assessment process for all populations, and a lack of an assessment process for all life areas.

At this time, CFC remains a service with great promise and the state should invest the effort and resources necessary to increase utilization and improve coordination.

Recommendations

1. Increase awareness of CFC through a concerted, statewide outreach effort.
2. Require HHSC to create a brochure and website content that describes CFC in a meaningful and, accessible way, to include eligibility requirements for the benefit and information on who to contact to request services. Distribute education material to all persons served, providers and advocates of persons with IDD and MCOs.
3. Require MCOs and LIDDAs to discuss CFC services at annual assessments to ensure persons with IDD are aware of CFC and are routinely screened for eligibility and interest in the benefit. Ensure schools provide information to students with disabilities who may qualify for CFC services.

4. Enhance the CFC service array by adding transportation and respite services to the benefit.
5. Set sustainable CFC rates that allow for hiring and retention of direct service workers with skills and abilities in teaching habilitation. Set rates for CFC services across all programs, including rates paid by MCOs, to attract and retain direct service workers. Rates for direct service workers who support persons with IDD must consider the lifelong needs of persons with IDD and the distinct skills and abilities required to teach persons to perform tasks independently.
6. Require HHSC to track and report compliance data on timeliness to include periods of time from the date of request or determination for the need of assessment for CFC services until the date the services are rendered or denied. Require HHSC to report data on declines to include reasons for decline.
7. Establish a clear and streamlined funding mechanism and payment rate for the LIDDAs to perform eligibility determinations and CFC functional assessments for persons with IDD. This includes funding mechanisms and rates for CFC eligibility and/or assessments for persons with IDD who receive CFC in non-waiver programs such as STAR+PLUS, STAR Kids and STAR Health.
8. Require HHSC to provide strong oversight and training to MCOs, LIDDAs, providers and CDS employers on the CFC benefit. This includes when to provide, how to report and how to bill for services. Training must include information on how to provide habilitation for persons with IDD, as well as additional resources. Habilitation providers, as members of the Service Planning Team, must contribute to the development of outcomes, implement strategies to achieve habilitation goals, and report progress on a regular basis.
9. Allow flexibility within the CFC benefit, utilization policies, and PCP such as:
 - ▶ The ability to access CFC habilitation services from one provider to more than one person at the same time considering appropriate rates.
 - ▶ Allowing, through the amendment to the HCS and TxHmL waiver, individuals living in the household of the waiver recipient to provide CFC if they meet the qualifications and want to be the provider.
 - ▶ Ease in changing service delivery models. The system should not pressure families to use natural supports further overburdening families caring for

their family member. This includes any tools requiring use of natural supports.

10. Use data-driven decision-making to commit to ongoing evaluation and improvement in CFC. Request HHSC to work in concert with the MCOs and LIDDAs to allow for identification and tracking of CFC utilization data for specific populations (i.e. persons with IDD). Analyze the utilization data to address network adequacy and to determine additional training needs and process improvement.
11. Request HHSC to streamline and create less administratively burdensome processes for MCOs and LIDDAs to share information such as referrals, eligibility determinations, IPCs and the authorization processes. NOTE: Currently MCOs and LIDDAs may exchange information through a portal, but there are challenges with access and inconsistent usage.
12. Require HHSC to recognize that a person remains eligible when eligibility was determined by a DID assessment completed after age 18. The requirement for a DID update every five years should only apply to a person whose eligibility was determined by a DID completed prior to the 18th birthday.
13. Request HHSC to improve, revise and further develop the CFC assessment tool and processes in consultation and coordination with the IDD SRAC. In addition, consider revisions to the instructions and directions to assessors, to include training requirements for assessors on the use of the tool and technical assistance on the development of justification for identified services.

Impact of COVID-19

Background

HHSC has made many changes to the Medicaid and CHIP program in 2020 and 2021 as a result of the COVID-19 pandemic. Some of the changes involved the use of telecommunications or information technology in the delivery of services under Medicaid and other public benefits programs. House Bill (H.B.) 4, passed by the Texas 87th Legislature, Regular Session, mandated that some of these provisions continue after the PHE ends. Though not inclusive, H.B. 4:

- Directs HHSC to ensure individuals receiving services through Medicaid, CHIP, and other public benefits programs administered by HHSC, or another health and human services agency, have the option to receive certain

services, such as telemedicine medical services, telehealth services, or otherwise using telecommunications or information technology, to the extent permitted by federal law if it is determined cost-effective and clinically effective by HHSC. Covered services include preventative health and wellness services; case management services, including targeted case management; behavioral health services; occupational, physical, and speech therapy services; nutritional counseling services; and assessment services, including nursing services under certain Section 1915(c) waiver programs (HCS, TxHmL, CLASS and DBMD). This provision applies regardless of whether the services are provided through a managed care delivery model or another delivery model.

- Allows Medicaid MCOs to reimburse for home telemonitoring services as defined in Government Code Section 531.02164.
- Requires HHSC to implement a system that ensures behavioral health services may be provided using an audio-only platform in Medicaid, CHIP, and other public benefits programs administered by HHSC or another health and human services agency and allow HHSC to authorize the provision of other services using an audio-only platform.

In addition to learning efficiencies through alternate service delivery, HHSC, service providers and Local IDD Authorities learned lessons that will help entities prepare for future disasters. Examples of these experiences include: the recognition of the importance of agile decision-making in an emergency situation, the accessibility of decision makers when approvals are needed, the acknowledgement that extraordinary costs to rapidly shift services must be covered by state financing models, and the importance of allowing flexibility for locally focused decisions as needed for local factors.

Some of the changes should be considered on a long-term basis to more efficiently address needs of Medicaid recipients and to prepare for future disasters. Changes made now will simplify future needs and will serve Medicaid recipients more efficiently.

Recommendations to Gain Efficiencies in the Medicaid and CHIP Programs

1. Allow qualified individuals living in the same household as a person receiving waiver services to be providers of CFC services. NOTE: Currently, this is not allowed in TxHmL and HCS programs. This change would keep individuals

safe by limiting the number of people coming into the home as well as assist with the recruitment and retention of direct service providers. Qualified individuals are age 18 or older, meet all required screening requirements, and provide CFC services to adult persons with IDD. Parents of minor children and spouses are not eligible providers.

2. Allow for individuals in different waivers to share attendants when deemed appropriate in accordance with the person-centered plan and ensure flexibility in rates when an attendant is supporting more than one person.
3. Add PPE as a reimbursable Medicaid benefit for all recipients including those using CDS.
4. Streamline the Medicaid provider enrollment process by combining and using one vendor for Medicaid managed care credentialing verification and HHSC Medicaid provider enrollment. HHSC relaxed some of the requirements for becoming a Medicaid provider during COVID-19. NOTE: This was crucial in allowing providers to enroll to provide telehealth services. However, prior to the crisis, becoming a Medicaid provider had become a long complex process often taking many months to complete. Once completed, the provider must become credentialed by Medicaid managed care health plans. The health plans simplified the process by use of one entity to assist providers for all the Medicaid managed care plans. The same changes are needed to the burdensome Medicaid enrollment process.
5. Permanently remove the 30-day spell of illness limitation for hospitalizations for adults in the STAR+PLUS and FFS programs. This has been a concern during this COVID crisis for Medicaid recipients who have exceeded the 30-day length of stay for COVID 19.
6. Allow the use of social determinants of health to develop value-added services. During this crisis, health plans have been asked to support food, housing, PPEs and other social determinants of health services. Additionally, HHSC should issue a list of Social Determinants of Health supports that health plans can provide as optional enhanced services.
7. Amend the Medically Dependent Children Program (MDCP) to create a nursing facility diversion target group for children with medical fragility who are at imminent risk of nursing facility admission. NOTE: Currently it is the only program that requires institutionalization through a nursing facility to access crisis diversion slots through Medicaid. Requiring that this population be exposed to additional risks by staying in a nursing facility for up to 30 days puts the medically fragile child at risk.

8. Explore opportunities for Direct Service Workers/attendants to work remotely, virtually or off-site to the extent allowed by federal regulations particularly during a PHE or other federal, state or local declared disaster or public emergency. Consider options for Day Habilitation, habilitation activities and E.
9. Develop televisit options for the provision of some attendant and habilitation services for persons with IDD. NOTE: There are some services that attendants can provide during a crisis such as teaching and verbally prompting a person through the completion of tasks such as doing the laundry or making a meal.

Recommendations to Guide Future Disaster Response

1. During an emergency or disaster, allow CDS employers of record to be the providers of CFC services, unless the individual is their own CDS employer of record. Currently this is not allowed in the CDS option. This change would keep individuals safe by limiting the number of people coming into the home as well as assist with the recruitment and retention of direct service providers. CDS employers of record are age 18 or older, meet all required screening requirements, and provide CFC services to adult persons with IDD. Parents of minor children and spouses are not eligible to be CDS employers of record.
2. To hasten the employment process in both of the instances addressed above as Recommendations 1 and 2 to Gain Efficiencies, allow flexibilities for the new employee training requirements for family members of the individuals receiving services during an emergency or disaster. These would be the same flexibilities in place for all programs in regard to the crisis. Flexibilities may include allowance for a tele-education model for training or delaying deadlines or timeframes for the training requirement.
3. Include IDD providers and CDS employers on the list of essential providers who need PPE to ensure they get the PPE needed during COVID-19 and any other PHE.
4. Include a communication plan within the person-centered plan that explains how a person communicates their needs in the event that the person is separated from their primary care provider due to hospitalization or other circumstance.

5. Extend all Medicaid waiver plans of care, level of care assessments, and CFC assessments expiring during the pandemic by one year as allowed by the state's CMS approved Appendix K submissions. This will allow Medicaid recipients in waiver programs to continue to receive services while protecting them from unnecessary exposure from waiver or assessment providers.
6. Require Medicaid managed care health plans to expand their emergency disaster plans to include situations such as a pandemic rather than only natural disasters such as hurricanes.
7. Screen for early detection and identification of abuse and neglect during times of crisis.
8. Allow the use of on-line CPR training and certification such as the training offered by the American Heart Association during and beyond the COVID-19 PHE. HHSC should allow for modifications to CPR training and certification requirements in all Medicaid waivers to allow for easier onboarding of new employees and easier recertification of existing employees during a PHE.
9. Disallow the reduction in waiver eligibilities, services or budgets if persons are temporarily under-utilizing the services in their plans due to emergencies or pandemics like COVID-19.
10. Increase and expedite access to and enrollment in IDD 1915 (c) waivers, MDCP and STAR+PLUS HCBS to avoid admission to and provide transition from institutions during local, regional, or statewide disasters.
11. Improve timely dissemination of information about vaccines and timely access to vaccinations. Review and expand who can obtain and administer vaccines.
12. Ensure standards of care do not discriminate or deny access to care and treatment on the basis of disability.

Appendix B: Historical IDD System Redesign Implementation Activities

STAR+PLUS Transition

STAR+PLUS is a Texas Medicaid managed care program specifically designed to meet the health care and support needs of adults who are 65 and older or have a disability. STAR+PLUS members receive a full package of acute health care benefits, along with LTSS (for those who are not receiving LTSS through an IDD waiver program) and service coordination. In September 2014, many adults with IDD transitioned from Medicaid FFS to the STAR+PLUS managed care program for their acute care services.

In fiscal year 2020, an average of 565,697 individuals were enrolled in STAR+PLUS each month. Of that total, approximately 16,778 individuals were also enrolled in an IDD waiver or ICF/IID each month.

Eligibility

Adults with IDD receiving IDD waiver or ICF/IID services are eligible for STAR+PLUS for their regular health care (also called “acute care”) benefits if they:

- Participate in the CLASS, HCS, TxHmL, or DBMD waiver programs; or
- Are in a community-based ICF/IID and not a SSLC; and
- Do not receive Medicare Part B, in addition to Medicaid benefits. Individuals who receive Medicare Part B as well as Medicaid are dually eligible and receive their acute care services through Medicare.

Services

Adults with IDD receiving IDD waiver or ICF/IID services who are in STAR+PLUS receive acute care services through one of five Medicaid MCOs contracted to operate the program. These adults continue to receive LTSS services through FFS.

STAR Kids Transition

STAR Kids is the Texas Medicaid managed care program for children and adults ages 20 and younger who have disabilities. STAR Kids members receive a full

package of acute health care benefits, along with LTSS (for those who are not receiving LTSS through an IDD waiver program). In alignment with the requirements in Texas Government Code, Section 534.051, STAR Kids provides person-centered service coordination for children with disabilities and their families to support their needs related to health and independent living.²⁵

In fiscal year 2020, an average of 159,764 eligible children and young adults were enrolled in STAR Kids each month. Of that total, an average of 4,392 eligible children and young adults were enrolled in an IDD waiver or community-based ICF/IID each month.

Eligibility

Children and young adults under the age of 21 with disabilities are eligible for STAR Kids if they:

- Receive SSI;
- Receive SSI and Medicare;
- Receive services through MDCP waiver;
- Live in an ICF/IID or nursing facility;
- Receive services through a Medicaid Buy-In program;
- Receive services through the Youth Empowerment Services (YES) waiver; or
- Receive services through the following waiver programs:
 - ▶ CLASS;
 - ▶ HCS;
 - ▶ TxHmL; or
 - ▶ DBMD.

Services

Children and young adults in STAR Kids receive acute care services and some Medicaid state plan LTSS and CCP services, such as private duty nursing and personal care services, through one of nine Medicaid MCOs contracted to operate

²⁵ <https://hhs.texas.gov/services/health/medicaid-chip/programs/star-kids>

the program. Children and young adults receiving IDD waiver or ICF/IID services continue to receive LTSS services, including CFC, through FFS.

STAR Health

STAR Health is the Medicaid managed care program for children and young adults in DFPS conservatorship and children and young adults who are transitioning out of conservatorship.²⁶ STAR Health is a statewide program that began April 1, 2008.

STAR Health members receive a full package of health care and dental benefits, along with LTSS (for those who are not receiving LTSS through an IDD waiver program). STAR Health provides the same LTSS as STAR Kids. Superior Health Plan is the single MCO serving all children in STAR Health.

In fiscal year 2020, an average of 34,512 children and young adults were enrolled in STAR Health each month. Of that total, approximately 139 were enrolled in an IDD waiver or community-based ICF/IID each month.

Community First Choice

In June 2015, the CFC option became available for Texans, expanding basic attendant and habilitation services to individuals with disabilities meeting the criteria for an institutional level of care. Federal law allows the CFC option under Section 1915(k) of the Social Security Act. CFC services are provided in home and community-based settings. Services are not time- or age-limited and continue as long as an eligible individual needs services and resides in their own home or another family home setting.

Eligibility

Individuals may be eligible for CFC services if they:

- Are eligible for Medicaid;
- Meet criteria for an institutional level of care;²⁷ and
- Have functional needs that can be addressed by CFC services.

²⁶ https://www.dfps.state.tx.us/Child_Protection/Medical_Services/

²⁷ Meeting an institutional level of care means needing the level of care provided in a nursing facility, ICF/IID, or Institution for Mental Disease.

Services

CFC services are provided by LTSS providers, including home and community support services agencies and service provider agencies for the IDD waiver programs. CFC services include:

- PAS
- HAB
- Emergency response services
- Support management

CFC for Non-Waiver Recipients

CFC provides an opportunity for people with IDD who are not currently receiving services in an IDD waiver to receive personal assistance and habilitation services. Eligible Medicaid beneficiaries no longer must wait to receive these services through the waiver programs, which have interest lists with wait times ranging from one to 16 years depending on the waiver program. In fiscal year 2020, a total of 104,207 individuals were concurrently enrolled in Medicaid and on the HCS, TxHmL, CLASS, and/or DBMD interest lists.²⁸

Individuals may be on multiple interest lists at any given time, meaning that there is duplication across interest lists, and eligibility for waiver services is not assessed at the time people are added to the interest list. There are also people on the interest lists who have not been determined to be Medicaid eligible.

MCOs began using new procedure code combinations for STAR+PLUS PAS and CFC services on September 1, 2019. Due to this change, HHSC anticipates improved CFC reporting accuracy in the future. This more accurate reporting reflects a higher number of people receiving CFC services in managed care. In fiscal year 2019, there were an average of 1,478 non-waiver recipients receiving CFC services each month through STAR+PLUS. In fiscal year 2020, there were an average of 1,963 non-waiver recipients receiving CFC services each month through STAR+PLUS.

In fiscal year 2020, there were an average of 3,762 non-waiver recipients receiving CFC services each month through STAR, STAR Kids, STAR Health, STAR+PLUS and

²⁸ Unduplicated total of individuals on HCS, TxHmL, CLASS and DBMD interest lists in fiscal year 2020 with concurrent Medicaid eligibility in TIERS.

the Dual Demonstration.²⁹ These individuals meet at least one of the eligibility criteria for institutional services: nursing facility, ICF/IID, or Institution for Mental Disease. Table 1 below shows the average monthly enrollment for non-waiver recipients by age group, and unduplicated CFC services provided in state fiscal year 2020.

Due to COVID-19 challenges, HHSC has temporarily allowed for: extensions to existing prior authorizations, renewals of ID/RC assessments, and a temporary suspension of in-person service coordination visits.

Additionally, HHSC instituted a temporary policy change allowing service providers of CFC PAS/HAB to live in the same residence as an individual receiving HCS and TxHmL program services to provide needed services for individuals living in their own or family’s home as the PHE continues.

Table 1. Average Monthly Enrollment for Non-Waiver Recipients by Age Group, and Unduplicated CFC Services Provided in Fiscal Year 2020³⁰

Program	Age Group³¹	Average Monthly Unduplicated Program Enrollment³²	Average Monthly Unduplicated Individuals Utilizing CFC Services³³
STAR³⁴	0-20	N/A	133
STAR Kids	0-20	147,723	1,384
STAR Kids	21+	433	11

²⁹ The Dual Eligible Integrated Care Demonstration Project, or Dual Demonstration, is a fully integrated managed care model for individuals age 21 and older who are dually eligible for Medicare and Medicaid and required to be enrolled in the STAR+PLUS program. This capitated model involves a three-party contract between an MCO with an existing STAR+PLUS contract, HHSC, and CMS for the provision of the full array of Medicaid and Medicare services. The Dual Demonstration operates in six Texas counties.

³⁰ Beginning September 1, 2019, new codes were used by MCOs, that improved CFC reporting accuracy.

³¹ An individual was counted as under 21 through the end of the month of their 21st birthday.

³² The average enrollment column does not include members concurrently enrolled in a waiver, ICF/IID, or nursing facility. The STAR Kids, STAR Health, STAR+PLUS, and Dual Demonstration average enrollment numbers do not match the numbers in the body of the text because earlier enrollment numbers represent the entire managed care program, including members in nursing facilities, ICFs/IID, or receiving services through a waiver.

³³ CFC utilization counts for all managed care programs (excluding STAR) based on encounter records from the TMHP Vision 21 Enc. Best Picture universe. All counts are unduplicated by client Medicaid number.

³⁴ CFC utilization counts for STAR based on acute care FFS claims (CFC is carved out of managed care for children in STAR). All counts are unduplicated by client Medicaid number. Further, all STAR participants are not eligible for CFC. For all other programs represented in the report, all clients under each program are potentially eligible for CFC services.

Program	Age Group ³¹	Average Monthly Unduplicated Program Enrollment ³²	Average Monthly Unduplicated Individuals Utilizing CFC Services ³³
STAR Health	0-20	34,489	121
STAR Health	21+	23	0
STAR+PLUS	0-20	4	0
STAR+PLUS	21+	400,814	1,963
Dual Demonstration	21+	30,612	150
All Programs Combined, Ages 0-20	0-20	182,216	1,638
All Programs Combined, Ages 21+	21+	431,882	2,124
All Programs Combined, All Ages	All ages	614,098	3,762

CFC for Waiver Recipients

HCBS 1915(c) waivers allow states to provide HCBS as an alternative for people who meet eligibility criteria for care in an institution (nursing facility, ICF/IID, or hospital). The STAR+PLUS HCBS program allows Texas to operate and expand Medicaid managed care by providing acute health care and LTSS, including HCBS, as an alternative to residing in a nursing facility. Individuals in Texas receive CFC services through both 1915(c) waivers and the STAR+PLUS HCBS program.³⁵ CFC for waiver recipients is presented below based on the type of institutional level of care.

Intermediate Care Facility – Level of Care

The HCS, TxHmL, CLASS, and DBMD waivers provide HCBS as an alternative to residing in an ICF. As outlined in Table 2, an average of 38,912 individuals with IDD were enrolled in the four IDD waiver programs each month during fiscal year 2020, with nearly three-quarters of the individuals served enrolled in HCS.

CFC services were utilized at the highest rate by all ages in CLASS, with an average of approximately 5,035 individuals in CLASS receiving CFC services each month out of the total 11,361 individuals each month across all four waiver programs.

³⁵ Due to CFC federal income limitations, not all people enrolled in STAR+PLUS HCBS are eligible to receive CFC services. However, the STAR+PLUS HCBS program offers PAS and emergency response services for those persons not eligible for CFC.

Table 2. Average Monthly Enrollment in CLASS by Age Group, and CFC Services Provided by Age Group to Individuals Enrolled in an IDD Waiver in Fiscal Year 2020

Age Group³⁶	Average Monthly Unduplicated Individuals Enrolled in IDD Waivers³⁷	Average Monthly Unduplicated Individuals Utilizing CFC Services³⁸
0-20	1,366	1,171
21+	4,018	3,864
All Ages Combined	5,384	5,035

Table 3. Average Monthly Enrollment in DBMD by Age Group, and CFC Services Provided by Age Group to Individuals Enrolled in an IDD Waiver in Fiscal Year 2020

Age Group	Average Monthly Unduplicated Individuals Enrolled in IDD Waivers	Average Monthly Unduplicated Individuals Utilizing CFC Services
0-20	149	97
21+	198	107
All Ages Combined	347	204

Table 4. Average Monthly Enrollment in HCS by Age Group, and CFC Services Provided by Age Group to Individuals Enrolled in an IDD Waiver in Fiscal Year 2020

Age Group	Average Monthly Unduplicated Individuals Enrolled in IDD Waivers	Average Monthly Unduplicated Individuals Utilizing CFC Services
0-20	1,815	508
21+	25,630	2,186
All Ages Combined	27,445	2,694

Table 5. Average Monthly Enrollment in TxHmL by Age Group, and CFC Services Provided by Age Group to Individuals Enrolled in an IDD Waiver in Fiscal Year 2020

Age Group	Average Monthly Unduplicated Individuals Enrolled in IDD Waivers	Average Monthly Unduplicated Individuals Utilizing CFC Services
0-20	1,146	808
21+	4,590	2,620
All Ages Combined	5,736	3,428

³⁶ An individual was counted as under 21 through the end of the month of their 21st birthday.

³⁷ Enrollment counts for HCS and TxHmL based on data from the CARE system. Enrollment counts for CLASS and DBMD based on data from Service Authorization System. All counts are unduplicated by client Medicaid number.

³⁸ CFC utilization counts for CLASS, DBMD, HCS, and TxHmL based on LTSS FFS claims. All counts are unduplicated by client Medicaid number.

Table 6. Average Monthly Enrollment in All Waivers Combined by Age Group, and CFC Services Provided by Age Group to Individuals Enrolled in an IDD Waiver in Fiscal Year 2020

Age Group	Average Monthly Unduplicated Individuals Enrolled in IDD Waivers	Average Monthly Unduplicated Individuals Utilizing CFC Services
0-20	4,476	2,584
21+	34,436	8,777
All Ages Combined	38,912	11,361

Nursing Facility -Level of Care

MDCP is a 1915(c) waiver that provides HCBS as an alternative to a nursing facility for children and young adults. The STAR+PLUS HCBS and Dual Demonstration HCBS programs operated through the 1115 waiver provide a cost-effective alternative to living in a nursing facility to older adults or adults who have disabilities.

Institution for Mental Disease -Level of Care

YES is a 1915(c) waiver that HCBS to children as an alternative to an institution for mental disease.

As indicated in Table 3, an average of 38,494 individuals received CFC services each month in fiscal year 2020 across MDCP, YES, STAR+PLUS HCBS, and Dual Demonstration HCBS.

Table 7. Average Monthly Enrollment in LOC Nursing Facility & IMD Waivers by Age Group, and CFC Services Provided by Age Group to Individuals Enrolled in Fiscal Year 2020

Program	Age Group ³⁹	Average Monthly Unduplicated Enrollment ⁴⁰	Average monthly Unduplicated Individuals Utilizing CFC Services ⁴¹
MDCP	0-20	5,874	2,224
YES	0-20	1,416	59

³⁹ An individual was counted as under 21 through the end of the month of their 21st birthday.

⁴⁰ Enrollment counts for the YES waiver and all managed care programs based on data from is Prospective Payment System compiled in the HHSC Center for Analytics and Decision Support 8-month eligibility file. All counts are unduplicated by client Medicaid number.

⁴¹ CFC utilization counts for YES waiver and all managed care programs based on encounter records from the TMHP Vision 21 Enc. Best Picture universe. All counts are unduplicated by client Medicaid number.

Program	Age Group³⁹	Average Monthly Unduplicated Enrollment⁴⁰	Average monthly Unduplicated Individuals Utilizing CFC Services⁴¹
STAR+PLUS HCBS	21+	59,486	33,410
Dual Demonstration HCBS	21+	4,567	2,801
All Waivers Combined, Ages 0-20	0-20	7,275	2,275
All Waivers Combined, Ages 21+	21+	64,068	36,219
All Waivers Combined, All Ages	All ages	71,343	38,494

CFC for All Programs

In fiscal year 2020, an average of 53,617 individuals utilized CFC services each month for all programs including waiver and non-waiver recipients. Of the 53,617, 6,497 were 20 years old or younger and 47,120 were 21 years old or older.

Appendix C: Related State and Federal Legislation

State Legislation

Rider 42 Interest List Study

2020-21 General Appropriations Act, H.B. 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 42), directs HHSC to work in consultation and collaboration with the IDD SRAC to conduct a study of the interest lists and develop strategies to eliminate the interest lists for STAR+PLUS HCBS and the HCS, CLASS, DBMD, MDCP, and TxHmL waivers.

As part of the study, HHSC obtained information on the experiences of other states in reducing or eliminating interest lists, identified factors that have affected the interest lists for the five most recent biennia, and gathered existing data on persons on the interest list for each waiver program. Based on the information obtained for the study, HHSC offered strategies and cost estimates for eliminating the interest list for each program.

The 87th Legislature passed the below legislation and rider directing HHSC to take certain actions related to policy and procedures governing the HCBS waiver interest lists:

- H.B. 3720, 87th Legislature, Regular Session, 2021 requires HHSC, in consultation with the IDD SRAC and State Medicaid Managed Care Advisory Committee, to develop a questionnaire to be completed by or on behalf of an individual who requests to be placed on or is currently on an interest list for a waiver program. HHSC is directed to ensure the questionnaire requests specific information such as general demographic information, the individual's living arrangement and types of assistance the individual requires. The bill also directs HHSC to designate an individual's status on an interest list as inactive if the individual or LAR does not respond to written or verbal requests from HHSC to update information concerning the individual. If the individual or LAR contacts HHSC, the individual shall be designated as active and restored to the individual's position on the interest list. A designation of inactive will not result in an individual being removed from the interest list.
- S.B. 1648, 87th Legislature, Regular Session, 2021 requires HHSC, in consultation with the IDD SRAC and STAR Kids Managed Care Advisory Committee, to study the feasibility of creating an online portal for

individuals to request to be placed and check the individual's placement on a Medicaid waiver program interest list. As part of the study, HHSC is directed to determine the most appropriate and cost-effective automated method for determining the LON of an individual seeking services through a Medicaid waiver program. HHSC is directed to prepare and submit a report not later than January 1, 2023 to the governor, lieutenant governor, the speaker of the house of representatives and the standing legislative committees with primary jurisdiction over health and human services summarizing HHSC's findings and conclusions from the study. The bill also directs HHSC to develop a protocol in the Office of the Ombudsman to improve the capture and updating of contact information for an individual who contacts the office regarding Medicaid waiver programs or services.

- The 2022-2023 General Appropriations Act, 87th Legislature, Rider 41 allocated funds to revise the Questionnaire for LTSS Waiver Program Interest Lists and administer the revised questionnaire to all individuals on the waiver interest lists. Rider 41 also directs HHSC using funds appropriated for revision of the questionnaire and administration of the questionnaire to evaluate the use of available technology to create a "no-wrong-door" approach, allowing individuals access to an online portal for requesting interest list placement and providing current interest list questionnaire information.

Senate Bill 50: Employment Initiative

The 87th Texas Legislature passed S.B. 50 to bolster the state's EF policy, set forth in Section 531.02447, Government Code, S.B. 50 requires HHSC to develop a uniform process to assess competitive and integrated employment goals and opportunities available to people in the IDD waivers and STAR+PLUS HCBS and use those identified goals and opportunities to direct plans of care.

The bill also requires HHSC to identify strategies to increase the number of people receiving employment services through waiver programs and TWC programs, set targeted increases in those numbers, and report on the progress and status every two years to the governor and legislature.

Federal Legislation

American Rescue Plan Act of 2021

The American Rescue Plan Act of 2021, an economic stimulus bill to speed up recovery from the COVID-19 pandemic, was signed into law on March 11, 2021.

Section 9817 of the American Rescue Plan Act of 2021 provides states with a time-limited 10 percent enhanced FMAP for Medicaid HCBS as well as a number of state plan services. The enhanced FMAP must be used to supplement, rather than supplant, enhancements to a state’s HCBS programs and services. States can claim the enhanced FMAP during the period beginning April 1, 2021 and ending on March 31, 2022. To claim the funds, states must submit a spending plan to CMS with an accompanying narrative that attests the state meets maintenance of effort requirements and a commitment to supplement rather than supplant state funds and explain how the state intends to sustain the activities beyond March 31, 2024.

HHSC submitted a proposal for expending the enhanced FMAP funding on July 12, 2021⁴². The proposal contained 22 activities, which were developed collaboration with internal program experts, as well as submissions from external stakeholders. Proposals fall under the following broad categories: supporting providers, supporting HCBS enrollees, and enhancing and strengthening the state’s HCBS infrastructure.

⁴² <https://www.hhs.texas.gov/sites/default/files/documents/govdelivery/arpa-hcbs-funding-plan.pdf>