



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

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

**Texas Health and Human Services  
September 2023**



**TEXAS**  
Health and Human  
Services

# Table of Contents

<b>Executive Summary .....</b>	<b>1</b>
<b>1. Introduction .....</b>	<b>2</b>
<b>2. Background .....</b>	<b>3</b>
<b>3. Implementation Activities .....</b>	<b>5</b>
STAR+PLUS Pilot Program.....	5
Information Technology Modernization .....	6
Employment First .....	7
Critical Incident Management System .....	7
Interest List Questionnaire .....	8
<b>4. Effects on the System .....</b>	<b>9</b>
Complaints, Appeals, and Fair Hearings.....	9
Requirements for MCOs .....	9
Office of the Ombudsman .....	12
<b>5. Initiatives to Improve Access and Outcomes.....</b>	<b>13</b>
Person-Centered Planning .....	13
IDD Assessment Tool Pilot.....	15
HCBS Services Settings Requirements.....	16
Transition of Day Habilitation Services .....	17
<b>6. Promoting Independence and Preventing Institutionalization .....</b>	<b>19</b>
Money Follows the Person Demonstration .....	19
Crisis Intervention and Crisis Respite Services.....	22
<b>7. IDD System Redesign Advisory Committee.....</b>	<b>23</b>
<b>8. Challenges and Areas for Further Consideration.....</b>	<b>25</b>
Attendant Workforce .....	25
Improving the Electronic Visit Verification System .....	27
<b>Conclusion .....</b>	<b>31</b>
<b>List of Acronyms .....</b>	<b>32</b>
<b>Appendix A. IDD System Redesign Advisory Committee Recommend .....</b>	<b>A-1</b>
Transition to Managed Care Subcommittee .....	A-1
Meaningful Skills Development and Employment Services Subcommittee .....	A-33
System Adequacy Subcommittee .....	A-39
<b>Appendix B. Historical IDD System Redesign Implementation Activities. B-1</b>	

STAR+PLUS Transition .....	B-1
Eligibility .....	B-1
Services .....	B-1
STAR Kids .....	B-2
Eligibility .....	B-2
Services .....	B-2
STAR Health .....	B-3
Community First Choice (CFC) .....	B-3
CFC Eligibility .....	B-3
CFC Services.....	B-4
CFC for Non-Waiver Recipients.....	B-4
CFC for Waiver Recipients .....	B-5
Intermediate Care Facility – Level of Care.....	B-6
Nursing Facility Level of Care.....	B-8
Institution for Mental Disease Level of Care .....	B-8
<b>Appendix C. Related State and Federal Legislation .....</b>	<b>C-1</b>
State Legislation.....	C-1
Federal Legislation .....	C-2

# 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 Texas 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. HHSC is also required under this statute to implement the federal Community First Choice (CFC) option. Chapter 534 also created the IDD System Redesign Advisory Committee (IDD SRAC) to advise HHSC in the development and implementation of the system redesign. This report provides an overview of the work HHSC and the IDD SRAC completed in 2022 to further progress towards achieving the goals laid out in statute.

Since 2019, HHSC has collaborated with the IDD SRAC and STAR+PLUS Pilot Program Workgroup (SP3W) to design the STAR+PLUS Pilot Program (SP3) and operationalize the design. The 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023, does not include a specific appropriation to operate SP3. HHSC is unable to implement SP3 without an appropriation. Additional details can be found in this report.

# 1. 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 the goals 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.

Section 534.112, added by House Bill (H.B.) 4533, 86th Legislature, Regular Session, 2019, requires HHSC, in collaboration with the IDD SRAC and SP3W, to report by September 1, 2026, an analysis and evaluation of the SP3 and recommendations for improvement. Because HHSC is unable to implement SP3 without an appropriation, work on the SP3 has stopped. Additional details can be found in the “Implementation Activities” section of this report.

## 2. 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 several important goals that are outlined in the code.

H.B. 4533, 86th Legislature, Regular Session, 2019, amends Government Code Chapter 534 and outlines two stages for the transition of LTSS. [Stage one](#)<sup>a</sup> directs the following activities related to the SP3:

- Development and implementation of SP3 in phases, beginning 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 the SP3W to assist with developing and advising HHSC on the operation of the SP3;
- Coordination and collaboration throughout development and implementation of the SP3 with the IDD SRAC and the SP3W; and
- A dental evaluation to determine the most cost-effective dental services for SP3 participants.

Stage one also includes the managed care carve-in of acute care services for most individuals in a home and community-based services (HCBS) waiver serving individuals with IDD. This was completed in 2014.

[Stage two](#)<sup>b</sup> includes development and implementation of a plan to transition all or a portion of LTSS provided through community-based intermediate care facilities for individuals with intellectual disabilities (ICF/IID) or a Medicaid waiver program to a Medicaid managed care model.

The results of stage one must be used to inform the development and implementation of 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-

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<sup>a</sup> See Texas Government Code, Chapter 534, SUBCHAPTER C for stage one requirements.

<sup>b</sup> See Texas Government Code, Chapter 534, SUBCHAPTER E for stage two requirements.

residential Home and Community-based Services (HCS) and Deaf Blind with Multiple Disabilities (DBMD) services by September 1, 2031. HHSC must conduct a second SP3 to evaluate the feasibility and cost efficiency of transitioning HCS and DBMD residential services and community-based ICF/IID services to managed care.

The 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023, did not include a specific appropriation to operate SP3. HHSC is unable to implement SP3 without an appropriation. Additional details can be found in the body of this report.

### 3. Implementation Activities

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

#### **STAR+PLUS Pilot Program**

Texas Government Code, Chapter 534, Subchapter C directs the SP3W to advise HHSC in collaboration with the IDD SRAC in developing, operating, and evaluating the SP3. Over the past year HHSC continued work with internal workgroups comprised of multiple departments across HHSC, cross-agency staff, and the IDD SRAC and SP3W to operationalize key design elements of the SP3 and finalize needed systems to support enrollment, person-centered service planning and delivery, and regulatory oversight.

Prior to the 88th legislative session, HHSC submitted an exceptional item requesting funding for SP3 participant services and administrative costs. However, the final budget from the 88th Texas Legislature does not include a specific appropriation to operate SP3. HHSC is not able to move forward with implementing SP3 without an appropriation. Based on the statutory direction, a pilot must be implemented before HHSC can move forward with transitioning some or all LTSS for individuals with IDD to managed care. HHSC is completing SP3 project closeout activities to finish work that may be used in the future and to archive all decisions, documents, and stakeholder collaboration.

The June 1, 2023, meeting was the last joint meeting of the IDD SRAC and SP3W to discuss the SP3, and there will be no further SP3W meetings (full or subcommittee) scheduled because the statutory charge of the workgroup was solely focused on SP3.

HHSC's implementation and planning efforts for the SP3 included:

- Established the SP3W, developed and implemented a SP3 statewide stakeholder engagement plan, and collaborated with the SP3W and IDD SRAC during ongoing bi-monthly subcommittee meetings and quarterly full meetings.
- Determined proposed SP3 design in collaboration with IDD SRAC and SP3W including needs-based eligibility criteria and target groups; service array and service descriptions; alternative payment methodologies; roles and

responsibilities for service coordination and providers; outreach and education plan for SP3 participants and providers; and modifications to consumer-directed services (CDS) to increase access and use.

- Drafted and posted SP3 contractual requirements in Exhibit G of the STAR+PLUS Request for Proposal.
- Designated SP3 service area as Bexar managed care service and backup service areas as Medicaid Rural Service Area Northeast and Tarrant.
- Identified and pursued the use of the International Resident Assessment Instrument Intellectual Disability (interRAI ID) and corrective action plan as the functional needs-based assessment and the My Life Plan as the person-centered planning (PCP) tool.
- Contracted with the external quality review organization (EQRO) to conduct the evaluation and collaborated on the evaluation protocols.
- Pursued a new contract for an interRAI ID software vendor and contract amendments to support systems changes required for SP3 operation.
- Held monthly meetings with the Centers for Medicare & Medicaid Services (CMS) regarding federal authority and operation of the SP3.
- Collaborated with stakeholders to determine a model for comprehensive LTSS providers in managed care.
- Developed systems needed to support SP3 eligibility and enrollment, person-centered service planning and delivery, and regulatory oversight.
- Completed a dental study required by H.B. 4533 to inform dental benefits for SP3 participants.

## **Information Technology Modernization**

An exceptional item for Information Technology modernization was funded during the 86th Legislature to support the future transition of the IDD waiver programs into managed care. The first phase of this transition was deployed May 1, 2022, 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. Details of the implementation and system changes were announced via the Texas Medicaid and Healthcare Partnership (TMHP) website. Training and support continue as needed for this migration. The second phase includes two deployments. The first release occurred December 2022. The final release,

continuing the transition of IDD Waivers programs (HCS and TxHmL) into managed care, implemented July 1, 2023.

## **Employment First**

Senate Bill 50, 87th Legislature, Regular Session, 2021, bolsters the state's Employment First policy, set forth in Section 531.02448, Government Code, by requiring 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 to use those identified goals and opportunities to direct plans of care. HHSC has developed and published the Employment First Uniform Assessment Tool to address the uniform process for assessing employment goals and using goals in the service planning process. HHSC has also developed rules to codify provisions of Senate Bill 50 relating to the employment initiative.

The initial roll-out of the Employment First Uniform Assessment Tool is for voluntary use by waiver case managers and service coordinators. HHSC intends to use feedback received during this period along with information collected during the rule public comment period to adjust the tool as necessary and appropriate, with a final version deploying for mandatory use coinciding with adoption of the rules in fall 2023.

In partnership with Texas Workforce Commission (TWC), HHSC continues to collect data to determine the number of Medicaid waiver members who are receiving employment services. The data includes whether the employment services are provided by TWC, through the waiver program in which an individual is enrolled, or both. This data will inform a report submitted to the Governor, Lieutenant Governor, Speaker of the Texas House of Representatives, and Legislature beginning in 2024.

## **Critical Incident Management System**

The Critical Incident Management System (CIMS) allows HHSC to monitor, track, and trend critical incidents that occur in the delivery of 1915(c) waiver services and, ultimately, managed long-term services and supports (MLTSS). Critical incidents include abuse, neglect, and exploitation as well as law enforcement involvement with an individual, emergency room visits, hospital admissions, serious injuries, medication errors, deaths, elopement or lost and missing persons, seclusions, and restraints.

As of November 1, 2022, CLASS, HCS, DBMD, and TxHmL, waiver providers are required to use CIMS to report critical incidents to HHSC. Local intellectual and developmental disability authorities (LIDDAs) also use CIMS to record critical incidents involving individuals receiving general revenue (GR)-funded services. MLTSS waiver providers are expected to be added for CIMS utilization in year 2024. MLTSS managed care organizations (MCOs) currently report critical incidents into an MLTSS specific reporting system.

## **Interest List Questionnaire**

H.B. 3720, Section 2 (87th Legislature, Regular Session, 2021) requires HHSC to consult with the IDD SRAC and State Medicaid Managed Care Advisory Committee to develop the interest list questionnaire with certain minimum information. HHSC will implement this project by:

- Updating Community Services Interest List application and Questionnaire for LTSS Waiver Program Interest Lists, form 8577, with revised questionnaire elements.
- Gathering input from the IDD SRAC external stakeholders for questionnaire element inputs.
- Developing a plan for the administration of the revised questionnaire to existing individuals on interest lists.
- Creating an annual IDD SRAC report with active and inactive statistics.

HHSC gathered input on the revisions to the questionnaire from external stakeholders and IDD SRAC in December 2022. The Questionnaire for LTSS Waiver Program Interest Lists, Form 8577, updates were completed in March 2023. The new version is available on the HHSC website. The updates to Community Services Interest List and the annual report with active and inactive statistics were completed in August 2023.

## 4. 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.

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. 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.

### 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,<sup>c</sup> and, may file an

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<sup>c</sup> 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.

appeal with their MCO if they are dissatisfied with an adverse benefit determination taken by the MCO.

Table 1 below shows the average monthly number of individuals in an IDD waiver or ICF/IID compared to the number of complaints from these members, regarding acute care, received in fiscal year 2022 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 2022 regarding Acute Care**

<b>Managed Care Program</b>	<b>Average Monthly Number of Individuals Receiving Services who were in an IDD Waiver or ICF/IID</b>	<b>Number of Acute Care Complaints Received by Members in an IDD Waiver or ICF/IID in Fiscal Year 2022</b>
<b>STAR+PLUS</b>	18,312	253
<b>STAR Kids</b>	4,218	103
<b>STAR Health</b>	209	3

**Source: TexConnect – MCO self-reported data**

The top two reasons for complaints from members in an IDD waiver or ICF/IID across managed care programs in fiscal year 2022 were access to care and quality of care. The third reason was a combination of prescription related issues and customer service. All reasons for complaints in fiscal year 2022 from members in an IDD waiver are listed below.

- Access to care
- Access to durable medical equipment
- Balance billing
- Behavioral health
- Claims payment
- Customer service
- Diagnostic testing/imaging/lab
- Electronic visit verification (EVV)
- Home health
- Medical transportation
- Office visit
- Pain management

- Pharmacy/prescription services
- Policies and procedures
- Quality of care
- Value-added services
- Suspected fraud, waste, or abuse

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: Appeal Outcomes for Recipients in an IDD Waiver or ICF/IID Enrolled in STAR+PLUS, STAR Kids, and STAR Health in Fiscal Year 2022**

<b>Program</b>	<b>Total Number of Acute Care Appeals Filed</b>	<b>Number of Appeals Upheld by MCO</b>	<b>Number of Appeals Overturned by MCO</b>	<b>Number of Appeals Withdrawn by Member</b>
<b>STAR+PLUS</b>	396	222	163	11
<b>STAR Kids</b>	271	113	155	2
<b>STAR Health</b>	22	6	15	1
<b>Total</b>	<b>689</b>	<b>341</b>	<b>333</b>	<b>14</b>

**Data Source: TexConnect – MCO self-reported data**

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 2022 for members enrolled in an IDD waiver or ICF/IID were related to therapies, durable medical equipment, and home health (including personal care services and private duty nursing). All reasons for state fair hearings in 2022 for members enrolled in an IDD waiver related to reduction or denial of services and supports are listed below.

- Access and Availability
- Clinically-administered drugs
- Dental
- Durable medical equipment
- Health plan eligibility

- Home health
- Medical
- Personal care services
- Private duty nursing
- Therapy services

## Office of the Ombudsman

The Office of the Ombudsman received 51 complaints, nine substantiated<sup>d</sup> and 42 unsubstantiated<sup>e</sup> or unable to substantiate<sup>f</sup>, in fiscal year 2022 for STAR+PLUS and STAR Kids members enrolled in an IDD waiver. Access to care and therapy were the primary general complaint categories. All general complaint categories received are listed below.

- Access to care (31)
- Claims and payment (3)
- Customer service (1)
- Member enrollment (1)
- Policies and procedures (2)
- Prescription services (4)
- Quality of care (1)
- Therapy (8)

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<sup>d</sup> A substantiated complaint is a complaint for which research clearly indicates HHS policy was violated or HHS expectations were not met.

<sup>e</sup> An unsubstantiated complaint is a complaint for which research clearly indicates HHS policy was not violated or HHS expectations were met.

<sup>f</sup> An unable to substantiate complaint is a complaint for which research does not clearly indicate HHS policy was violated or HHS expectations were not met.

## 5. Initiatives to Improve Access and Outcomes

For details on past HHSC initiatives to improve access and outcome, see the [2022 Implementation of Acute Care Services and Long-term Services and Supports System Redesign for Individuals with an Intellectual or Developmental Disability](#) report.

### Person-Centered Planning

In 2022, the Office of Disability Services Coordination took the lead on systemic integration of PCP values and initiatives. HHSC continues to use the PCP Steering Committee, which is composed of internal and external partners, as the primary resource for sharing, developing, and informing PCP initiatives and projects across the agency.

Since the last report, HHS has made the following progress to strengthen and infuse person centered practices:

- Hosted a panel discussion at the Annual Judicial Commission of Mental Health regarding, Dignity of Risk: Decision Making Supports for People with IDD or Cognitive Impairment. This panel spotlighted procedures and policies within the HHS system that align with person-centered approaches. Participants included HHS staff and Disability Rights Texas.
- Continued to build person-centered thinking (PCT) training infrastructure and capacity. 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 (TLCPCP) have collaborated to certify more trainers. HHSC expanded its capacity to provide PCT training to LIDDA staff as well as certify additional PCT trainers.
- Implemented an online training entitled "Documentation of Outcomes in Person-Centered Plans". This computer-based training provides guidance to service coordinators to connect the dots between gathering discovery information and developing outcomes for people receiving IDD services. The training also reinforces the PCT skills taught in the required PCT training.

- Secured a grant through the Administration of Community Living that entails investigation and evaluation of the state’s No Wrong Door System. A component of this project is to assess person-centered counselingg in various “doors” against the Administration of Community Living tool, “Key Elements of a NWD System of Access to LTSS for All Populations and All Payers”. This is being completed by representatives from the LIDDA, Area Agencies on Aging, Aging Disability Resource Centers, Centers for Independent Living, MCO, Community Care Services & Eligibility, and 2-1-1 networks.
- Provided individual training presentations and policy consultations for various HHSC program staff upon request. During this reporting period, the Office of Disability Services Coordination provided support to the financial management services agency (FMSA) enrollment team, Child Protective Services Division of the Department of Family and Protective Services, HHS Human Resources, and behavioral health policy development staff.
- Promoted awareness of PCP and resources at various conferences including the HCBS-Adult Mental Health Best Practices Conference and the Annual Brain Injury Awareness Conference.
- Finalized the My Life Plan, a person-directed discovery tool intended to be utilized within the SP3 pilot. Developed and reviewed an instruction guide with IDD stakeholders and worked to build this new form within the LIDDA electronic health record. Although SP3 was not funded in the most recent legislative session, HHSC will review the framework and determine future steps that may include accompanying tools, guidance, rules, policies, and procedures, including adaptations for use with all HHSC populations.

#### Accomplishments and efforts of the PCP Steering Committee:

- Collaborated with the National Center on Advancement of Person-Centered Practices and Systems and The Learning Community (TLC) to host a nine-segment webinar for various members of HHSC leadership to spotlight and inform on PCP efforts and recommendations identified by the PCP Steering Committee.
- Completed final review by HHS and TWC of the employment crosswalk, an internal navigation tool for staff who support individuals that may be receiving services through both agencies to achieve their employment goals.

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<sup>9</sup> This term was coined by the Administration of Community Living and aligns with the CMS definition and scope.

- Collaborated with TLCPCP to develop 'Texas Stories', a project that tailors the principles of PCT training to specific populations to increase impact and applicability of PCP. Stories were created for people who may have experienced a brain and spinal cord injury and children who are being supported by Child Protective Services. These stories are available to all certified PCT trainers at HHS and align with the TLCPCP.
- Developed a PCP training video for all new HHSC employees. This video is available on the National Center on Advancement of Person-Centered Practices and Systems website.
- Initiated development of a PCP mapping project to identify key internal and external stakeholders, referred to as "PCP Champions." The PCP Champions participate in and empower all people to advance the continued growth and development of person-centered thinking, planning and practices.

HHS continues to track PCP initiatives and best practices trends at an agency, state, and national level to inform future efforts in advancing person-centered thinking, planning and practices.

## **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 appropriate 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). As part of the initial planning activities for the pilot, HHSC researched nationally recognized comprehensive assessment instruments for individuals with IDD and obtained input from external stakeholders.

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

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. HHSC secured Money Follows the Person grant funding in April 2021 and May 2022 for the development of a resource allocation algorithm. In March 2022, HHSC contracted with a Texas university to develop the algorithm. The resource allocation algorithm for the interRAI ID assessment was developed in conjunction with a stakeholder workgroup established by HHSC. The resource allocation algorithm was validated by comparing the level of need (LON) determined by the interRAI ID versus the Inventory for Client and Agency Planning for a designated sample, using the assessments gathered during previous phases of the pilot. LON categories were evaluated in conjunction with the stakeholder workgroup. The results of the comparison are being assessed to understand impact of a statewide rollout of the interRAI ID. Statewide rollout would require an appropriation from the Legislature.

## **HCBS Services Settings Requirements**

In March 2014, CMS issued the federal HCBS settings rule, which adds requirements for settings where Medicaid HCBS are provided. The HCBS settings rule supports individuals' rights to:

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

States were required to fully comply with these rules by March 17, 2023. HHSC has promulgated rules for Medicaid IDD waiver programs to align with requirements of the HCBS Settings Rule. This includes rules for HCS and TxHmL which were adopted in December 2022; and rules for CLASS and DBMD adopted in January 2023.

CMS allows states to request a corrective action plan (CAP) for certain requirements of the rule for which the state is not fully compliant as result of the novel coronavirus (COVID-19) public health emergency (PHE). HHSC is currently working

with CMS to develop a CAP for aspects of the HCBS settings rule for which it has not yet achieved full compliance.

CMS also requires states to submit a transition plan describing their planned initiatives and activities to achieve compliance with the federal HCBS settings regulations. The transition plan must include:

- An assessment of settings where Medicaid HCBS are provided.
- Remediation strategies for settings that do not meet the requirements of the regulations.
- A summary of public and stakeholder input on the assessment processes and remediation strategies; and
- A summary of public comments received on the transition plan and any revisions made to the plan in response to public comments
- Individual choice concerning daily activities, physical environment, and social interaction.

Texas submitted an initial statewide transition plan (STP) to CMS in 2014 and has made multiple updates to the plan based on feedback from CMS. HHSC received initial approval of its STP from CMS in December 2022 and final approval in July 2023.

## **Transition of Day Habilitation Services**

As part of HHSC's plan to achieve compliance with the HCBS settings rule, HHSC replaced day habilitation services in HCS, TxHmL, and DBMD waiver programs with a more integrated service that maximizes participation and integration of individuals with IDD in the community as of March 1, 2023. The new, more integrated service is called individualized skills and socialization.

In 2021 the Texas Legislature appropriated approximately \$1.7 million to fund the implementation of individualized skills and socialization. A portion of these appropriations was designated to develop a licensure process of individualized skills and socialization providers to ensure ongoing monitoring and oversight by HHSC Long-Term Care Regulation (LTCR). Individualized skills and socialization providers must apply for a day activity and health services facility license with a special designation for individualized skills and socialization.

Both the programmatic rules and regulatory rules for individualized skills and socialization were effective in January 2023. Day habilitation was officially discontinued as of March 2023 and day services in the HCS, TxHmL, and DBMD Programs have fully transitioned to individualized skills and socialization. Individualized skills and socialization includes both an on-site (center-based) component and an off-site (community-based) component. An in-home component is included in the HCS and TxHmL Programs only for individuals who meet specific requirements. Off-site individualized skills and socialization includes staff ratios to allow staff to provide more individual attention to program participants.

## 6. Promoting Independence and Preventing Institutionalization

### Money Follows the Person Demonstration

The 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.<sup>17</sup> 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 expects to increase the number of eligible participants by making changes to the criteria for eligibility qualifications as follows:

- 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.

The most recent notice of award, dated August 12, 2021, extends Texas 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*<sup>18</sup>, in response to the U.S. Supreme Court ruling in *Olmstead v. Zimring*. Some of the projects are highlighted below.

- Integrated and competitive employment initiatives designed to increase the number of persons with intellectual and developmental disabilities (IDD) in competitive integrated employment. This includes employment recruitment coordinators who work to promote hiring people with IDD; EF coordinators to promote employment in the general workforce; an EF website; and web-based training. MFP funds were also used to allow Texas to establish a membership with a national organization, the State Employment Leadership Network (SELN). The SELN is a membership-based network of state IDD agencies that work together to achieve system improvements, particularly in paid employment for individuals with IDD.

- Texas has 8 regional Transition Support Teams (TSTs), often referred to as "hubs", to serve all 254 Texas counties, including all 39 LIDDAs and the community waiver providers within a designated region. A licensed professional, such as a clinical social worker, serves as each TST coordinator. TSTs include licensed medical staff such as physicians, physician's assistants, nurse practitioners, and registered nurses as well as psychiatrists, psychologists, behavioral specialists, and other professionals who have expertise working with individuals with IDD. These interdisciplinary teams support the LIDDAs and service providers within their designated service areas. These interdisciplinary teams provided the following support services from September 1, 2021, through August 31, 2022:
  - ▶ 1,302 educational and training activities such as webinars, videos, and other correspondence, focused on increasing the expertise of LIDDAs, providers, and community members in supporting individuals with complex needs;
  - ▶ 1,772 instances of technical assistance provided to LIDDAs, program providers, and other community support services on specific disorders and diseases, emerging and best practices, and evidence-based services for individuals with significant challenges; and
  - ▶ 3,351 case consultations and peer reviews provided to service coordinators, crisis intervention staff, direct care staff, and other members of an individual's service planning team who needed assistance providing effective care for an individual.
- LIDDA Enhanced Community Coordination - Enhanced Community Coordination (ECC) is provided by experienced staff from LIDDAs to people with IDD who transition or divert from institutional settings, including SSLCs, nursing facilities, and large and medium ICFs/IID to community settings. ECC strengthens the services and supports for individuals who have both IDD and complex medical or behavioral health needs as they transition or divert to services in community-based settings.
- ECC provides intensive and flexible support delivered in a person-centered manner including pre- and post-transition services, monitoring the person for one year after the transition, and arranging for support needed to prevent and manage a crisis. From September 1, 2021, through August 31, 2022, 3,100 people received ECC.
- MFPD funds transition specialists and a continuity of services specialist at the SSLCs. These specialists provide training to SSLC staff, residents, LARs, and

family members about the community transition process and planning. They serve as a resource for the individual's interdisciplinary team (IDT) to help identify services and supports for individuals in the community, to identify obstacles to community transition, and to develop strategies to mitigate barriers for transitioning. The continuity of services specialist monitors the final community living discharge plan and post-move support to assure quality of services and provides consultation to IDTs for improvement and best practices.

- The Affordable Housing Partnership is a 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, Bexar, Harris, and Travis Counties for qualified individuals receiving or eligible for Medicaid LTSS in the community. The project has contractual agreements with developers of seven housing projects and is on track to create 30 new units for individuals with disabilities transitioning out of institutions. Priority for available units will be designated for individuals transitioning into their communities from nursing facilities or ICFs/IID. Two properties (10 units) have been completed and three are under construction (13 units). Seven units to date have been occupied.
- 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 to create rental assistance opportunities for persons with extremely low incomes who have a disability and are eligible to receive services and supports. MFPD funding supports this housing effort. Texas Section 811 Project Rental Assistance 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 severe mental illness (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.
- The direct service workforce development project supports the implementation of a multi-year strategic plan to improve recruitment and retention of direct service workers. The DSW Taskforce was launched in March 2021 and all project objectives address two primary goals:

- ▶ Goal 1: Enhance Workforce Development; and
- ▶ Goal 2: Improve Data Collection.
- Please see the “Attendant Workforce” section below for more information on this project.

## **Crisis Intervention and Crisis Respite Services**

The 84th Legislature, Regular Session, 2015 allocated \$18.6 million for crisis intervention and crisis respite services. This funding was increased by \$10 million over subsequent sessions, for a total of \$28.6 million 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 provide crisis intervention and crisis respite services to support individuals to maintain independent lives in the community, and to avoid unnecessary institutionalization. During fiscal year 2022, 2,368 individuals were provided therapeutic supports for successful community integration through crisis intervention services and 479 individuals were diverted from institutionalization or hospitalization by receiving crisis respite services. Of these, 416 utilized IDD Crisis Respite, and 63 utilized Mental Health Crisis Respite services.

## 7. 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 (TMC)
- Day Habilitation and Employment Services (DHES)
- System Adequacy (SA)

The IDD SRAC meets quarterly, and subcommittees meet bi-monthly.

Since passage of H.B. 4533, IDD SRAC members have worked with HHSC to organize requirements for the SP3 and prioritize subcommittee work based on the project timeline. The IDD SRAC also partnered with the SP3W to coordinate recommendations and work collaboratively on developing the SP3.

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 2022, in addition to work on the SP3, the IDD SRAC worked to enhance and build upon recommendations for suggested improvements to the service system (whether provided under fee-for-service (FFS) or managed care) for legislative and HHSC consideration. The recommendations address a host of suggested service improvements to:

- Simplify access to dental services
- Education on nonemergency medical transportation benefits
- Create affordable housing options and housing support specialist as a Medicaid waiver benefit
- Improve use of consumer directed services option
- Improve the electronic visit verification system
- Expand capacity for health care services including physician, specialty care, behavioral health, and LTSS services

- Identify and develop acute health care initiatives
- Improve the IDD assessment process
- Develop and implement a regional partnership
- Identify employment and meaningful day goals and increase utilization of employment services
- Improve community access through home and community-based services regulations

## 8. 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.

### Attendant Workforce

Community attendants (also known as direct service workers, personal care assistants, and home health aides) [account for approximately 3,636,900 jobs nationwide and 320,780 in the state of Texas](#). Community attendants play an important role in providing care for older adults and people with disabilities enabling them to complete daily tasks and activities within their homes and community.

The 2020-21 General Appropriations Act, H.B. 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 157) directed 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 Plan for retention and recruitment of community attendants. Many of the strategies described in this plan are being explored through the Direct Service Workforce (DSW) Taskforce.

In pursuit of goal one of the taskforce, *“to enhance workforce development”*, the taskforce has accomplished the following activities to date.

- Dedicated a space on the HHSC website for attendant resources and promotional material.
- Explored recruitment and education models developed by Texas universities for persons with disabilities to join the attendant workforce through programs such as the PATHS certificate and E4Texas.
- Compiled a resource guide for existing training and educational materials for direct care work.
- Researched and compiled recruitment and retention methods from the national level and employed by other states to strengthening their direct care workforce.

- Began collaboration with TWC regarding the viability of developing a senior community service employment program to pay older adults aged 55 and older to be attendants.
- Conducted a comprehensive policy review of CDS policies and how the policies impact the DSW workforce.
- Began a multi-part series of brief documents focusing on various topics related to the workforce.
- Initiated research with the Texas Department of Higher Education regarding promoting the attendant role within The Texas Working Off-Campus: Reinforcing Knowledge and Skills (TXWORKS) Internship Program, a program that provides students with opportunities to build their resumes through paid and professional work experiences aimed at strengthening their career readiness.
- Partnered with ADvancing States, a national entity that supports aging and disability state agencies to innovate and collaborate on the development of Direct Care Careers, a customized, web-based portal for providers and agencies delivering HCBS to recruit and hire attendant positions. This portal launched in Fall 2023.
- Secured grant dollars for Local Workforce Boards, supported by TWC, to fund strategies aimed at improving the recruitment and retainment of the HCBS workforce.

The DSW Taskforce efforts for goal two to “*improve data collection*” include:

- Conducting and publishing a [Community Attendant Survey Report](#), which included demographic information, impacts of the COVID-19 pandemic and strategies to strengthen the attendant workforce.
- Conducting and publishing a pre-survey of the local workforce development board to gauge their perceptions and knowledge of the workforce and the challenges they face.
- Partnering with the TWC to pursue modifications of search count and job placement data.
- Leveraging data reporting elements of the Direct Care Careers Portal to collect additional data points to illustrate statewide needs and trends.

# Improving the Electronic Visit Verification System

## Background

EVV is a computer-based system that electronically documents and verifies service delivery information, such as date, time, service type and location for certain Medicaid service visits. HHSC must comply with the federal Cures Act EVV requirements. Texas HHSC implemented the Cures Act as follows:

- Effective January 1, 2021, program providers must use EVV for Medicaid personal care services, including those services provided through CDS.
- Effective January 1, 2024, program providers must begin to use EVV for Medicaid home health care services.
- Texas Medicaid program providers and FMSAs must ensure that the service attendants, CDS employers and CDS employees use an EVV system to document service visits.
- EVV vendor system: An EVV vendor is an entity contracted with TMHP, the state's Medicaid claims administrator, to provide a cost free EVV system option for program providers and FMSAs contracted with HHSC or an MCO. The program provider or FMSA may select one of the EVV vendors available from the state vendor pool. Visit the TMHP EVV Vendors webpage for additional information about EVV vendors and their systems.
- EVV proprietary system: An HHSC-approved EVV system that a program provider or FMSA may choose to use instead of an EVV vendor system from the state vendor pool.

Service attendants or CDS employees must use one of three approved electronic verification methods to clock in at the beginning of service delivery and clock out at the end of service delivery when providing services to a member in the home or the community.

The EVV vendors offer the following three approved clock in and clock out methods:

- Mobile method (smart phone or tablet): The service attendant or CDS employee may use a mobile method for clocking in and clocking out of the EVV system.

- Home landline: The service attendant or CDS employee may use the member's home phone landline, if the member agrees, for clocking in and clocking out of the EVV system by calling the EVV vendor's or EVV proprietary system operator's toll-free number.
- Alternative device: An alternative device is an HHSC-approved electronic device provided at no cost by an EVV vendor or proprietary system operator, if applicable, that allows the service attendant or CDS employee to clock in and clock out of the EVV system from the member's home.

## **Fiscal Year 2023 EVV Improvements**

During fiscal year 2023, HHSC made the following changes to the EVV systems to add EVV optional services, give service providers and CDS employees access to more visit information, update training, and prepare for the expansion of EVV for the home health care services:

- Updated the list of services that the EVV Systems can capture and manage to include EVV optional services, or non-EVV services. This new capability allows the service attendant or CDS employee to clock in and clock out for each of the services that they deliver, even those that do not require the use of EVV. Program providers, FMSAs and CDS employers may track these non-EVV visits within the EVV system.
- Required EVV vendors to give service providers and CDS employees access to visits that they previously delivered. This allows the service provider or CDS employee to look back on EVV visits and time worked using the EVV mobile application or through an EVV system online web portal.
- Facilitated multiple work sessions with home health care services program providers to identify those CMS-required home health care services that must use EVV starting on January 1, 2024. As part of the development of the EVV list of home health care services, HHSC reviewed and updated service bill codes to ensure program providers can bill in-home/family home visits separately from community-based services and instructed EVV vendors to load home health care services bill codes into the EVV systems.
- Streamlined the process for HHSC to approve a program provider's or FMSA's use of a proprietary EVV system, shortening the time required for a proprietary system operator to adopt or transfer to a proprietary system previously approved by HHSC.

- Updated 508-compliant self-paced EVV policy training on the [HHS Learning Portal](#) for CDS employers to access and complete training using assistive technology such as screen reader programs. This training includes options for videos with audio and closed captioning that require minimal navigation.
- Offering EVV policy training as a webinar with live closed captioning services including an option for CDS employers to attend by telephone only.
- Updated initial EVV policy training for CDS employers on their responsibilities pertaining to EVV, specific to the option the CDS employer selects on Form 1722, Employer’s Selection for Electronic Visit Verification Responsibilities.
- Offering new self-paced training on the [HHS Learning Portal](#) as well as in webinars starting in July-August 2023 on new EVV policies for CDS employers on what to do if the CDS employee fails to clock in, clock out, or both.

## Community First Choice Initiatives

To ensure everyone entitled to receive CFC services can access them, HHSC is exploring the feasibility of the following initiatives to increase the accessibility and utilization of CFC services for those who qualify, including:

- Offering training to MCOs and providers on how to assess, deliver and bill for CFC services;
- 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.

## Public Health Emergency

In March 2020, Congress passed the Families First Coronavirus Response Act, allowing states to receive enhanced federal match provided they maintained continuous coverage for most people enrolled in Medicaid until the end of the federal PHE. The Consolidated Appropriations Act of 2023 separated the continuous Medicaid coverage requirement of the Families First Coronavirus Response Act from the PHE declaration. The requirement to maintain continuous coverage ended as of March 31, 2023. HHSC is now redetermining the eligibility of all Texans receiving Medicaid, in alignment with Texas’ federally approved End of Continuous Medicaid Coverage Mitigation Plan.

Renewals are being processed in three cohorts, first prioritizing redeterminations for those most likely to no longer qualify for Medicaid and maintaining coverage for those remain eligible.

H.B. 4, 87th Legislature, Regular Session, 2021, required HHSC to allow telehealth and telemedicine delivery of services if clinically appropriate and cost-effective. HHSC analyzed the clinical and cost effectiveness of PHE-related flexibilities to align with H.B. 4 requirements and transitioned many state plan and 1915(c) waiver services delivered in the FFS system from temporary PHE flexibilities to permanent policy effective September 1, 2022. HHSC authorized FFS providers to submit claims for reimbursement for synchronous audio-visual delivery for several benefits and services including, but not limited to:

- Behavioral health services and benefits, which included reimbursement for audio-only delivery for many services;
- Many professional and specialized therapy services including speech therapy, occupational therapy, and physical therapy; and
- Certain case management services.

HHSC also authorized telehealth and telemedicine reimbursement for rural health clinics and federally qualified healthcare centers, and reimbursement of patient site fees for telemedicine. Teleservices policies require providers to defer to the needs of the person receiving services, allowing the mode of service delivery to be accessible, person- and family-centered, and primarily driven by the person's choice and not provider convenience.

The federal PHE ended on May 11, 2023, and with that HHSC ended flexibilities to allow remote delivery of comprehensive nursing assessments, and other assessments and case management services where in-person delivery was determined necessary for clinical effectiveness.

## Conclusion

Opportunities exist for systemic improvement, as outlined in the previous sections and appendices of this report. Members of the IDD SRAC have also provided recommendations for consideration in Appendix A. HHSC is committed to continuing to collaborate with stakeholders for Texans with IDD.

In the past year, HHSC has been focused on the development of the SP3 in collaboration with the IDD SRAC and SP3W. While work on SP3 has come to an end, there is still a statutory requirement for a pilot to be completed before the full carve-in of IDD waiver services.

## List of Acronyms

Acronym	Full Name
ADL	Activity of Daily Living
ADS	Analytical Data Store
ALF	Assisted Living Facility
ARPA	American Rescue Plan Act
CAP	Corrective Action Plan
CDS	Consumer-Directed Services
CFC	Community First Choice
C.F.R.	Code of Federal Regulations
CHIP	Children’s Health Insurance Program
CIMS	Critical Incident Management System
CLASS	Community Living Assistance and Support Services
CMS	Centers for Medicare & Medicaid Services
COVID-19	Novel Coronavirus
CPR	Cardiopulmonary Resuscitation
CSP	Comprehensive Service Provider
DADS	Department of Aging and Disability Services
DBMD	Deaf Blind with Multiple Disabilities
DD	Developmental Disability
DFPS	Department of Family and Protective Services
DHES	Day Habilitation and Employment Services
DID	Determination of Intellectual Disability
DSA	Direct Service Agency
DSW	Direct Service Workforce
EA	Employment Assistance
ECC	Enhanced Community Coordination
EF	Employment First
EQRO	External Quality Review Organization
ESP	Employment Services Provider
EVV	Electronic Visit Verification
FFCRA	Families First Coronavirus Response Act
FFS	Fee-for-service
FMAP	Federal Medical Assistance Percentage
GR	General Revenue
H.B.	House Bill
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

<b>Acronym</b>	<b>Full Name</b>
IDD SRAC	Intellectual and Developmental Disabilities System Redesign Advisory Committee
InterRAI ID	International Resident Assessment Instrument Intellectual Disability Assessment
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
MFPD	Money Follows the Person Demonstration
NCAPPS	National Center on Advancement of Person-Centered Practices and Systems
NEMT	Non-Emergency Medical Transportation
PAS	Personal Assistance Services
PCP	Person-Centered Planning
PCT	Person-Centered Thinking
PHE	Public Health Emergency
QAI	Quality Assurance and Improvement
SP3	STAR+PLUS Pilot Program
SP3W	STAR+PLUS Pilot Program Workgroup
SSI	Supplemental Security Income
SSLC	State Supported Living Center
STAR+PLUS	State of Texas Access Reform PLUS
STP	Statewide Transition Plan
SA	System Adequacy
TBI	Traumatic Brain Injury
TEA	Texas Education Agency
TMHP	Texas Medicaid & Healthcare Partnership
TMC	Transition to Managed Care
TWC	Texas Workforce Commission
TxHmL	Texas Home Living

# Appendix A. IDD System Redesign Advisory Committee Recommendations

In 2019 through H.B. 4533, the Texas Legislature directed HHSC to develop a STAR+PLUS Pilot program (SP3) to test person-centered strategies and improvements for people with IDD through managed care. As the pilot was not funded by the Legislature, IDD SRAC many of the pilot-related recommendations made over the last several years as well as the committee’s position on a future pilot have been moved to IDD SRAC Recommendations section regarding H.B. 4533 SP3. More detailed recommendations related to the pilot can also be found in the appendices of previous Annual Reports which contain IDD SRAC recommendations.

## Transition to Managed Care Subcommittee

### 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 1: Requirements for Accessing Dental Services by Waiver or Program**

Waiver or ICF/IID Program		
HCS	\$2000	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.
ICF/IID	Traditional Medicaid	Discussed at the annual staffing and recommendations for three months, six months or annual dental care based on need. There are follow-up meetings and appointments based on what was recommended in the staffing.

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 Transition To Managed Care (TMC) Subcommittee has the following recommendations.

## **Recommendations**

1. For each HCBS waiver, include in the person's yearly plan of care the budget dollars for services needed and available funds for dental for the year. Assure the amount is included in the yearly budget each year without delays for approvals. Eliminate the prior authorization process. Develop a retro-review process after completion of services if needed.
2. Educate participants, case managers and providers about their dental benefits and the process for submitting paperwork for approval, review and payment.
3. HHSC shall analyze and improve the process between the member, the case manager and the direct service agency for the entire dental submission process including prior authorization, obtaining information from the contracted dentist, approval and submission into the system for payment and the payment to the provider. Special attention is needed to review the timeframes for each step and the overall timeframe from request to payment to the dentist.
4. 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. More guidance is needed concerning use of implants and dentures to individuals.
5. Analyze and seek the resources needed to align waiver processes to improve access to dental services. HHSC should explore other options such as centralizing the dental process for all IDD waivers and ICF/IID programs to simplify and standardize dental services and benefits.
6. Allow for the utilization of dental benefits across two service plan years.

7. 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. If the member has other dental insurance that will pay for the dental services, no prior authorization is needed or should be requested.
8. 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. If anesthesia is being used, a prior authorization process may be utilized. But once long-term medical necessity is established, prior authorization is not needed for approval for anesthesia. The dentist may utilize a form such as "Criteria for dental therapy under general anesthesia" to explain the need for general anesthesia.
9. For any prior authorizations or remands needed for dental services reviewed by HHSC, HHSC will provide a response within three business days of receipt of the treatment plan.
10. If the approved dental procedure exceeds the authorized amount in the initial budget for the individual, the excess amount will be retrospectively reviewed and approved if determined medically necessary. Therefore, the individual receiving the services would not have to return for another procedure under anesthesia. Need to educate providers.
11. 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.
12. HHSC must 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.
13. HHSC and the Higher Education Coordinating Board shall work to build access to services for this population by working with dental schools across Texas.

14. HHSC 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.
15. For those dental Individual Plan of Care (IPC)s requiring Utilization Review (UR), that exceed the budget year, dental provider and care coordinators should be educated on development of structured treatment plans. The maximum trigger for utilization review should exclude costs of anesthesia when determining overall costs. They should ensure strong and clear communication between the client's Service Planning Team, Direct Services Agency (DSA), and the client's treating dentist. This communication must ensure that all members of the client's Service Planning Team, especially the treating dentist, understand the correct process for developing the client's dental treatment proposal and staying within the CLASS or DBMD fee schedules. Improved communication can be achieved by sending a reminder update based on the April 2019 Information Letter describing HHSC's guidance for developing dental treatment proposals. Enhanced communication will result in a better understanding of CLASS or DBMD as it relates to dental services and should help reduce the need for remands, thereby helping to prevent delays in IPC UR approvals.
16. Review impact of H.B. 2658 or similar legislation from the 87th Texas legislative session adding preventative dental benefits for persons in STAR+PLUS non-HCBS. Determine change in policy and impact on waiver benefits. Included in impact is use of dental provider under state plan versus dental provider in waiver or private insurance.

## **Education on Non-Emergency Medical Transportation Benefits**

### **Background**

HHSC has made changes to the Non-Emergency Medical Transportation (NEMT) benefit for persons with disabilities. There is very little information on how to access NEMT for persons on Medicaid. The IDD SRAC received several inquiries from persons with disabilities on how to access NEMT, changes to the guidelines on NEMT and how to receive reimbursement when NEMT 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 NEMT

benefit. HHSC developed a brochure approved by the IDD SRAC Transition to Managed Care (TMC) subcommittee which provided more guidance for persons with IDD. The brochure will be distributed by HHSC.

## **Recommendations:**

1. Require HHSC to update the brochure with the following: verify process to manage after hours requests for MCO's and FFS to add information regarding any after hour situation including weekend and evening NEMT requests and access.
2. Distribute the brochure in accessible formats to the public through websites and share with organizations serving Medicaid participants to distribute to their members. In addition, it should also be provided at annual service planning meetings or during contacts with service coordinators and case managers, as well as included in HHSC Medicaid certification and renewal packets.
3. Align NEMT policies and access for FFS with MCO's.
4. Monitor call center hold times for NEMT to assure timely access to Medicaid transportation benefits and assure that MCOs and FFS provide reports quarterly to HHSC. HHSC should consider increased hours for access to call centers beyond standard workday hours.
5. FFS and MCO members should have access to on-line scheduling and communication from the NEMT members. This transportation system needs to be accessible, and information and scheduling must be available in multiple accessible formats.
6. Standardize and simplify NEMT applications for Individual Transportation Participants (ITP), who provide mileage-reimbursement transportation services to Medicaid recipients.
  - A. 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.
  - B. Develop and implement process for automatically transfer NEMT data for ITP drivers. 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.

- C. Develop and implement process for loadable data card for reimbursement to ITP.
- 7. Develop and implement person centered process and communicate to individuals when attendants are needed for transportation to non-Medicaid or Medicaid providers and need reimbursement for the attendant. Review the policies for the IDD Comprehensive provider and the Medical Transportation benefit to assure clarity.

## **Create Affordable Housing Options and Housing Support Specialist as a Medicaid Waiver Benefit**

### **Background**

The Arc reports that nationally many people with disabilities are experiencing a crisis accessing affordable housing. Additionally, The Arc reports there are approximately 4.8 million non-institutionalized people with disabilities who rely on Supplemental Security Income (SSI) <sup>8</sup> and their incomes average approximately \$9,156 per year and that this is low enough to be priced out of every rental housing market in the nation. Many individuals with IDD conditions live with and rely on aging caregivers (age 60 and older). As caregivers continue to age, this places people with IDD at risk for institutionalization or homelessness.

The National Low Income Housing Coalition (NLIHC) reports that nationally there is a shortage of affordable housing. Specific to Texas the NLIHC reports that there is a shortage of rental homes affordable and available to extremely low-income individuals and to those with incomes at or below the poverty guideline of thirty percent of the area median income. The report identifies burdened low-income households are more likely than others with greater resources to sacrifice healthy food and healthcare to pay rent and cites that many are spending more than half their income on housing. Twenty-two percent of the Texas renter households are reported as extremely low income.

According to a report by the Technical Assistance Collaborative and the Consortium for Citizens with Disabilities, *Priced Out: The Housing Crisis for People with Disabilities*, from 2017, calls attention to the affordability challenges that people with disabilities face in the rental housing market. Rents for a modest apartment in a number of markets can exceed the entire typical income of people with disabilities

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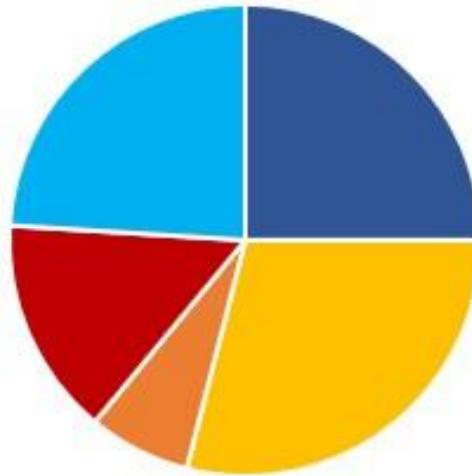
<sup>8</sup> SSI is a federal program that provides cash assistance to people with significant, long-term disabilities and less than \$2,000 in wealth.

who rely on SSI to meet their basic needs. Approximately 4.8 million adults with disabilities between the ages of 18 and 64 receive SSI income. In most cases, SSI is the only source of income they have to meet their personal and living expenses. The report shows that SSI payments are too low for recipients to afford their housing and other necessities without other housing subsidies provided through federal and local programs. Nationally, the average Fair Market Rent (FMR) for a studio apartment was \$752 per month. Department of Housing and Urban Development (HUD)'s FMR is the upper end of the monthly price range that families moving this year could expect to pay for a modest apartment (typically set at the 40th percentile of recent rents). An SSI recipient relying on the average SSI payment of \$763 would have just \$11 left to cover all other expenses after paying for their studio apartment. The vouchers are in high demand, and many remain on waitlists to access for several years.

The Governor's Committee on People with Disabilities report on people with disabilities cited, Texas has the second largest number of individuals with disabilities of all the states. The percentage of individuals with disabilities relative to the entire Texas population (11.8 percent) has remained stable over the past seven years, although the Texas population has grown considerably over that same time period according to their 2019 report. Approximately 54 percent of Texans 75 and older had a disability. Overall, 11.84 percent of females (1,686,794 individuals) and 11.81 percent of males (1,660,211 individuals) reported having a disability. Disability varies in this report, and data was not available specific to the IDD population. The population of individuals with disabilities in Texas is not evenly distributed across the state. More than half (52 percent) of Texas' population of individuals with disabilities resided in these 10 counties: Harris, Bexar, Dallas, Tarrant, Hidalgo, Travis, El Paso, Collin, Denton, and Cameron according to the People with Disabilities: A Texas Profile from 2019.

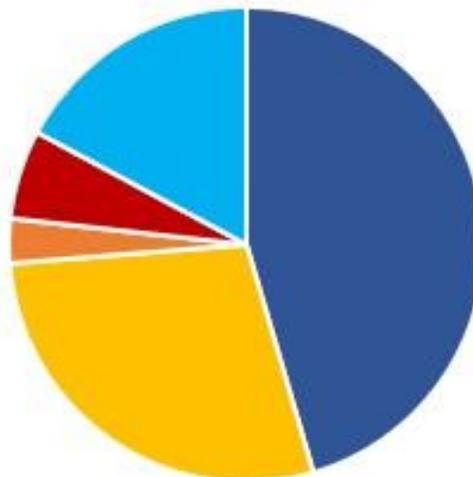
Charts below represent the gap in household type by income.

### Extremely Low Income Renter Households



- Non-disabled non-elderly without children
- Non-disabled non-elderly with children
- Disabled with children
- Disabled
- Senior

### All Other Renter Households



- Non-disabled non-elderly without children
- Non-disabled non-elderly with children
- Disabled with children
- Disabled
- Senior

**Source: NLIHC tabulations of 2016 ACS PUMPS data.  
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NOTE: Senior means householder or householder’s spouse is at least 62 years of age, regardless of children in the household.

Disabled means householder and householder’s spouse (if applicable) are younger than 62 and at least one of them has a disability.

Using the HUD 2023 FMR data, the below table shows the range of average rents for these counties:

<b>Service Delivery Area</b>	<b>HUD FY 2023 FMR Texas Efficiency</b>	<b>HUD FY 2023 FMR Texas One Bedroom</b>
<b>Bexar</b>	\$880	\$1020
<b>Dallas</b>	\$1164	\$1233
<b>El Paso</b>	\$652	\$799
<b>Harris</b>	\$894	\$988
<b>Hidalgo</b>	\$657	\$682
<b>Jefferson</b>	\$762	\$840
<b>Tarrant</b>	\$1053	\$1161
<b>Travis</b>	\$1053	\$1169
<b>MRSA Central</b>	\$705	\$750
<b>MRSA Northeast</b>	\$675	\$724

Key federal housing initiatives utilized in Texas by people with IDD and mental health conditions include the Section 811 Program Rental Assistance Program for persons with disabilities. Texas has prioritized people with IDD and mentally health conditions populations for access Section 8 Housing Choice Vouchers and National Housing Trust Fund. However, HUD reports that the value of many vouchers distributed has not increased with the increase in rental markets. These housing vouchers failure to keep pace between the voucher value and rental market rates has created a dilemma for renters with disabilities and limited incomes seeking affordable housing options.

US Department of Housing and Urban Development has ruled that ABLE accounts are exempt when determining eligibility for affordable housing programs, per [HUD Notice PIH 2019-09 and Notice H-2019-06](#), Treatment of ABLE Accounts in HUD-Assisted Programs.

“Per the mandate of the ABLE Act, for the purpose of determining eligibility and continued occupancy, HUD will disregard amounts in the designated beneficiary's/individual's ABLE account.”

Furthermore, access to vouchers is impacted by the limited numbers of vouchers available and the number of people with disabilities who are not able to rent without rental subsidy. The risk to Texans requiring these vouchers who have them but cannot locate affordable housing, is that the federal programs administering these benefits can revoke the quantity of future vouchers when a state allotment is not fully utilized.

There is a lack of affordable housing options statewide and no assistance for persons with IDD to find the best housing solution. It is critical that Texas seek solutions for housing to our most vulnerable populations in light of an aging population of caregivers and develop risk mitigation for people with IDD who are at greater risk for institutionalization to live successfully in the community. Additionally, considering housing subsidies that are more fixed and a rental market that has exceeded available resources, it is critical that we find solutions for the future housing needs of our populations with disabilities through development of networks and collaboratives that involve local, state, and federal governments and agencies and private and public sector organizations.

## Recommendations

1. Require Texas ABLE to update their website to provide accurate information regarding UD HUD that ABLE accounts are exempt when determining eligibility for affordable housing.
2. Require TAA to update their eligibility policies to exempt ABLE accounts when determining eligibility for affordable housing.
3. Review and implement the Housing and Health Services Coordination Council 2022-2023 Biennial Plan and Report recommendations. Please see links below:
  - A. [Housing and Health Services Coordination Council Findings and Recommendations](#)
  - B. [TDHCA 2022-2023 HHSCC Biennial Plan](#)
4. HHSC to develop a housing strategic plan maximizing grant, state programs, and both state and federal dollars to include both short- and long-term housing programs and solutions.
5. Establish an umbrella organization consisting of housing providers, developers, community based, and faith-based organizations, state agencies, and managed care, etc. to have a broader vision for integrated housing for low, moderate, and middle income populations within integrated communities

for adults and families with children with disabilities. These organizations should:

- A. Develop a statewide strategic plan for developing affordable, accessible, and integrated housing;
  - B. Develop and consult with like focused regional or more local subsidiary organizations within communities;
  - C. Promote and work to create integrated housing development within local communities and with local governments;
  - D. Develop and promote housing developments that contribute to the vitality and diversity of the local communities and business districts;
  - E. Develop or support housing projects that minimizes adverse fiscal and infrastructure impacts;
  - F. Establish a vision and mission that ensures reflection of a collaborative approach by the developer and the local community; and
  - G. Enhance access and contribution to communities for all residents whether housing is subsidized, rented, or owned.
6. Identify, develop, and ensure alignment between both short term and long-term rental assistance programs building bridges for transitions where applicable. Example may be the HOME program when used for rental housing and home ownership, TBRA benefits and home ownership programs, and Tax Credit programs for example.
  7. State should work with federal partners for programs to establish conscientious housing criteria in conjunction with transportation projects. This could promote collaboration between housing resources and developers and transportation projects to enhance accessible transportation in areas where transportation is not available, but housing is or where both transportation and housing can be developed together and that has a requirement for positive impact to the community and without negative impact to people residing in the community or to the community. This needs to be a thoughtful process.
  8. State and federal government resources should decentivize or simply make it illegal for communities that take a "not in my backyard" approach to having affordable housing and public transportation in their community.
  9. Service and resource coordination between managed care, local healthcare and social service agencies, housing developers, owners, and property

managers needs to be enhanced. There are many agencies working on housing but do not appear to be talking or working together. Need to operationalize and make it happen through a statewide housing collaborative or the like.

10. Develop and implement a systemic service delivery system to include screening and referral requirements for community-based resources and Medicaid services for Non-Medical Social Determinants of Health (NMSDOH) by any public facing state service agencies, managed care organizations, or Medicaid service providers. Develop consistent quality measures to track and trend outcomes and to inform best practices for service choice and delivery, and program development. This would encourage early identification of housing instability as well as the need for funds to maintain housing such as services, food, utilities, transportation, and community connections.
11. Develop Finance and Capacity building strategies to encourage the development of housing opportunities in midsized cities and rural areas of the state including:
  - A. Replicating the Housing and Services Partnership Academy<sup>9</sup> to include specific emphasis on the housing needs of individuals with intellectual and developmental disabilities;
  - B. Expanding the Capacity Building Initiative for Community Living to encourage set-asides for individuals with intellectual and development disabilities. Public Housing Authorities (PHAs) across Texas have obtained approval on their PHA Plan from the U.S. Department of Housing and Urban Development to set aside units and vouchers for people with IDD;
  - C. Educating property managers about people with intellectual and developmental disabilities. A statewide disability advocacy organization has partnered with the Texas Apartment Association (TAA) to include education about people with IDD in the TAA property manager training. Suggest outreach to this organization and replicating their efforts as part of a strategic educational initiative.
12. Develop strategies and resources for increased housing opportunities through private and public funding and enhanced relationship between developers, non-profits, and local and state government agencies similar to what HHSC

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<sup>9</sup> The initiative is a partnership at the federal level that brings together housing and human services agencies on state and local levels who have implemented a number of strategies to address the housing and services needs of people with disabilities and older adults.

has done with the Affordable Housing Partnership and through the Healthy Community Collaborative, etc. with focus on all Medicaid populations not only mental health.

13. Develop and implement educational strategies for housing developers, owners, and property managers to better understand support services available especially regarding physical and behavioral health services that can support a person to remain safely in the community. It can be difficult to maintain a person in the community, not because there are not sufficient Medicaid services and supports but because there is lack of knowledge for what is available and how a person can be supported safely or because a landlord is ignorant of the rights of people with disabilities to live in the community.
14. Develop education materials for housing management to improve effective service coordination for tenants with disabilities and elderly tenants through increased coordination of care, housing tenancy support services to reduce homelessness and decrease use of costly emergency services by providing timely intervention when a tenant is experiencing a health or behavioral health crisis and at risk of losing their housing. This could be supported with the Housing Support Specialist role.
15. Identify dedicated funding for housing resources for people with IDD conditions.
16. Assist with continued eligibility to ensure and maintain stable housing. Texas HHSC work closely with entities such as the Texas Department of Housing and Community Affairs (TDHCA), the PRA 811 program, Centers for Independent Living, Aging and Disability Resource Center (ADRC), apartment locator services, and other local or state funded housing resources to assure priority funding for the pilot population and their willingness to accept and assist with referrals.
17. Require local communities to provide public information, through housing websites, affordable housing websites, and/or Local Housing Authorities, about affordable housing options that exist in local communities, in addition to existing HUD and Sections resources.

## **Housing Support Specialist**

The second part for the housing solution is to create a Housing Support Specialist as a Medicaid waiver benefit to assist consumers and families, case managers,

service coordinators, and low-income persons with IDD transition by providing housing related services. A Housing Support Specialist could assist case managers and service coordinators as low-income people with intellectual disabilities transition from institutional settings and residential programs within waivers and into integrated community settings. Suggest funding for a Housing Support Specialist role in all Medicaid programs. The Housing Support Specialist role consists of two primary functions: to provide individual housing transition services and to provide individual housing and tenancy sustaining services as part the person-centered plan. The IDD SRAC TMC Subcommittee recommends that assistance to find appropriate housing may be considered and funded as a Medicaid waiver benefit.

The Housing Support Specialist will:

- Educate a potential housing applicant on community living options, property availability, and the application process.
- Assist prospective applicants applying for housing.
- 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.
- 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.
- Assist with creative problem solving to resolve landlord/tenant issues and will make referrals to other community resources.
- 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.
- Work with other community housing services and resources, in order to identify safe, affordable, accessible, and integrated community living housing.

Having the additional supporter will assist persons with IDD in obtaining housing in the least restrictive, integrated community environment.

## **Recommendations**

The below are recommendations concerning a Housing Support Specialist:

1. Fund the Housing Support Specialist benefit to assist persons with IDD to transition to the most integrated, appropriate housing for the person.
2. Fully fund the Housing Support benefit as a Pilot 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.

## **Improve Use of Consumer Directed Services Option**

### **Background**

While funds for competitive and appropriate wages and benefits is an important factor, it is only one of numerous factors that impact long standing challenges with attendant recruitment and retention in delivering LTSS to individuals with IDD and other disabilities. The ability to offer enhanced training and ongoing skill development, including habilitation training, are equally important and would contribute significantly to increasing attendant confidence and competence, and ensuring quality in service delivery.

CDS employers need to receive information and hands-on opportunities to train new employees. This is especially important for young adults who are becoming their own CDS employer. Although they are their own guardian, a young person or new CDS employer may not have had an opportunity to interact as an employee or employer in the workplace. Extra training may be needed to enhance managerial

skills, such as interviewing, hiring, training, supervising, conflict training, and terminating employees.

As more services are expanded to the CDS option, FMSAs are not as familiar with payment to CDS employees who are professional providers with tax ID numbers who are working as CDS employees for CDS employers. A CDS individual may select a speech therapist that is part of an employer to provide services or an employment specialist who works for an employment agency to provide services.

CDS is a service delivery option which encourages flexibility for time and service delivery. In order for this service delivery model to work, Texas HHSC must allow a certain amount of trust to the employer of record for the service delivery model to be effective. EVV has made process more complicated for CDS which has made it more difficult to train and retain employees. Some employers under CDS have had to give up autonomy as an employer because EVV makes employment responsibilities less accessible.

Many people do not have the option to voluntarily switch waivers due to different eligibility criteria among waivers. The individual does not have ability to change waiver at will and must meet eligibility criteria and there must be a slot opening.

## **Recommendations**

1. Allow additional funding within CDS to support the ability of CDS employers and non-CDS providers to offer attendants enhanced training/ongoing skill development. The funds requested could be made available through a "program" similar to the current Attendant Compensation Rate Enhancement Program, via an add-on rate, or as a program service for which evidence must be demonstrated and verified that the funds were used in accordance with their intended purpose.
2. Allow additional funding within CDS to train employers to develop and enhance managerial skills, such as interviewing, hiring, training, supervising, conflict resolution, and terminating employees.
3. Assure all FMSAs have the capacity to pay not only individuals hired by the CDS employer to provide services to the CDS individual, but also CDS employees who are professional providers with tax ID numbers who are working as CDS employees for CDS employers. HHSC should do readiness to assure the capability and approve for implementation.

4. Develop training that demonstrates both scenarios for when CDS may use as well as how to present CDS as strategies to increase use.
5. Address wage discrepancies among the waivers. CDS employees will see the wage discrepancies among the waivers and will opt out of working for people with lower wage waivers.
6. Address concerns that employees will be disincentivized to work with people in lower paying waivers through the job board.
7. Ensure job board access is limited to people who are actively serving or seeking jobs with people with disabilities.
8. Develop and implement a process for reporting abuses of the job board.
9. Provide accessible and comparable waiver information to enable people to make informed choices about pathways of access to each waiver.

## **Improving the Electronic Visit Verification System**

### **Background**

- EVV is a computer-based system that electronically documents and verifies service delivery information, such as date, time, service type and location for certain Medicaid service visits. HHSC must comply with the federal Cures Act EVV requirements. To comply with the law Texas HHSC implemented the Cures Act as follows:
- Effective January 1, 2021, EVV is required for Medicaid personal care services, including those services provided through CDS.
- Effective January 1, 2023, EVV is required for Medicaid home health care services.

The service attendant or CDS employee is required to use one of three approved electronic verification methods to clock in at the beginning of service delivery and clock out at the end of service delivery when providing services to a member in the home or the community.

The EVV vendors offer the following three approved clock in and clock out methods:

- Mobile method (smart phone or tablet): The service attendant or CDS employee may use a mobile method for clocking in and clocking out of the EVV system.

- Home landline: The service attendant or CDS employee may use the member's home phone landline, if the member agrees, for clocking in and clocking out of the EVV system by calling the EVV vendor's or EVV Proprietary System Operator's toll-free number.
- Alternative device: An alternative device is an HHSC-approved electronic device provided at no cost by an EVV vendor or Proprietary System Operator, if applicable, that allows the service attendant or CDS employee to clock in and clock out of the EVV system from the member's home.

Texas Medicaid program providers and FMSAs are required to use EVV.

- EVV vendor system: An EVV vendor is an entity contracted with TMHP, the state's Medicaid claims administrator, to provide a cost free EVV system option for program providers and FMSAs contracted with HHSC or an MCO. The program provider or FMSA may select one of the following EVV vendors available from the state vendor pool. Visit the TMHP EVV Vendors webpage for additional information about EVV vendors and their systems.
- EVV proprietary system: An HHSC-approved EVV system that a program provider or FMSA may choose to use instead of an EVV vendor system from the state vendor pool.
- HHSC is moving from three EVV vendor to a single EVV vendor system effective October 1, 2023. Users of the current vendor systems (Datalogic/ Vesta or First Data/ AuthentiCare must transition to HHAexchange.

## Recommendations

We recommend additional enhancements for training and ongoing skill development for CDS and non-CDS Attendants.

### For EVV CDS Employers

- Training should include effective data entry, with assistive technology to maintain self-direction while complying with EVV standards.
- CDS employers may need direction on where they fit into the larger service system regarding timekeeping and payroll; employees may have questions and concerns that they may expect their CDS employer to answer.
- More training is needed regarding call ins and call outs and what to do if they fail to record. There should also be a way for CDS employees to collect

missing pay due to rounding errors created by switching to non-EVV services in the middle of a worked shift.

## For EVV Systems

- EVV systems need to be upgraded to include timekeeping for non-EVV services and a way to track total number of hours per week per employee. In the current model, attendants are being asked to switch back and forth between two timekeeping systems throughout a shift, when performing services such as transportation and SE. Each timekeeping system rounds differently when calculating hours and pay. Because of this, an employee cannot accurately know how many hours they have worked or how much they are being paid, and they lose time while swapping between systems. This negatively affects recruitment and retention, and causes undue stress to the employers, possibly leading to unnecessary reduction in self-determination and discouraging use of EF practices.
- Require all FMSAs to perform visit maintenance to identify any pending visits that are approved but not paid within a three-month period. The EVV system is complex and can often pend a visit that is beyond the current payroll period. The FMSA must monitor the system to assure all visits that have been approved from the CDS employer have been paid. Any FMSA not complying should be sanctioned.
- Require easy access for CDS employees to account for their total hours worked and approved in each pay period. CDS employees cannot look at their work history for the current pay period on EVV. Once an employee sign out they cannot access the information for that EVV session. There is no way to look back at hours worked during the week. The only way to keep up with the hours is for the employee to ask the CDS employer to look up their work hours.
- Create a non-EVV option as a part of the EVV service menu. This would reduce the episodes of non-compliance with visit maintenance standards and noncompliance with signing in and out.
- For people that have employees work an entire shift where they switch tasks between EVV and non-EVV services, include an option that allows them to sign in once and sign out once and select which services the employee did throughout the day and allocate the hours to the correct services at the end of the day, the week, or the pay period.

- Prompt if the visit is overnight at the beginning of sign in and not at the end for sign out. Evaluate other systems for how this is documented.

## **Expanding Capacity for Health Care Service including Physician, Specialty Care, Behavioral Health and LTSS Services**

### **Background**

Having access to Medicaid physicians and specialists can be difficult for various reasons including physician capacity, lack of knowledge and training to effectively manage the unique medical needs of many people with IDD conditions, and the low rates of reimbursement in comparison to Medicare and commercial insurance rates. In addition, physicians may already have higher number of individuals that fill the capacity of a physician's practice prior to considering additions of individuals on publicly funded benefits. Physicians may also be reluctant to provide primary care when specialty care in their area may be limited resulting in higher liability for the primary care provider and more time needed to treat more medically complex individuals. The limitations impacted by federal regulations requiring a person to transition to an adult provider as he/she ages into adult Medicaid programs further limits access in the absence of adult primary care providers and specialists available. Texas requires creative options when considering solutions that provide individuals on Medicaid with complex conditions better primary and specialty care.

The use of Telemedicine to address shortages is becoming a strong solution for Medicaid programs across the country. As we have seen in the COVID-19 PHE, more and more options have become available for the use of telemedicine for both primary and specialty care, but also for behavioral health and certain LTSS in mainstream healthcare as well as in Medicaid programs across Texas. In order for our vulnerable populations to receive access to quality and necessary services, additional progress is required. The IDD SRAC recommends the following to create access solutions for treatment and service delivery to our most vulnerable populations as follows:

## Recommendations

### Funding

- Provide additional funding to expand primary care physician and specialty capacity for persons with intellectual and developmental disabilities.
- Provide additional funding to increase pay rates that encourage and utilize Alternative Payment Methodologies (APM) to reimburse LTSS providers to ensure quality, availability, and retention of qualified staff.
- UT Austin University Center for Excellence in Developmental Disabilities, Education, Research, and Services, UT Center for Disability Studies and Texas A&M Center on Development and Disabilities and HHSC collaborate with other agencies and organizations to establish a Center for Excellence for Texans with Intellectual and Developmental Disabilities. The “Center” could be utilized by Texas physicians, clinicians and paraprofessionals, families and caregivers, and for person’s served within our state. Information is scattered and some resources may be out of date or inaccurate in our age of increased information access to the internet. Establishing this centralized resource would support evidenced based and accurate information for training, both written and teledelivery, as well as on demand educational forums and supports by establishing a repository for educational materials and other resources that is accessible to all.
- Develop policy and require the use of flexibilities for current benefits to improve access, availability, and delivery of services to people who are underserved. This would promote opportunity for increased service delivery efficiencies and effectiveness to promote independence, employment, and community living.
- Fund current comprehensive care clinics and transition clinics. Expand these clinics throughout the state of Texas for children and adults including those with IDD.
- Require policy that establishes qualifications for comprehensive and transition clinics in Texas.
- Incentivize development of more comprehensive and transition clinics across the state. Encouraging and incentivizing the development of satellite clinics and increased use of remote technologies and payment strategies for in rural and under populated areas of the state may increase access where none may

exist, for example. This is a strategy has been used in the private sector by providers and payers but only recently adopted by HHSC.

- Direct HHSC to collaborate and engage professionals in the field to establish best practices and quality standards of care with people with IDD conditions and other complex medical needs for comprehensive and transition clinics and across care continuums. Distribute and make available these best practices and quality standards while also encouraging adoption and continued opportunity for development by providers receiving Medicaid funding to improve the access and the quality of care standards and service delivery to vulnerable populations.
- Cover the additional costs of directed payment programs for comprehensive care and transition clinics that continue to treat adults with IDD and related conditions. Clinics must meet HHSC-defined criteria and Medicaid MCOs must be required to contract with them. Comprehensive care and transition clinics should be fully prepared to service a variety of disabilities, including IDD.
- Prohibit MCO cost savings based on rate reductions to physicians and specialty care providers, or direct support service reductions that limit patient access to care and diminish provider network adequacy.
- Prohibit MCO cost savings that are related to reductions in services that fail to address the person-centered plan of care and changing needs over time.

## **Telemedicine/Telehealth/Telemonitoring (including access to LTSS)**

- Experience from the COVID-19 PHE should be used as best practice for telemedicine and telehealth allowing for more use of telemedicine and telehealth for basic and specialty visits, including psychiatry.
- Support use of telemonitoring to expand access to services.
- When necessary or preferred, and without diminishing access to physicians, expand use of telehealth and physician extenders, such as physician assistants and nurse practitioners with knowledge of services for individuals with IDD. Other states use flexible physician extenders supervised by physicians.
- HHSC should consider such telemedicine programs with expertise in the population to be considered as waiver benefit unless paid for through Medicaid. An example is urgent, emergency, behavioral health care with expertise in serving persons with intellectual disabilities.

- Not all participants may have access to telemedicine due to lack of access to broadband services and or technology. Make funding available for broadband access and accessible technologies needed to participate in telemedicine, telemonitoring and telehealth.

## **LTSS Telehealth Access**

Develop policy and Medicaid benefit that promotes remote monitoring and supports to include the monitoring of a person in his or her residence by staff using one or more of the following systems: live video feed, live audio feed, motion sensing system, radio frequency identification, web-based monitoring system, or other device approved by the commission. The system shall include devices to engage in live two-way communication with the individual being monitored as described in the individual service plan. Each type of remote monitoring must be agreed to by the person based on informed consent. Telehealth already exists in Texas. This is not telehealth.

For appropriate tasks, develop flexible person-centered policies that allow direct support workers to provide services via telehealth and telemonitoring to support a person with disabilities. Examples include:

- If a person with a disability is working at home and needs assistance with note-taking.
- If a person with disabilities is working on digital content and needs assistance to finalize content due to fine motor issues, etc.
- If a person with disabilities does not understand an activity of daily living (ADL) and needs a direct support worker to walk through steps to accomplish the task.
- HHSC should consider implementing remote monitoring to help address the workforce shortage.
- When determined medically appropriate and when licensure does not require face to face, therapies may be delivered through telehealth upon request of the individual or the family and when noted on the IPC and consistent with the person-centered process.

As part of integrated service coordination for persons with IDD, HHSC needs to develop appropriate data sharing between the MCOs, LIDDAs and Comprehensive Service Providers to provide better integrated care.

## System Changes

1. Maximize use of medical training programs; such as physician residency, nursing training, psychologist, and other behavioral health therapies, etc. to increase access to care.
2. Direct Medicaid to ensure access and continuity of care pediatric or adult providers regardless of a person's disability or age.
3. Ensure continuity of care and coordination of benefits for adults and children by fully funding and implementing S.B. 1207 (85th Legislature) and S.B. 1648 (86th Legislature).
4. Evaluate best value when contracting with MCOs, not limited to cost of care and cost savings, to incorporate holistic, person-centered care that:
  - A. Delivers Person-Centered Service Coordination that connects participants the care they need;
  - B. Ensures participants have timely access to the services they need;
  - C. Encourages providers to participate in the Medicaid program;
  - D. Ensures a sustainable Medicaid program by incentivizing value in the service delivery model and optimizing resources; and
  - E. Uses data, technology, and reporting to facilitate and demonstrate strong performance and oversight.

## Identify and Develop Acute Health Care Initiatives

### Background

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. These conditions could be reduced or better managed through initiatives designed to maintain optimal health and to avoid unnecessary emergency room (ER), hospital and institutional admissions, including unnecessary law enforcement involvement, that often result from misunderstood, mis-managed or mis-diagnosed health conditions.

According to a November 2017 Policy Data Brief Titled Health and Healthcare Access among Adults with Autism Spectrum Disorder (ASD) and 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

individuals, who receive state developmental disability services who were surveyed using NCI, 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.), yet diagnostic overshadowing, the phenomenon of making assumptions about diagnoses without exploring other factors - mental health, for example, is prevalent among healthcare providers. 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. Some results may be unreliable due to incomplete claims that exclude the private insurance claims for members with both private insurance and Medicaid, or both Medicare and Medicaid.

## **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 and other diagnoses and appropriate treatments, including assessment and treatment for applied behavioral analysis for individuals with ASD.
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 S.B. 1207, 86th Legislature, Regular Session, regarding coordination of benefits, and S.B. 1648, 87th Legislature, Regular Session, are

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 of changes prior to implementation, including people on the Health Insurance Premium Payment 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. 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 and healthy lifestyle.
8. Identify opportunities for health care initiatives through data analysis and expanded data collection to include access, availability, experience, utilization, and the results of health care activities (outcomes) patient perception of care, and use of NCI health and wellness data for the populations of ASD, ID, and other developmental disabilities. Provide separate results for persons with private insurance and those with dual Medicaid/Medicare coverage.
9. Identify opportunities for health initiatives to prevent unnecessary ER, hospital or institutional admissions and facilitate returning to the community for individuals with IDD. 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.
10. Track and report quarterly to IDD 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. Utilize telemedicine for urgent care and behavioral health needs for persons with IDD performed by physicians experienced with the population in instances when an in-person visit is either not advisable or expedient.

## **Improve the IDD Assessment Process**

### **Background**

S.B. 7, 83rd Legislature, 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. Legacy DADS determined it would pilot the InterRAI ID.

HHSC used an outside vendor to conduct assessments using the InterRAI ID assessment on voluntary pilot participants. During Phase I, 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.

In Phase II, HHSC contracted the University of Texas Arlington School of Social Work (UTASSW) to develop a resource allocation algorithm for the InterRAI ID assessment and Collaborative Action Plan (CAP) instruments and test it with the identified sample population from Phase I.

Phase III of the InterRAI assessment project is nearing completion. The algorithm has been completed and UTASSW is working with HHS to conclude the data transfer and other contracted deliverables, and final invoices. Once received, HHSC will move forward with sharing this information with executive leadership for next steps.

The IDD SRAC strongly recommends HHSC to pilot the utilization of InterRAI ID and CAP instruments algorithm in the development of service plans for the ID population currently receiving services and complete a comparison analysis of needs and supports needs identified using the ICAP and needs and support needs identified using the InterRAI ID and CAP. The analysis should include comparison of identified needs and support services authorized utilizing the ICAP and identified needs and support services authorized using the InterRAI ID and CAP. The analysis

should evaluate if there were reductions, increases, or a neutral impact in services received by individuals. The analysis should also assess whether there was an overall reduction, increase, or neutral impact on the total services received by the pilot participants.

## **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 assessments.
2. 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.
3. Allow and encourage using a variety of evidence-based, empirically-valid tools as necessary to accurately identify needs such as:
4. Level of support and resources needed to live inclusively in the community.
5. Self-direction (ability to participate in the planning and directing services).
6. Preferences, long term goals, and life plan. Coordinate with IDD SRAC to determine the necessary and allowable revisions to the InterRAI ID and CAP Assessments and other assessment tools in order to determine each individual's needs and appropriate resources to meet those needs.
7. 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, behavioral, or psychosocial.
8. Ensure high quality services that align resources with assessed needs and preferences (adjust rates that support quality).
9. Ensure that assessment is flexible and can be readily modified to capture an individual's needs and goals for the person as they change.
10. Requires an evaluation of the accuracy and reliability of the InterRAI Intellectual Disability Assessment and Collaborative Action Plan and submit a written report to the IDD SRAC.
11. Ensure that other assessments used in conjunction with the InterRAI ID and CAP Assessment are not duplicative and do not create an unnecessary burden on individuals and families.

12. Must commit to reevaluating the adequacy and use of the InterRAI-ID and CAP tools and resource algorithm at a minimum of annually with the IDD SRAC.
13. Develop and implement flexibility within and across programs and settings for service planning that ensures resource allocation based on assessed needs, including for, but not limited to, individuals transitioning across geographical areas, settings, programs and changes in need. (i.e., individual transitioning to community settings from institutional settings who may need higher levels of support during periods of transition.
14. Ensure timely implementation of services. Eliminate the unnecessary Utilization Review processes that are not based on cost caps and are inconsistent with the assessment of client needs.
15. Ensure individuals receive the amount, type, and duration of services needed without requiring natural supports beyond those voluntarily provided.
16. Increase and improve training for assessment personnel to ensure assessments and staff appropriately address cultural, language, communication (including alternatives to verbal communication), learning differences, abilities and needs of children and adults and their families.
17. Increase access to board certified behavior analysts to identify and provide timely and appropriate functional behavior assessments, behavior intervention plans, and access to applied behavioral analysis addressed by additional recruitment and increase in rates.
18. Identify and develop of an evidence based mental health screening tool for people with IDD.
19. Increase and enhance mental health screening to obtain baseline information, identify needs including trauma informed care strategies and to mitigate risk and prevent requirement for more costly services.
20. During system redesign that implements new or modified assessments, ensure people obtain and maintain their necessary services.
21. For the purposes of evaluation to inform the IDD system redesign, ensure that the assessment process and tools identify and distinguish pilot participants with IDD from pilot participants with functional needs similar to IDD.
22. HHSC must develop resource allocation to be used with the InterRAI that:

- A. Establishes criteria for demonstrating competency for those who may administer the InterRAI IDD and CAP.
  - B. Provides standardized training for accurate and consistent administration and completion of the InterRAI IDD and CAP.
  - C. Focuses on meeting the actual, individualized needs of the person(s) without the use of tiers, caps, thresholds, or levels of need to determine approval of the person-centered service plan.
  - D. Determines the frequency and indicators for assessment and reassessment intervals including eligibility and service assessments. Note: Consider including under Access in IDD SRAC).
  - E. Requires stakeholder input from the IDD SRAC, and representatives across all LTSS community programs prior to the continuation of the InterRAI ID and CAP in the pilot or expansion to other HHSC programs.
23. Ensure any algorithm is comprehensively tested for the InterRAI ID and CAP accurately assesses the support needs of the intended population for other programs prior to use.

## **Develop and Implement a Regional Partnership**

### **Background**

Funding is needed to develop and implement a regional partnership throughout Texas for LIDDAs, MCOs, providers, and 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 accessing housing and work in an integrated environment. The goals of the regional partnership are:

- To develop local solutions to address barriers;
- To create better outcomes for persons with IDD; and
- To better coordinate services and support for persons with IDD.

Recently, with the input of stakeholders, HHSC developed a framework for regional partnerships to achieve the above noted goals. The IDD SRAC recommends that HHSC operationalize strategies identified in the framework and implement regional partnerships throughout the state of Texas.

## Recommendations

1. Identify regional partner to include LIDDAs, Medicaid MCOs (STAR+PLUS and STARKIDS), Texas Education Agency (TEA), TWC, comprehensive providers, diverse representations of persons with IDD, and families.
2. Explore options for leadership roles to develop and operationalize regional partnerships including persons with lived experience.
3. Implement Regional Collaboratives in all MCO service delivery areas referencing a unified framework for development.
4. Increase coordination and collaboration between LIDDAs, MCOs, local providers and state agencies (e.g., TEA, HHSC, Department of State Health Services, LIDDAs, TWC, and DFPS) to ensure appropriate and timely transition to adult services including competitive and integrated employment.
5. Regional Collaborative to work with STARKIDS MCOs to develop best practices for STAR KIDS transitions to prepare young adults for adult programs and services including community living and life skills, etc.
6. Increase coordination and collaboration between entities to ensure appropriate interagency referrals including guardianship, services, placement options, independent living, focus on solutions for transition regardless of supported decision making, guardianship and other alternatives.
7. 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.
8. 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.
9. Increase regional and statewide resources and personnel to develop and implement inclusive competitive and integrated employment programs for students.
10. Develop and facilitate regularly scheduled regional and/or local collaboration on employment issues, including state agencies that provide employment services (MCOs, DSAs, TWC, TEA, and HHSC) which will develop:
  - A. A joint plan for identification of federal and state funding and resources to promote competitive integrated employment;

- B. A joint phase-out plan that transitions individuals with disabilities out of subminimum wage and segregated work environments;
- C. Annual goals for increasing the numbers of persons with disabilities employed in competitive integrated employment; and
- D. A requirement for each agency to develop a system for collecting and aggregating data that follows Workforce Innovation and Opportunity Act (WIOA) requirements and is reported to the HHSC EF designated staff annually (this recommendation also requires TEA and TWC participation).

# Meaningful Skills Development 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, 83rd Legislature, 2013.

### Recommendations

Due to the negative connotation to the abbreviation of Individualized Skills and Socialization it is recommended not to use the acronym for this service. It is this committee's experience that history has shown the acronym was and has been used as a tool to manage behaviors that were manifestations of a person's disability rather than giving students needed supports in the classroom. Therefore, it is recommended to replace Individualized Skills and Socialization with Meaningful Skills and Socialization.

1. Require all person-centered service plans for all individuals to address 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 activities.
    - a. People Planning Together - 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. Ensure that the

- assessment is implemented to all program participants accessing Medicaid services.
- a. The service planning discovery tool currently in development should include a specific module on employment along with modules on assisting people to develop activities which represent their personal preferences for meaningful activities for leisure, volunteerism, health and wellness, spirituality and other activities which augment employment.
  - b. Transportation is critical for accessing meaningful day activities and should be available to implement the person-centered plan.
2. HHSC will be required to provide training in the principles of EF, waiver employment program services, steps to become an Employment Service Provider (ESP)/ Contracted Service Provider (CSP) with TWC, the development and implementation of an Employment Plan, work incentives and other resources to maintain benefits while working and the process to have a seamless transition of employment services from TWC/ Vocational Rehabilitation (VR) to the individuals LTSS waiver employment services. This training will be REQUIRED for all TWC/ VR staff and all LTSS providers including all case managers, service coordinators, Individualized Skills and Socialization Services providers and DSAs.
- A. Improve information sharing between TWC and LTSS providers including MCO's.
  - B. Develop electronic communication channels between TWC and LTSS providers and MCOs.
  - C. Require HHSC staff, LTSS providers, and MCO/ LIDDA service coordinators, case managers, and DSAs 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.
3. Provide training that is affordable, accessible and available across Texas for all IDD LTSS providers and Individualized Skills and Socialization Services providers to become successful CSPs (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 provider. Ensure that the rate structure enables the provider to deliver the service
- A. 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.
- B. Encourage HHSC staff and LTSS providers to register to receive notifications on TWC website to be informed of information related to vocational rehab.
  - C. Allow the open enrollment period for ESPs contracts to be available year-round.
  - D. 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.
4. Include TWC ESPs 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.
  5. Promote awareness of employment supports through all means: case management, service coordination, PCP, assessments, reviews, etc.
  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.
  8. Increase additional strategies that lead to skill development to increase competitive employment.
  9. HHSC to work collaboratively with the TEA and TWC to develop policy, strategies, and training to promote meaningful day activities to support development of the foundations for vocational services and goals for those not ready to enter into TWC-VR services who are enrolled in Medicaid programs.

## **Increase Utilization of Employment Services**

### **Background**

Despite the passage of S.B. 1226 that establishes competitive, integrated employment as the primary goal and priority for citizens using publicly funded

services, and the availability of 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, VR services and Medicaid waiver EA and SE services.

## **Recommendations**

1. Require all MCO and LTSS providers to contract or employ EA and SE providers who meet quality standards to provide SE and EA services in order to meet the needs of the participants, including ESPs. The recommended Quality Standards include:
  - A. The ESP must have and utilize 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 services are expected to lead to competitive, integrated employment and to transition to SE Services or to support SE goals for those with established competitive, integrated employment.
  - 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 ESP 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 match 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, DSAs, TWC, TEA, 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 WIOA requirements and is reported to the HHSC EF designated staff annually. This recommendation is included in Develop and Implement a Regional Partnership recommendations of the Transition to Managed Care Subcommittee.

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 Individual Employment Plan (IEP) used by TWC. This service would provide assistance for 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 pre-employment initiative to educate persons and families on retention of Medicaid and Social Security benefits with EA and SE services.
6. Establish a centralized source of resources for employment related services and supports including information regarding continued Medicaid/ SSI eligibility. Offer information on competitive, integrated employment and develop and expand existing educational campaigns and other initiatives to increase awareness of work incentives for participants.
7. Add SSA benefits counseling as a service in all HHSC waivers programs 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 SSA benefits. Currently there are less than 30 state certified benefits counselors in Texas.
  - B. Develop script and/or talking points, not questions prompting solely a yes/no response, to use when offering or inquiring about the interest in vocational services and goals. These should include talking points for the individual and approaches to caregivers/families who may be resistant to employment for their loved ones due to fear for loss of benefits, lack of insight or vision for a person's abilities. This could be done in a workgroup.
8. 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.
  9. 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.
  10. 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.
  11. HHSC require development of a transportation plan for individuals enrolled in state waiver programs to be included in service planning to support employment and the seamless transition from TWC or waiver EA services to support successful integrated competitive employment services in the community.
  12. Maximize the use of Community First Choice habilitation, and Individualized Skills and Socialization Services to support prevocational and vocational activities and goals for integrated and competitive employment across all waiver programs.

## **Improve Community Access through Home and Community Based Services Regulations**

### **Background**

On March 1, 2023, a new program service Individual Skills and Socializations was implemented to allow for greater access to the greater community through their HCBS services.

## Recommendations

1. Evaluate rates to ensure the Individualized Skills and Socialization service is fully funded to enable full participation by all participants in the Community. Compensate for the cost of providing the service to waiver and non-waiver participants.
2. Ensure that Individualized Skills and Socialization funding and regulatory structure do not create barriers to participants in the HCBS program from maintaining and creating relationships and participating in activities with their friends in other programs.
3. Ensure that the funding stream allows for an adequate number of contracted providers to meet the need of program participants.
4. HHSC should reevaluate any unintended consequences which occurred due to the implementation of Individualized Skills and Socialization services i.e.: reduced provider availability, ratio difficulties, impact on other program participants in Individualized Skills and Socialization settings and quality of services offered.
5. Availability of funding for individuals to participate in community activities needs to be evaluated.
6. Seek input from stakeholders in various settings with varying services to increase awareness of barriers to community inclusion.
7. Adequately address wages for direct support professionals in order to recruit and retain a workforce to allow for meaningful implementation of the HCBS Settings Rule regulations across all programs.
8. Individuals in residential services should have increased flexibility and options for how they spend their daytime hours.

## System Adequacy Subcommittee

### Access to Services

The SA Subcommittee recommends improving access to services for persons with IDD by:

1. Expanding initial access to IDD Medicaid Waivers, and
2. Improving access to services through system reform

# Expanding Initial Access to IDD Medicaid Waivers

## Background

In order to prevent unnecessary institutionalization, individuals with IDD need timely access to waivers for interest lists and Promoting Independence. In addition, Medicaid beneficiaries eligible for CFC need education and information about CFC to enhance integration into the community, maintain or improve independent functioning and quality of life, and prevent admission to an institution.

Timely access to IDD Medicaid waivers, or to other waivers serving persons with IDD, is limited. Waiting lists are long and do not move at a reasonable pace. As of April 30, 2023, the IDD Medicaid-waiver interest list included the following number of persons on the list: 80,796 for CLASS; 1,588 for DBMD; 115,121 for HCS; 104,046 for TxHmL; 1,544 for STAR+PLUS Waiver; and 6,266 for Medically Dependent Children Program (MDCP)<sup>10</sup>. The unduplicated count across all six Interest Lists was 158,375. In comparison, as of April 30, 2023, the following number of persons were enrolled in these waiver programs: 6,224 in CLASS; 314 in DBMD; 31,744 in HCS; 3,728 in TxHmL; 63,964 in STAR+PLUS HCBS; and 6,233 in MDCP.

The Texas Legislature funds IDD waivers enrollments to support children and adults, who are enrolling from the Interest List, enrolling as a diversion from admissions to facilities, or enrolling as a transition from facilities, as part of its commitment to the Olmstead decision, the Texas Promoting Independence Plan and permanency planning for children. In 2023, the 88th Legislature funded new waivers slots for 1,831 persons on the interest lists to enroll during the 2024-2025 biennium. However, the past three 86th, 87th and 88th Legislatures did not appropriate funds for Promoting Independence waiver slots, which are slots to prevent unnecessary institutionalization. With no Promoting Independence slots during the 2020-2021, 2022-2023, and 2024-2025 bienniums, HHSC used attrition slots for persons seeking diversion from admission to an institution or wanting to transition from institutions to the community. NOTE: Attrition slots are created when previously funded HCS slots are permanently discharged by an individual after enrollment.

The tables below outline the Texas Legislature funding for waiver services: HCS and other waiver appropriations for fiscal year 2014 through fiscal year 2025, the

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<sup>10</sup> <https://www.hhs.texas.gov/about/records-statistics/interest-list-reduction>

attrition for HCS waiver slot utilization for the 2020-2021 and 2022-2023 biennium, and interest list counts by years on the list.

**Table 2: HCS Targeted Group Appropriated Slots by Biennium**

<b>HCBS Program</b>	<b>Purpose</b>	<b>FY 2014-15</b>	<b>FY 2016-17</b>	<b>FY 2018-19</b>	<b>FY 2020-21</b>	<b>FY 2022-23</b>	<b>FY 2024-25</b>
<b>Crisis Diversion<sup>11</sup></b>	To prevent institutionalization/crisis	300	400	0	0	0	0
<b>Nursing Facility Diversion<sup>12</sup></b>	For persons with IDD diverted from nursing facility admission	150	600	150	0	0	0
<b>Nursing Facility Transition</b>	For persons with IDD moving from nursing facilities	360	700	150	0	0	0
<b>Child Protective Services Aging Out</b>	For children aging out of foster care	192	216	110	0	0	0
<b>Nursing Facility Transition for Children<sup>13</sup></b>	For children moving from nursing facilities	0	20	0	0	0	0
<b>Large or medium ICF/IIDs</b>	For persons moving out of an ICF/IID, including an SSLC	400	500	325	0	0	0
<b>DFPS General Residential Operation (GROs)</b>	For children moving out of a DFPS GRO	25	25	0	0	0	0
<b>State Hospital (MDU)</b>	For persons moving out of state hospitals	0	120	0	0	0	0

<sup>11</sup> Crisis Diversion was known as SSLC Diversion in FY14-15 and FY16-17.

<sup>12</sup> FY14-15 HHSC (Prior to Transformation DADS used resource allocations to designate 150 slots for the purpose of diverting admission to nursing facilities.

<sup>13</sup> None specified in appropriations, but HHSC historically provides about 20 slots per biennium to help transition children from nursing facilities.

<b>HCBS Program</b>	<b>Purpose</b>	<b>FY 2014-15</b>	<b>FY 2016-17</b>	<b>FY 2018-19</b>	<b>FY 2020-21</b>	<b>FY 2022-23</b>	<b>FY 2024-25</b>
<b>HCS Interest List Reduction</b>	Statewide interest list reduction	1,324	2,134	0	1,320	542	1,144
<b>TxHmL Interest List Reduction</b>	Statewide interest list reduction	3,000	0	0	0	471	305
<b>Total</b>	<b>N/A</b>	<b>5,451</b>	<b>4,295</b>	<b>735</b>	<b>1,320</b>	<b>1,013</b>	<b>1,449</b>

**Table 3: CLASS, DBMD, MDCP, & STAR+PLUS HCBS Appropriated Slots by Biennium**

<b>HCBS Program</b>	<b>Purpose</b>	<b>FY 2014-15</b>	<b>FY 2016-17</b>	<b>FY 2018-19</b>	<b>FY 2020-21</b>	<b>FY 2022-23</b>	<b>FY 2024-25</b>
<b>CLASS Interest List Reduction</b>	Statewide interest list reduction	712	752	0	240	381	213
<b>DBMD Interest List Reduction</b>	Statewide interest list reduction	100	50	0	8	6	8
<b>MDCP Interest List Reduction</b>	Statewide interest list reduction	120	104	0	60	42	161
<b>STAR+PLUS HCBS Interest List Reduction</b>	Statewide interest list reduction	490	0	0	0	107	0
<b>Total</b>	<b>N/A</b>	<b>1,422</b>	<b>906</b>	<b>0</b>	<b>308</b>	<b>536</b>	<b>382</b>

**Table 4: HCS Attrition Slot Utilization for the 2020-2021 and 2022-2023 Biennium<sup>14</sup>**

<b>Attrition Target Group</b>	<b>Purpose</b>	<b>FY 2020-21 Released</b>	<b>FY 2020-21 Enrolled</b>	<b>FY 2022-23 Released</b>	<b>FY 2022-23 Enrolled</b>	<b>FY 2022-23 Pending</b>
<b>Crisis Diversion</b>	To prevent institutionalization/crisis	770	647	812	507	245
<b>Nursing Facility Diversion</b>	For persons with IDD diverted from nursing facility admission	265	220	210	133	56
<b>Nursing Facility Transition</b>	For persons with IDD moving from nursing facilities	346	172	244	79	63
<b>Nursing Facility Transition for Children</b>	For children (age 21 or younger) moving from nursing facilities	13	13	15	10	3
<b>Child Protective Services Aging Out of care</b>	For children aging out of foster care	190	173	161	87	61
<b>Large or Medium ICFs-IID</b>	For persons moving out of an ICF-IID, including SSLC	125	109	267	113	89
<b>Total</b>	<b>N/A</b>	<b>1,709</b>	<b>1,334</b>	<b>1,709</b>	<b>929</b>	<b>517</b>

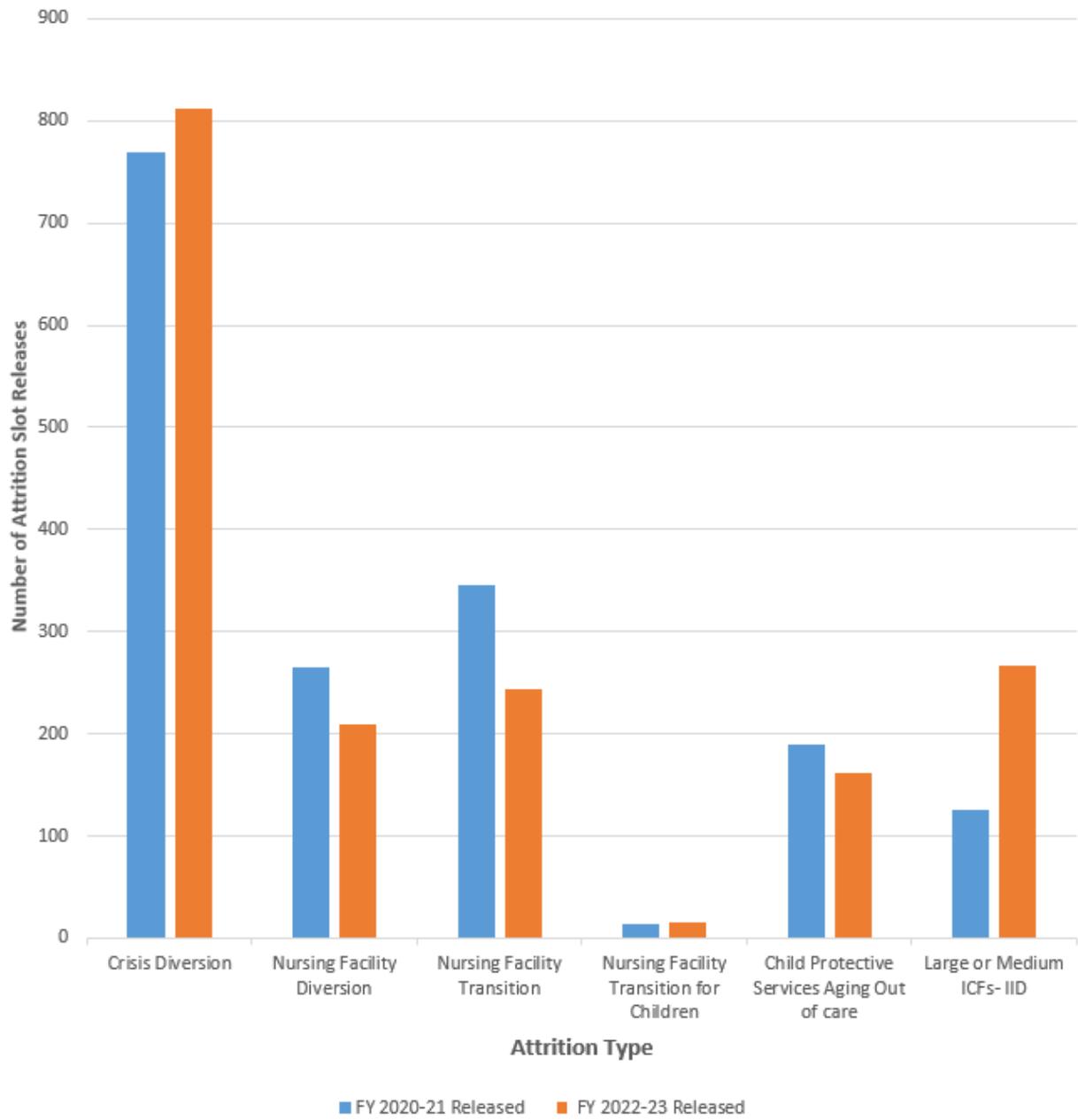
NOTE: Slots for persons transitioning from State Hospitals (MDU) or (DFPS) General Residential Operation may receive a Crisis Diversion slot, but there is no dedicated attrition slot type for these populations.

<sup>14</sup> Table data is for September 1, 2019, through June 30, 2023, tracked in HHSC monthly slot reports. HHSC continues to track issued slots across fiscal years. Attrition slots require input from HHSC Budget to determine if resources are available and to what capacity for the specified point in time.

**Table 5: 2023 SSLC Admissions with Comparison to Attrition Slots**

<b>Fiscal Year</b>	<b>FY 2013</b>	<b>FY 2014</b>	<b>FY 2015</b>	<b>FY 2016</b>	<b>FY 2017</b>	<b>FY 2018</b>	<b>FY 2019</b>	<b>FY 2020</b>	<b>FY 2021</b>	<b>FY 2022</b>	<b>FY 2023</b>
<b>New Admission</b>	166	187	178	160	139	149	129	89	104	120	103
<b>Transition Returns</b>	16	9	8	10	6	5	5	0	1	7	3

### Attrition HCS Attrition Slot Releases Biennium Comparison



**Table 6: 2023 Interest List Counts, by Years on List<sup>15</sup>**

<b>Years on List</b>	<b>CLASS Count</b>	<b>CLASS %</b>	<b>DBMD Count</b>	<b>DBMD %</b>	<b>HCS Count</b>	<b>HCS %</b>	<b>MDCP Count</b>	<b>MDCP %</b>	<b>STAR+ Count</b>	<b>STAR+ %</b>	<b>TxHmL Count</b>	<b>TxHmL %</b>
<b>0-1</b>	3173	3.9	347	21.9	7203	6.3	2839	45.3	1410	91.3	7216	6.9
<b>1-2</b>	4999	6.2	260	16.4	5424	4.7	2311	36.9	113	7.3	5394	5.2
<b>2-3</b>	3952	4.9	268	16.9	6132	5.3	1113	17.8	2	0.1	6151	5.9
<b>3-4</b>	5607	6.9	267	16.8	7943	6.9	1	0.0	N/A	N/A	8079	7.8
<b>4-5</b>	5811	7.2	173	10.9	8303	7.2	N/A	N/A	11	0.7	8453	8.1
<b>5-6</b>	6316	7.8	130	8.2	8448	7.3	2	0.0	N/A	N/A	8659	8.3
<b>6-7</b>	5755	7.1	142	8.9	8644	7.5	N/A	N/A	4	0.3	8812	8.5
<b>7-8</b>	5389	6.7	N/A	N/A	8092	7.0	N/A	N/A	4	0.3	8113	7.8
<b>8-9</b>	4594	5.7	N/A	N/A	6989	6.1	N/A	N/A	N/A	N/A	6810	6.5
<b>9-10</b>	4707	5.8	N/A	N/A	6653	5.8	N/A	N/A	N/A	N/A	6813	6.5
<b>10-11</b>	4952	6.1	N/A	N/A	7685	6.7	N/A	N/A	N/A	N/A	7796	7.5
<b>11-12</b>	5624	7.0	N/A	N/A	7550	6.6	N/A	N/A	N/A	N/A	7511	7.2
<b>12-13</b>	6731	8.3	N/A	N/A	7931	6.9	N/A	N/A	N/A	N/A	7773	7.5
<b>13-14</b>	6089	7.5	N/A	N/A	7679	6.7	N/A	N/A	N/A	N/A	6485	6.2
<b>14-15</b>	5518	6.8	N/A	N/A	6027	5.2	N/A	N/A	N/A	N/A	1	0.0
<b>15-16</b>	1580	2.0	N/A	N/A	4417	3.8	N/A	N/A	N/A	N/A	N/A	N/A
<b>16-17</b>	4	0.0	N/A	N/A	1	0.0	N/A	N/A	N/A	N/A	N/A	N/A
<b>Totals</b>	<b>78265</b>	<b>100</b>	<b>1239</b>	<b>100</b>	<b>108838</b>	<b>100</b>	<b>7651</b>	<b>100</b>	<b>19723</b>	<b>100</b>	<b>96895</b>	<b>100</b>

<sup>15</sup> Senate Bill 1, 87th Legislature, Regular Session, 2021 (Article II, HHSC, Rider 19) requires HHSC to post interest list counts (individuals) by years on list. <https://www.hhs.texas.gov/about/records-statistics/interest-list-reduction>

# Initial Access to IDD Waivers

## Recommendations

### Ensure Access to Waiver Slots and Benefits

1. Fully fund interest list reduction to serve all individuals currently on the interest lists no later than August 31, 2035. At a minimum, fully fund 10 percent interest list reduction per year (20 percent per biennium). Additionally, future funding considerations should ensure no individual is on an interest list for more than five years and also, take into account population growth and increased needs. To better address reasonable promptness, the committee recommends:
  - A. Accessing funds through all current and future available federal initiatives, to include MFP, MFPD, and the 10 percent increase in the HCBS Federal Medical Assistance Percentage (FMAP); and
  - B. Considering waivers under Section 1915(c), 1915(k) or 1915(i) of the federal SSA, 42 U.S.C. Section 13(c), in addition to 1115 waivers, or any future pilot, which may be used to provide HCBS services to people with IDD who meet eligibility criteria.
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, effectively working, and timely in meeting demands.
3. Ensure Texas has a comprehensively and effectively working Promoting Independence Plan that, when implemented, supports individuals and their LAR to make informed choices and decisions. The plan should help prevent and avert unnecessary institutionalization, provide comprehensive and accurate information, and support timely access to services in the most integrated setting. The plan must ensure that Texas children grow up in families, have access to services, and receive needed services.
4. Ensure immediate access for eligible MDCP recipients who receive SSI and are enrolled in STAR Kids or STAR Health managed care programs through a no-interest list policy. If additional LTSS services are carved into managed care over the next decade, ensure access for recipients with SSI who qualify for IDD waivers through a no-interest list policy.

5. Implement Transition Assistance Services in the DBMD waiver to include transition assistance for moving into a group home. These services are currently included in the HCS waiver and should be available in all IDD waivers.
6. Develop provider network for the DBMD waiver throughout the state. Currently, in counties where the DBMD waiver is not available, eligible persons are referred instead to the HCS waiver.

## **Ensure Efficient Interest List Management and Processes**

1. Implement strategies to reduce the growth rates of the waiver interest list by providing the right community-based service at the right time. Prioritize funding to address the following: strengthening the CFC program, supporting sustainable rates for DSWs, enhancing the program service array with the addition of transportation and respite, and increasing awareness through a concerted, statewide outreach effort.
2. Implement sub-strategies and potential actions, included in the [2022 Texas Statewide Intellectual and Developmental Disabilities Strategic Plan](#), for expanding “Individual Services to Support Diversion, Transition, and Interest List Enrollments.”
3. Implement the strategies recommended by the IDD SRAC as outlined in the 2021 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 comprehensive programs and support referrals to available services. In addition, 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.
4. Provide outreach and training on how to access community services, including those services that may require time on an interest list. Outreach should include information about the various attrition waiver slots and be provided to the IDD population (persons and families), schools, pediatric primary care physicians and specialists, and those staff responsible for assisting persons to access attrition slots. Expand outreach resources, to include webinars and online resources with a focus on decision-making and system navigation. Ensure outreach efforts are required statewide, including all rural counties.

5. Streamline and simplify the waiver enrollment processes, to include processes for establishing timely waiver and Medicaid eligibility.
6. Ensure access to knowledgeable Medicaid Eligibility for Persons with Disabilities (MEPD) staff to authorize, facilitate and correct Medicaid eligibility errors through a transparent escalation hotline.
7. Streamline and simplify the diversion processes for accessing waivers. Consider flexibilities for expediting the Determination of ID.

## **Improving Access through System Reform**

### **Background**

The Texas Government Code 534 as amended by H. B. 4533, 86th Legislature, Regular Session, charged the IDD SRAC to make recommendations for a redesigned system for acute care services and long-term services and supports. Although the 88th Legislature did not fund the pilot to test the redesign, the IDD SRAC assessment of the existing system's capacity to meet service needs led to recommendations for system reform. Recommendations in this section suggest reforms to assist persons with IDD to access the services they need at the time that they need them.

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 fee-for-service.

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.

The IDD SRAC also considered lessons learned during the COVID-19 PHE as instructive for the IDD system redesign. During the past three years, HHSC made temporary changes to the Medicaid and CHIP program in response to the COVID-19 PHE. In essence, the PHE provided an opportunity for the state to test delivery of services under Medicaid and other public benefits through the use of telecommunications or information technology. H.B. 4, 87th Legislature, Regular Session, 2021, mandated that some of these provisions continue after the PHE ends. In addition to implementing H.B. 4, service providers and LIDDAs learned how to use alternate service models to gain efficiencies and how to prepare for future disasters. Examples of these experiences include the following: 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.

## **Recommendations**

HHSC should consider the following strategies in the development of a service system that ensures timely access to the right service at the right time for persons with IDD and ensures access to quality metrics specific to the population of individuals with IDD served in managed care programs:

### **Ensure Efficient Access to Data and Processes**

1. Improve interest list data collection, tracking, and reporting. Provide comprehensive data at least quarterly to the IDD SRAC, and post for the public regarding the requests for waivers, and enrollments by slot type, and the interest lists by waiver type. 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. NOTE: A person's status is inactivated when they are unable to be contacted to verify continued interest.
2. Improve institutional data collection, tracking and reporting. Provide comprehensive data at least quarterly to the IDD SRAC, and post for the public, regarding institutional census, admission and discharge of persons with IDD including SSLCs, ICFs, General Residential Operations (GROs), NFs,

and number of persons receiving institutional services, by institutional type, who are on an interest list, by waiver type.

3. Develop, in collaboration with MCOs, an automated identification of Persons with IDD and with related conditions who are served in the Managed Care programs (STAR Health, STAR Kids, STAR+PLUS HCBS LTSS, and STAR+PLUS acute care services).
4. 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, TxHmL, MFP, diversion for at risk people, and local community resources.
5. 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.
6. Continue processes to allow a person, or someone on their behalf, suspected as having an intellectual or developmental disability to register for IDD interest lists.
7. 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.
8. Improve access and quality of acute care and LTSS benefits through the required and funded use of electronic documentation by long-term providers:
  - A. Develop the capability to electronically maintain health and life records for all individuals served in LTSS programs that are interoperable with related systems.

- B. Develop the capability to allow individuals/LAR/an involved family member with participant consent to access and review information and data collected about them in their health and life records.
  - C. Provide life records to participants, MCOs, and all parties, with participant consent, involved and be on a shared platform.
  - D. Reduce and/or consolidate the number of portals/platforms that providers, FMSAs, MCOs, and LIDDAs must access in order to submit and retrieve data for the monitoring and reporting of performance outcomes.
  - E. Contract with an experienced vendor to replace other record management systems with a unified platform for the use of electronic health/electronic life record technology. The selected system must be capable of interoperability between MCOs, service coordinators, and long-term care providers.
9. Improve communications between LTSS program participants, providers and MCOs through the implementation of additional communication options, such as texts, phone, tele-communications, and other evolving means of engaging and expanding contacts to persons with participant consent.
10. Implement and charge a Statewide Intellectual Developmental Disability Coordinating Council, through strategic planning and annual reporting processes, to:
- A. 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.
  - B. 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.
11. Monitor the implementation and impact of managed care, new policies, and initiatives required by the 88th Texas Legislature.

## Ensure Access to the Most Appropriate Service Array

1. Provide choice of the most appropriate waiver when a person in a SSLC or other institutional setting, is transitioning to the community. Choice would include all waivers (CLASS, DBMD, HCS, STAR+PLUS HCBS, TxHmL and MDCP) for which a person qualifies.
2. Provide for a broad array of integrated community service options and a reasonable choice of service providers, consistent with home and community-based service settings requirements. Improve use and flexibility of CDS options and training for self-advocates to direct their own services when desired.
3. 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,” excerpted from the New Mexico Developmental Disabilities Supports Division, *The Meaningful Day Idea Book* (First Edition Updated: February 10, 2009), pg. 116:

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.

4. Implement policy and equitable funding to support persons when transitioning from institutional care to all community settings, such as one’s own-home or apartment, host home, group home or across all allowable waiver settings.
5. Establish and sustain partnerships through regional collaboratives to identify barriers to transition, address gaps in state and local community resources,

and implement improvements in access during transitions in care through development of community and inter-agency strategies.

6. Provide the services and support necessary to enable a person to remain living with their family, if desired, for children and adults with IDD.
7. Provide additional support for individuals in the hospital. Waiver participants may have lengthy hospital stays and require attendant care during their stay. If needed, the attendant care should be a waiver benefit.

### **Ensure Access to Technology**

1. Ensure access to emergency and behavioral telemedicine, such as StationMD, to reduce unnecessary emergency room admissions for all individuals including those who are dual eligible.
2. Review billable adaptive aids and allow for flexibility in billing requirements to improve access to technology by individuals.
3. Incentivize providers to utilize electronic health record systems and other provider-side technology that assists direct care staff with supporting people with complex behavioral and medical needs. This includes making it easier for providers to use electronic health records from a regulatory perspective, improving interoperability opportunities and/or financial incentive payments.
4. Provide access and funding for remote monitoring technology when agreed to by an individual in their person-centered service plan.

### **Ensure Efficiencies and Flexibilities in Medicaid and CHIP Programs**

1. 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 in a timely manner 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.
2. 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.

3. 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.
4. Add PPE, to include test kits, as a reimbursable Medicaid benefit for all recipients, including those using CDS and living in non-congregate settings, and their service providers.
5. Permanently remove the 30-day spell of illness limitation for hospitalizations for adults in the STAR+PLUS and fee-for-service programs. This has been a concern during this COVID-19 crisis for Medicaid recipients who have exceeded the 30-day length of stay for COVID-19 related illnesses.
6. Direct health plans to develop and provide services, using innovative approaches, that address non-medical drivers of health experienced by Medicaid eligible persons. This has been invaluable to support persons with food insecurities, housing needs, or experiencing other non-medical drivers of health.
7. Amend the 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 a medically fragile child to stay in a nursing facility for up to 30 days creates unnecessary risk.
8. Revise policies to allow Direct Service Workers/attendants to work remotely, virtually or off-site to the extent allowed by federal regulations and an individual's person-centered service plan. Consider remote service delivery options for habilitation activities including Individualized Skills and Socialization and SE. NOTE: Attendants can teach and train a person remotely using video and verbal prompts.

## **Ensure Access During a Disaster Response**

1. Require 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, or significant others, due to hospitalization or other circumstances. The plan should address the individual's right to have access to persons who may advocate for their health and safety.

2. During a declared emergency or disaster, for Consumer Directed Services, allow guardians who are the CDS employers of record to be the providers of CFC services. Currently, this is not allowed in the CDS option. This change would keep individuals safe by allowing them to access services during a declared emergency or disaster. Services would be provided by the guardian in the home rather than risking the safety of attendants traveling to and from the home during a disaster. In addition, this would reduce barriers to direct service provider recruitment and retention during a disaster.
3. Allow flexibilities for the new employee training requirements for family members of the individuals receiving services during a declared 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 telecommunications model for training or delaying deadlines or timeframes for the training requirement.
4. Extend all Medicaid waiver plans of care, level of care assessments, and CFC assessments expiring during a declared emergency or disaster by the period of time necessary to ensure uninterrupted waiver services and Medicaid eligibility. Apply these actions during a declared emergency or disaster while HHSC is processing the backlog of cases, and at the conclusion of a declared emergency or disaster. This will allow Medicaid recipients in waiver programs to continue to receive services while protecting them from unnecessary exposure from waiver or assessment providers. Recommend that HHSC focus first on the STAR and CHIP population and extend eligibility for IDD waivers until resolution of STAR and CHIP eligibility.
5. Screen for early detection and identification of abuse and neglect during times of crisis.
6. Allow the use of on-line Cardiopulmonary Resuscitation (CPR) training and certification such as the training offered by the American Heart Association. 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 declared emergency or disaster.
7. Disallow the reduction in waiver eligibilities, services or budgets if persons are temporarily under-utilizing the services in their plans due to a declared emergency or disaster.

8. 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 a declared emergency or disaster.
9. Through HHSC processes for public information, encourage timely dissemination of the most current information about vaccines and access to vaccinations.
10. Ensure standards of care do not discriminate or deny access to care and treatment on the basis of disability.

## **Strengthen Support for People with More Complex Behavior, Medical and Physical Needs**

### **Background**

Enhanced services, coordination, and monitoring are not available to persons with complex needs across all HCBS. Behavioral support professionals, nurses and direct care workers are in short supply, causing delayed assessments and services, which can lead to more restrictive, out-of-home placements. (See workforce recommendations in this report).

Due to lack of resources, insufficient rates, and lack of flexibility within the waivers, some providers have been unable, reluctant, or unwilling to take on the liability of serving a person due to the person's medical, physical, or behavior acuity (high needs) because it is hard to get services at the right amount approved.

HHSC continues to seek supports for persons with medically complex needs through a Medically Fragile Policy in an 1115 STAR+PLUS Waiver Amendment. However, the 1115 STAR+PLUS amendment was submitted to CMS on September 1, 2020 and is still pending approval. Meanwhile, it is hard to find nurses and attendants due to rates, billing restrictions and very limited use of nurse delegation.

As of the date of this report, the STAR+PLUS Pilot was not funded, and activities have ceased. However, the IDD SRAC recommendations included the development and implementation of enhanced services to better meet the complex needs of persons with IDD and similar functional support needs. To ensure access to high quality services in the most integrated setting, the need to address access to services for individuals with complex or high medical, physical and behavior needs must be addressed across all programs, not just limited to a pilot or geographic area. Access must include employment services and/or meaningful day supports.

HHSC completed a study as required in Rider 38. Rider 38 required HHSC to conduct a study on the provision of services under the HCS waiver program to individuals with IDD who have high behavioral and medical needs.

HHSC defined the scope of high behavioral and medical needs for which an individual with IDD may require enhanced services and service coordination under the waiver. HHSC identified certain individuals with IDD and similar behavioral needs enrolled in the program who have the highest behavioral and medical needs. [A report](#) on the results of the study was submitted to the Legislature on August 31, 2022. HHSC received input on the methodology and scope of the study from IDD SRAC and other stakeholders.

HHSC reports that the goal was to provide continuity of care and prevent institutionalization. IDD SRAC stakeholders made recommendations in their discussions with HHSC, to include a request that HHSC correct limitations of data systems to more accurately capture the count of individuals with complex needs and those accessing crisis diversion and nursing facility diversion.

IDD SRAC recommendations below provide options to address barriers for persons with complex and high needs to access or maintain stability in home and community-based programs and services.

## **Issue 1 - Comprehensive Assessments and Level of Need Determinations**

A quality, comprehensive assessment tool is needed to:

1. Provide a uniform method of gathering information for level of care and level of need to better identify and provide the types and amount of supports needed and facilitate robust program service planning;
2. Facilitate accurate and in-depth assessment of participant/member needs;
3. Eliminate unnecessary duplication of assessments; and
4. Promote sharing of information across programs and agencies.

Once needs are identified, an appropriate mechanism for assigning resources to meet those needs is critical. For Texans with complex needs, the inventory for Client and Agency Planning ICAP is used for IDD institutional and community services. However, the ICAP does not identify medical needs and does not adequately provide resources for medical, behavioral and/or physical supports and services in the most integrated setting. Although Texas planned to pilot a new

assessment tool to use with the STAR+PLUS Pilot Program, the pilot is not funded and work on that Pilot has paused at the time of this report due to lack of appropriations. The InterRAI-ID and the Collaborative Action Plan (CAP) are also under consideration in IDD programs not limited to the pilot. Until IDD assessment tool(s) improve, recommendations below apply to current assessments and subsequent resources allowed for purchasing supports and services in the community (see also SP3 assessment recommendations in the TMC section of this report).

1. Develop a high medical LON (similar to LON 9 for behavior supports in in CLASS, DBMD, HCS, and TxHmL) at enrollment and annually.
2. Assess and address the whole person. Without limiting consideration to specific diagnosis fully assess needs, including medical and behavioral, at enrollment and identify an appropriate Level of Need (LON), not dependent on temporary “bumps” for medical and behavioral supports.
3. For new HCS waiver enrollments, HHSC should collaborate with LIDDAs, providers, and MCOs to establish the initial LON for the first 12 months. HHSC should collaborate with providers and LIDDAs for initial LON to safely support the person for the initial twelve months without barriers and unnecessary Utilization reviews.
4. For enrollments and changes in condition, HHSC must promptly consider all medical and psychiatric history and hospitalization to establish an accurate LON.
5. Expand due process rights to appeal an initial or subsequent LON determination in HCS and level of care determination in CLASS to persons in or enrolling in HCS and CLASS and their representatives. Currently, LON appeal rights are only afforded to providers.
6. Implement a one-year presumption of LON 6 or LON 9 for persons enrolling from all institutional settings or aging out from the Medicaid CCP skilled nursing. Presumptive LON 6 or LON 9 is limited to SSLC transitions. Maintain, at a minimum, the LON of a person transitioning from another waiver or other IDD program for one year. The importance of adjustment to change for this population should be recognized. This allows for the individual transitioning to adjust to new environment and program structure to develop their routine before reassessment of LON. However, a new need or change in condition that warrants a higher LON should not be restricted to any time limits.

7. 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.
8. Add higher level of services with higher total cost allowance for persons with the most complex needs in Medicaid, including in managed care, all waivers, and any pilot. The increased level should include enhanced rates for Direct Service Workers.
9. Use the Nursing Facility RUG or its successor to supplement IDD ICAP assessments and to demonstrate the need for a LON 9 or HCS high medical needs services. NOTE: This cost-effective expansion of high medical needs initiatives can prevent a more restrictive, more expensive setting at a higher level of care and costs.
10. Develop and implement a comprehensive assessment for functional behavioral support and skilled nursing needs prior to program entry, so that for adequate services and supports to meet behavioral health and skilled nursing needs are provided upon entry. Services should be robust, flexible, appropriate, and communicated to providers prior to enrollment. Having this allows for a new program to be prepared to accept an individual new to their program, to provide for the person's needs, and facilitate successful transition for the program and the individual served.

## **Issue 2 – Ensure consistent statewide provider capability to meet complex needs**

1. Ensure adequate resources, waiver flexibility, and funding to include technical assistance, for providers to meet complex needs to support a zero reject policy. Establish clear expectations, enforce program rules and ensure compliance for providers who delay or deny services to persons with complex or high needs. Track and address enrollment delays and denials.
2. Continue to expand the behavioral, medical, and psychiatric regional teams to serve all waiver programs. Expand the use of best practices and evidence-based programs by supporting LIDDAs that are delivering evidence-based programs to provide training, technical assistance, and ongoing support to other additional LIDDAs.
3. Establish a Regional Collaborative with participation by IDD provider agencies, MCOs, LIDDA, 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.

4. HHSC develop clear guidance and training for LIDDAs and providers to improve quality of documentation for justification for services. Training should be available for new hires within 60 days of employment and no less than annually for staff thereafter.
5. Allow partial approval of an IPC when documentation is not clear for one or more services to allow for service delivery for approved services.
6. Define services and expanded services to allow for clarity, flexibility, ability to justify and obtain authorization when necessary for health, safety, and maintaining stable community services.
7. Add flexibility so that when circumstances, such as hospitalization or inability to secure consistent nursing as authorized, dollars and units of services can be adjusted accordingly, including allowing for more high-quality nurse delegation.
8. Improve and streamline the SSLC transition process and create successful and timely continuity of necessary supports and services.
9. Implement a medically fragile policy within the STAR+PLUS HCBS program to eliminate the cost cap when justified without further delay in fiscal year 2024.
10. Develop qualifications for advanced provider expertise to advertise provider ability to specialize for populations. Consider specialty provider designations that allow for more appropriate choice of provider based on unique needs of the person.
11. Allow providers to bill for supports provided when the individual is hospitalized, including skilled assessment for post discharge needs to ensure adequate supports to meet health and safety needs of the person. CMS has clarified allowing this service. HHSC needs to request update to Waiver.

### **Issue 3 - Enhanced Staffing and Supports to Address Complex Needs (See Workforce Shortages section in this report)**

12. Expand skilled nursing definitions and guidelines in all waiver programs similar to STAR+PLUS HCBS waiver program, to ensure adequate levels of nursing to maintain support of the person and to avoid institutionalization.

13. Expand billing requirements for skilled nursing services to ensure people get the level of service they need across all waivers.
14. Ensure enhanced rates in IDD waiver programs to address provider capacity to meet needs of individuals with complex needs.
15. Ensure ability to exceed the annual cost cap in IDD waiver programs, MDCP and STAR+PLUS HCBS to meet the rising cost of services when indicated by the individual's need determined by the nursing, behavioral and functional assessments.
16. Streamline access to GR and other additional funds for those who exceed the cost cap for Medicaid waivers, including in managed care, any waivers, and any pilot. Modify eligibility for GR funds to remove the institutional bias and use language consistent with maintaining services in the most integrated setting.
17. Ensure flexibility within the waivers that allows for use of GR to individuals with either high behavioral or high medical needs.
18. As costs and wages rise, increase the cost cap in all waivers programs consistent with 200 percent of the average costs in small ICFs.
19. Create and ensure access 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.
20. Ensure access to protective supervision /personal assistance services across all waiver programs. Reinstate access to protective supervision in the HCS waiver.
21. Create high needs services, such as enhanced behavioral and medical supports and enhanced case management, that support advanced direct service professional training, credentialing, supervision and compensation when supporting persons with high medical, behavioral, physical, or psychiatric needs.
22. Create enhanced rates and training in CFC services, provided through all waivers and non-waiver CFC services for persons with more complex needs. Consider a rate structure equivalent to that of Residential and Individualized Skills and Socialization rates based on LON in the HCS Medicaid waiver program. Support a higher rate for persons with higher acuity needs. NOTE: Currently a person with a LON 6 receives a higher rate for the residential and Individualized Skills and Socialization 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 is included for CFC services provided through all waivers and non-waiver CFC services and all service models (CDS and Agency options).

23. Incorporate enhanced services, in addition to fully accessing available services for technical assistance from eight regional teams, in the IDD 1915(c) Medicaid waiver programs and other programs serving individuals with IDD. HHSC should continue to provide oversight and structure to the Technical Support Teams through its MFP unit. Texas must ensure best practices and flexibilities so regions can do what is needed in their region.
24. Provide additional formal training on how to safely transfer people with mobility impairments and complex medical needs from one location to another without risking injury to the member or the attendant providers.
25. Create programs that are comprehensive in nature, meet the needs of individuals with complex behavioral, medical and physical needs, and include both out-of-home options and in-home supports. Programs, at a minimum, should include:
  - A. Develop targeted training for direct service workers, service coordinators and program providers for awareness evaluation and assessment of medical and physical health needs that may contribute to behavioral, psychiatric conditions and exacerbations to identify whether behavioral support needs are related to medical, physical, psychiatric, and/or environmental factors;
  - B. Coordination between the supports for the person including providers, family, specialized behavioral health supports;
  - C. Crisis respite services that allow for alternatives to hospitalizations and also allow for planned respite for evaluation purposes;
  - D. Sustain and expand behavior, medical, psychiatric health, and other recent program efforts that focus on preventing crisis and supporting families and providers of individuals who are at risk of placement in more restrictive settings;
  - E. Follow-up services to maintain progress;
  - F. Development of cross-system crisis prevention and interventions to assure providers and families have options that limit the inappropriate use of police and emergency rooms for behavior interventions;

- G. Development of a model program for meeting the behavioral health needs of people with IDD, including the enhancement of current services where available;
- H. Development of small community-based, short-term, therapeutic, emergency out-of-home options for persons in crisis until they reach stabilization and a plan for support is implemented for their return to the home; and
- I. Include the enhanced medical and behavioral health LTSS developed, but not implemented, to provide consistent services between waiver programs and the additional benefit to support the individual and caregiver in their waiver program. Benefits include:
  - a. Enhanced Behavioral/Family Caregiver Coaching Services: Service that helps families and caregivers in identifying their strengths and to discover constructive ways to address situations that may be causing concern. This service assists families/caregivers in identifying areas of concern (e.g., medication changes and assessing psychiatrists) and that may need additional clinical assessment and program considerations.
  - b. Enhanced Behavioral Extended Substance Use Disorder Services: Services are specialized services to meet the needs of adults with IDD, traumatic brain injury, or similar functional needs who have or are at risk of developing substance use disorders. The service is as an enhancement to the State plan substance use disorder benefit.
  - c. Enhanced Behavioral Peer Supports: Service to help the person to identify their strengths to develop psychosocial and interpersonal skills used in problem resolution, to access a desired level of community integration, and to identify community based social, recreational, or educational opportunities that enhance quality of life and support the person's goals. Provided by person with lived experience or self-advocate.
  - d. Enhanced Behavioral Therapeutic In Home Respite: Service provides relief for the primary caregiver; however, the activities are therapeutic in nature and are developed by licensed clinical staff. This service is provided by a trained behavioral direct support professional within the person's primary home. Therapeutic in-home respite services may be provided with or without the primary caregiver in the home.

- e. Enhanced Behavioral Therapeutic Out of Home Respite: Therapeutic support service provided in a safe environment with staff on-site providing 24-hour supervision to a person who is demonstrating a crisis that cannot be stabilized in a less intensive setting. Services is short term stabilization, assessment, and identification of appropriate interventions. Facilities where therapeutic out of home respite services can be offered will be small, calm, and home-like.
  - f. Enhanced Medical Services: Service provides assistance with ADLs and IADLs in addition to more complex medical tasks delegated by a registered nurse. An attendant providing enhanced medical supports requires advanced training and experience.
- J. Host Homes:
- a. Develop a separate billing rate for HCS that allows for respite, direct care supports, and transportation without lowering the daily rate, to support people with high behavioral and medical needs and to avert burnout or disruption to promote stability and continuity of community living arrangement.
  - b. Reevaluate waiver program design when an individual has high behavioral or medical needs to include additional in-home supports for people living in Host Home settings.

## **Issue 4 - Funding**

Provide funds to implement systemic changes that address barriers for individuals with high needs to access or maintain home and community-based services.

Providers must be able to demonstrate and verify that the funds are used for their intended purpose and, demonstrate that payment is both justified and sufficient to meet medical or behavior acuity (high needs) of individuals and prevent institutionalization. Policy should be developed to identify actions to be imposed on providers who deny or delay services to individuals with high needs. We support funding enhancements for both the provider agency model and CDS model that, at a minimum, include:

1. Ensure statewide providers have adequate flexibility and funding and allow for payments and billing for critical services such as nursing, direct care/attendant care workers and supervision of non-licensed staff based on a comprehensive assessment tool that captures all needs. Include funding for a LON 9 in HCS and other waivers.

2. Implement add-on rates for more complex services, service coordination, and monitoring for individuals with complex needs enrolling in waivers from the interest lists as well as those transitioning from an institution to the community.
3. Provide funds to expand programs and create new comprehensive IDD waiver benefits.
4. Fund overnight supports and/or protective supervision across all HCBS waivers.
5. Implement processes to raise allowable waiver cost cap based on 'the most integrated setting', health and safety and availability of community living arrangements in which the person's health and safety can be protected at that time, including but not limited to TxHmL, HCS, CLASS and DBMD waivers.
6. Implement program for medically fragile individuals in the 1115 STAR+PLUS program.
7. Update the 2024-2025 General Appropriations Act H.B.1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Rider 14 regarding Waiver Program Cost Limits (B) to add "continuation of those services is necessary for the person to live in the most integrated setting appropriate to the needs of the person" and strike "there is no other available living arrangement in which the person's health and safety can be protected at that time." HHSC should update this policy and statute for the 2024 -2025 appropriations and future appropriations.
8. Provide funding to assess and address the need for enhanced high needs services regardless of one's entry to an IDD 1915(c) Medicaid waiver, including:
  - A. Enhanced staffing ratios when justified by complex medical or high behavioral needs when necessary to maintain health and safety of the person to remain in the community;
  - B. Enhanced staffing ratios and enhanced wages for direct service workers/ staff serving individual with high medical and/ or behavioral needs across IDD programs to meet needs of the most medically involved individuals at risk of institutionalization or hospitalization. Reimbursement of staff and program must support level of need;
  - C. HHSC to develop training related to physical, medical, and environmental triggers for behavior. Training should include:

- a. Training of IDD providers;
  - b. Training and on-site consultation from highly trained clinical staff; and
  - c. Training and consultation for behavioral health systems in the specialized needs of the IDD population.
- D. Billable nurse supervision, oversight and coordination.

## **Direct Care, Attendant and Nursing Workforce Crisis**

### **Background**

#### **Direct Care Worker and Attendant Workforce Issues**

Texas is experiencing a significant shortage of direct care workers (DCWs) and attendants, the frontline workers who support people with intellectual and other disabilities in the community. Staff serving in this capacity are the most important persons in one's life, providing the day-to-day, hands-on services and supports to not only assist persons achieve their full potential, but to also remain and participate in the community. NOTE: Though DCWs and attendants (also known as, community attendants) provide similar services and supports – habilitative and/or personal assistance - to persons in the various Texas Medicaid programs, the term direct care worker or direct support staff is typically used in IDD programs whereas the term attendant is typically used in all other programs. While these terms may be used interchangeably, HHSC staff currently do not.

The workforce crisis places recipients of IDD services at risk and jeopardizes their health and safety. It further results in burnout for staff covering multiple shifts and opportunities for unintended consequences, reduction in critically needed services for persons when staff cannot be hired, reduction in quality of services and the inability of one's person-centered plan to be fully realized.

#### **Factors Contributing to the Workforce Crisis**

Stemming from decades of underinvestment in programs designed to support people living in the community and other factors, chronic staffing shortages existed before the pandemic. The pandemic only exacerbated the crisis.

While efforts over the years to address staff shortages have been attempted, the efforts have primarily focused on recommending non-monetary solutions and strategies such as developing a "public relations campaign to increase awareness of

the role of community attendant work and growing career opportunities in the field, enhance data collection to study wage equity, service gaps and other matters impacting individuals receiving community attendant services and providers of attendant services.” See [Community Attendant Workforce Development Strategic Plan, November 2020, Rider 157, 86th Legislature](#).

Other non-monetary solutions or recommendations have also included streamlining administrative tasks associated with many program requirements. One example is implementation of the EVV requirement. While EVV provides cost-savings to the state, its use has resulted in increased expenses to providers that are not accurately reflected in cost reports, due to the lag inherent in the Medicaid cost reporting process. However, when HHSC (and in the past, legacy DADS) have convened workgroups to examine what rules or processes could be either eliminated or streamlined, the outcome has resulted in little to no change to affect any meaningful reduction or streamlining of administrative tasks. NOTE: Though not inclusive, between 1999 and 2016 there were approximately 12 legislative directives (either via riders or legislation) directing streamlining of regulations and policy requirements, again, with the outcome of the efforts yielding little to no change in provider administrative tasks and requirements.

Monetary solutions to address both workforce shortages and increasing costs of service delivery across Texas Medicaid programs have been minimal, leading to stagnant reimbursement rates which have not kept pace with other hourly wage industries. Due to Texas’ conservative Medicaid service rates providers are not able to offer wages and benefits competitive with fast-food restaurants, grocery stores, Amazon, Walmart, Target, etc. Such large retailers and similar businesses offer starting wages between \$15/hour to \$20/hour or higher with additional benefits including paid time-off, full health insurance, college tuition reimbursement and regular raises or bonuses.

The lack of Medicaid rate and direct care worker wage increases has significantly harmed all Medicaid programs, jeopardized the health and safety of individuals relying on these services and, more importantly, has threatened the existence of community-based services. This includes community based ICF/IID services and 1915(c) waiver services. While all individuals suffer a host of consequences from not having access to needed services, individuals and their families who rely on residential group home services, which require staff 24/7, are at particular risk. Data from two surveys (one in December, 2022; one in April, 2023) conducted by the Texas Council of Community Centers, Private Providers Association of Texas and Providers Alliance for Community Services of Texas, there have already been at

least 100 group home closures as the result of providers not being able to recruit and retain direct care staff. These closures are anticipated to increase as the result of the March 1, 2023 raises in direct care staff wages at the SSLCs (starting wages were increased from \$15.00/hour on average to \$17.50 an hour, and in some cases, up to \$21.00/hour, but also the five percent increase in state employee wages on July 1, 2023 and September 1, 2023 appropriated by the 88th Texas Legislature.

Coupled with the above, the 88th Texas Legislature only funded a wage increase for all Medicaid programs with attendant services that equates to \$10.60/hour. As wage rates in the various programs vary, some attendants will receive an increase of about \$2.49/hour (or about a 31 percent increase), whereas many others will receive an increase in their hourly wages anywhere between \$0.75 to \$1.00 (ranging between one percent to seven percent increase).

NOTE: Reports detailing the crisis in Texas and across the nation are:

1. The Case for Inclusion 2022 - Blazing Trails to Sustainability for Community Disability Services (prepared by United Cerebral Palsy and ANCOR Foundation);
2. University of Minnesota, Institute on Community Integration – Policy Research Briefs on Direct Care Worker and Attendant Wages;
3. 2020 Texas Revised Promoting Independence Plan;
4. Community Attendant Workforce Development Strategic Plan, November 2020 – required by the 2020-21 General Appropriations Act, H.B. 1, 86th Legislature, Regular Session (Article II, HHSC, Rider 157) for fiscal year 2018 attendant turnover and vacancy rates for most community-based programs. The report does not include data for community based ICFs/IID. Also, HHSC only collects this data on a biennial basis through cost reports providers submit which renders the data outdated when presenting information to the Legislature;
5. The State of America’s Direct Support Workforce Crisis 2022 (Oct. 2022) – American Network of Community Options and Resources (ANCOR).

## **Nursing Workforce Issues**

Similar to the shortages of direct care workers and attendants, Texas (as with other states across the nation) is facing a shortage in nurses. Though predominately only reported in reference to hospitals, nursing homes and other medical facilities, this

shortage is also experienced by providers of Medicaid long term services and supports programs such as the community-based ICF/IID program, the HCS waiver program and home health agencies.

Though reasons for the shortages across these service-types may differ, in general they are the same: burnout from the PHE, excessive overtime, stressful working conditions with little room for flexibility to use 'best judgement and practices' in a very regimented and paper-work oriented profession, concern about getting COVID-19 themselves and infecting their families and lack of/difficulty in obtaining PPE. Similar to causes of direct care worker and attendant shortages, wages and benefits are a major contributor to nursing shortages across Texas Medicaid programs. The issue is exacerbated by hospitals and other medical facilities being able to attract nurses with lucrative wage and benefit packages and sign-on bonuses. Benefits are not available in the Medicaid programs as the rates set for

nursing limit the amount LTSS providers are able to pay. As reported by many LTSS providers, if funds are not made available to increase nursing wages, the health and safety of individuals will be at risk and providers will be at risk for adverse enforcement actions neither of which addresses the need to meet health and safety of the persons we serve. The issue is further exacerbated for Medicaid providers who operate in cities in which there is a SSLC and who must compete for staff due to disparate wage rates across the continuum.

## **Other Funding Sources**

Many Texas Medicaid programs have access to the Attendant Compensation Rate Enhancement (ACRE) program. The program is voluntary and participating providers are required to annually report to HHSC that at least 90 percent of the funds are spent on direct care/attendant compensation. While the 86th Legislature appropriated additional funds to certain Medicaid programs to adjust the amounts available in each level at least for certain services (such as group homes), any effectiveness of the funds in recruiting and retaining DCWs was short-lived given declaration of the COVID-19 PHE. More recently, the 88th Texas Legislature appropriated funds to certain Medicaid programs to adjust the fund amounts available through ACRE; however, the appropriated funds did not increase funds awarded to IDD providers. In addition, the 88th Texas Legislature, via Rider 30, Article II, directed HHCS to evaluate the effectiveness of ACRE and report back to the 89th Texas Legislature.

Though one-time funds to offer recruitment and retention payments to direct care workers, attendants and nurses were made available through the ARPA of 2021, the funds were not sufficient to stabilize the crisis or be a long-term solution for staff shortages and market retention and in some CDS cases these funds have not been distributed or have not been distributed accurately.

## **Recommendations**

While some hypothesize that the market will correct itself, economists, and other financial experts state otherwise. Without a longer-term solution to the crisis the above issues will only further jeopardize the health and safety of individuals and their access to community living, and potentially result in placement of persons in more costly institutional service settings (particularly if programs close) or hospital admissions.

To mitigate any unintended consequences between now and the 89th Texas Legislative Session and ensure persons receive the services and supports they need and at the levels they need, meaningful strategies to address the workforce crisis across all Medicaid-funded programs and services must be developed and implemented. Though not inclusive, following are recommended actions and strategies:

1. Recommend, support, and obtain funding to address the workforce crisis, along with increased access to waivers, the top priorities in HHSC's FY 2026-2027 Legislative Appropriations Request.
2. Request that HHSC educate lawmakers on the crisis, particularly with regard to group home closures and other limitations resulting in reduced access to community services, and immediately seek emergency funding from the Texas Legislative Budget Board as part of a legislative special session to address the crisis and its adverse impact on health, stability, and their lives.
3. Fund attendant and direct service worker wages to be competitive market wages commensurate with current labor market demand to increase and equalize the median or average wage rate of attendants and direct care workers to at least \$15/hour across all Medicaid programs and service delivery settings who use direct care workers/attendants.
4. Request funds to increase the amount provided through the ACRE program for all programs in which this program is available by at least \$0.20 per each level.

5. Reevaluate and implement the wage floor for nurses, direct care workers and attendants in all community-based programs, including the community-based ICF/IID program, to match the compensation of nurses and direct care staff working in the SSLCs and state hospitals. Consider local competitive market for wages across all Medicaid programs and service delivery settings.
6. Prior to the Texas 89th Legislative Session, conduct a survey, similar to the May 2022 Texas Center for Nursing Workforce Studies' 2022 Long-term Care Nurse Staffing Study/Survey. The survey would be to obtain information to assess direct care worker, attendant and nurse staffing issues among employers of community-based IDD waiver, community-based ICF/IID and other Medicaid-funded disability services. The survey should present the results by provider/program-types. The survey would assist HHSC and legislators in making informed decisions about the current workforce shortages across programs serving children and adults with disabilities.
7. Explore opportunities to achieve efficiencies without compromising accountability and the health and safety of persons receiving services. This includes re-evaluating, and as appropriate, pursuing past suggestions for achieving efficiencies and streamlining regulations as well as identifying new efficiencies that should be pursued.
8. Explore options for providers to be able to offer modest benefits to their employees including benefits that offer economic stability like health and dental insurance as well as benefits that protect employee's mental health and offer some opportunities for self-improvement. Providers are no longer able to provide these benefits without additional assistance in the form of increased rates, the availability of pooled insurance strategies, or other support to ensure a qualified workforce is in place to assist Texans with disabilities.
9. Develop and implement a monitoring plan for access to IDD services that includes direct service worker and attendant turnover and retention, availability, and provider capacity. The plan should include quarterly monitoring and reporting for the following:
  - A. Turnover and retention numbers and ratios for direct service worker and attendant roles across all Medicaid programs and settings including the reasons for leaving.
  - B. The number of ICF/IID and HCS/TxHmL voluntary contract terminations by HHSC region and county, company ownership and number of individuals (service recipients) affected including the number of

individuals who move to a more restrictive and higher cost care setting, who become homeless, or who die within 30, 60, or 90 days.

- C. To the extent possible the data should include the geographical location and service setting in which individuals were receiving services as well as the geographical location and service setting and provider to which they were transferred such as, were they moved to a nursing home, a SSLC, a community based ICF/IID if the person had been receiving HCS, etc. and the company name of the sending and receiving provider.
  - D. The number of voluntary ICF/IID and HCS group home closures not related to a voluntary contract termination by HHSC region and county, company ownership and number of individuals (service recipients) affected. [Current policy does not require HCS providers to notify the commission if a group home is being closed. To ensure accuracy in the data being collected and reported, it is recommended that the commission establish such a policy.]
  - E. To the extent possible the data should include the geographical location in which individuals were receiving ICF/IID or HCS group home services as well as the geographical location and service setting to which they were transferred such as, were they moved to a nursing home, a SSLC, a community based ICF/IID if the person had been receiving HCS, etc. and the company name of the sending and receiving provider.
  - F. The number of ICF/IID and HCS involuntary contract terminations and group home closures not associated with a contract termination which includes the same data elements as noted above for voluntary contract terminations and group home closures.
  - G. The number of approved HCS and TxHmL program caps by HHSC region, county and provider ownership, as well as the number of requests to cap which have yet to be approved and any requests to lift a cap.
  - H. The number of new contracts approved (new defined as a person/company which currently does not have an ICF/IID or HCS/TxHmL contract) and the number of contracts approved by an established provider; i.e., the provider is requesting to expand into a new contract area.
10. In addition to exploring options to achieve efficiencies, identify and, as feasible, implement both short and long-term policy and regulatory flexibilities that will assist providers in managing the workforce crisis with the

goal of preserving, to the extent possible, access to needed services and network adequacy. Though not inclusive, following are options that should be considered:

- A. Ensure all current vacancies in available in ICF/IID and HCS group homes are utilized; and
- B. Allow persons living in the home of an individual receiving CFC services to work as a paid attendant for the CFC service recipient.

## **Increase Community First Choice Utilization and Improve Coordination**

### **Background**

In 2015, Texas became one of the first states in the nation to implement CFC as a Medicaid State Plan benefit for children and adults 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 HAB. Personal Assistance Services involve assistance with ADLs, such as bathing, dressing, and eating, and health related tasks, and instrumental activities of daily living (IADL), such as money management, meal planning and preparation, cleaning, cooking, and shopping. Habilitation involves assisting a person to learn, develop and maintain skills for everyday life activities.

In Texas, CFC was designed as a cost-effective alternative to institutional care, providing limited services for many people on IDD interest lists awaiting a more comprehensive package of services. For persons with low service needs, CFC services could sufficiently meet their needs and possibly eliminate their need 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 awaits a more robust program or waiver. In addition, CMS provides a six percent enhanced federal match for services delivered through the CFC program.

Unfortunately, the full intent of CFC has not been realized. The uptake rate for CFC (the number of people offered the service who accept) is lower than anticipated. (According to "CFC Closures FY17" report, presented by HHSC to SA subcommittee on 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 children and adults with IDD and persons with mental health conditions. 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.
  - A. 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.
  - B. 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.
  - C. Ensure schools provide information to students with disabilities who may qualify for CFC services.
2. Enhance the CFC service array by adding Employment, Transportation and Respite services.
3. Request the IDD SRAC develop guidelines for CFC Employment services to include supported employment and prevocational services.
4. 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 take into account the lifelong needs of persons with IDD and the distinct skills and abilities required to teach persons to perform tasks independently.
5. Establish rates that support a higher wage paid to direct service workers who perform delegated nursing tasks.
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, STAR Health FFS programs.

8. Require HHSC to provide strong oversight and training to MCOs, LIDDAs, providers and CDS employers on the CFC benefit. Areas of focus include:
  - A. Habilitation training for direct service workers CFC;
  - B. Assessment completion training for Service Coordinators (LIDDA and MCO); and
  - C. Referral process training for all entities.
9. Allow flexibility within the CFC benefit, utilization policies, and PCP such as:
  - A. Allow two or more persons to receive CFC services from the same direct service worker at the same time;
  - B. Allow individuals living in the household of the waiver recipient to provide CFC if they meet the qualifications and want to be the provider; i.e., sustain the flexibility allowed during the PHE;
  - C. Allow persons to more easily change service delivery models between agency option and CDS option; and
  - D. Allow families to use paid support to prevent being overburdened by their family member's care needs.
  - E. Allow CFC benefit to authorize higher paid CFC when additional direct care services are essential to meet skilled needs. For example: When a nurse is not available allow for the additional services to be provided by a direct service worker.
10. Request HHSC to develop a portal 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 file exchange, but there are challenges with access and consistent usage.
11. 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.

# Strengthen Support for People with Related Conditions Served in the CLASS Program

## Background

The CLASS program provides home and community-based services to individuals with related conditions as a cost-effective alternative to an intermediate care facility for individuals with ICF/IID. A case management agency (CMA) and a DSA help CLASS Program individuals in organizing various services needed to achieve maximum levels of independence. Services provided are based on the unique needs of the individual and on an IPC developed by the service planning team, which includes (at a minimum) the individual, the case manager and DSA representative. CLASS services are available to Texas residents not living in an institutional setting who:

Have been diagnosed with a related condition prior to age 22 as described in the Texas Approved Diagnostic Codes for Persons with Related Conditions:

1. Have a qualifying adaptive behavior level;
2. Meet the level-of-care criteria for placement in an ICF/IID;
3. Do not exceed specified income and resource limits;
4. Are not enrolled in any other Medicaid waiver program; and
5. Demonstrate need for one or more services monthly.

CLASS is unique in that the qualifications for this waiver do not require a diagnosis of an intellectual disability. This waiver was developed for children and adults with related conditions, some of whom have complex needs. The waiver has evolved over time. CLASS participants are living longer and therefore losing their parental support.

CLASS is the last of the waivers to modernize to electronic eligibility and use of HIPPA compliant data systems to share data. As a result, the renewal process to continue receiving services is flawed. Many CLASS participants complain that the annual renewal process is so complex, without accountability and oversight of timelines, that each year the current plan of care expires before the new IPC is approved. This leaves individuals on the waiver either without services because their attendants and providers cannot get paid or with continuing services with the promise to pay the attendants and providers once the plan of care has been

approved. This strains the already fragile system where the pay is barely a living wage. Most attendant's live paycheck to paycheck. With any delay in payment the whole plan of care is at risk. In addition, EVV data must be submitted before an attendant can be paid, and this delays the renewal process even more.

## **Recommendations**

1. Streamline the renewal process for CLASS to ensure no gap in coverage. HHSC should review the CLASS renewal process to determine problems that delay the approval process:
  - A. Consider timelines, data entry points, utilization review asking for information not requested initially, and the interaction between the case manager and the direct service provider.
  - B. Develop strict timeframes for submission through approval.
  - C. Require all documents be gathered prior to submission.
  - D. Ensure providers understand and comply with assessment, service planning, and IPC expiration timelines.
  - E. Add accountability to the process that requires notification to the individual or their designee of the action taken for each step.
  - F. Allow access to paperwork process online for the individual and designee.
  - G. Correct EVV so hours can still be entered without manually entering once budget is approved.
  - H. Check employment laws to determine if pay can be withheld from attendants continuing to work without paychecks.
  - I. Allow continual payment to attendants until the budget is approved.
  - J. Require the case managers to collect and review all the annual reports before submitting to HHSC.
2. Revise EVV systems to be flexible for use of employment services as needed. Allow employment services to be reported through electronic means. The EVV systems do not allow for flexibility for supported employment and employment assistance. The staff member must switch between employment services and attendant services.
3. Add Individualized Skills and Socialization to CLASS benefits and base the needs for Individualized Skills and Socialization on the ISP, not level of need. Currently the CLASS Program has prevocational services, employment

assistance and supportive employment as a benefit. However, the other IDD waivers in Texas also include Individualized Skills and Socialization services. Individualized Skills and Socialization includes a greater benefit than prevocational needs. Individualized Skills and Socialization also includes community inclusion.

4. Streamline the approval process for employment services avoiding a 30 day wait to receive services due to the delayed approval times. Accessing employment assistance and supported employment may be challenging between the Texas Workforce and the waivers.
5. Revise CLASS benefits to include protective supervision and personal care services while asleep. The CLASS Program was developed for families to take care of their family members. As stated above the CLASS program has evolved with better outcomes for individuals living longer lives, but out living their family support. The program was not developed to support the needs of an individual while sleeping. An example is if an individual lives alone and uses a wheelchair, the individual will not be able to move once in bed. The CLASS program benefit does not cover attendant services while the recipient is sleeping. Consider additional revisions for this added benefit:
  - A. Allow the person providing protective supervision to also live in the home;
  - B. Add a benefit of host home and consider the host home benefit for half a day or evening hours. This allows for flexibility during the day for the individual to be in the community.
6. Revise the method for determining the number of hours needed for care. The CLASS program is structured based on the number of hours and minutes needed for tasks throughout the day. There may be multiple attendants, each assigned to a specific task. However, this is not practical as tasks may overlap such as preparing a meal while doing the laundry. A task-based system is challenging when there are multi attendants daily.
7. Establish parity in wages between waivers. A new portal assists families in locating attendants for hire. However, for CLASS, posting positions at a pay rate lower than the attendant position in other waivers reduces the number of persons willing to work in the CLASS program.
8. Create efficiencies through flexibilities for attendance services. Allow for the use of one attendant for two CLASS participants at the same time for portions of the day at a pay rate of one point five. This will save the state funds and provide better coverage for individuals.

9. Expand case management in the CLASS program. The CLASS case management system provides case management for waiver services but does not look at the holistic needs of the member. As more services move to a state plan benefit, broader case management is justified.
10. Implement changes for access to dental as recommended by the IDD SRAC Transition to Managed Care Subcommittee.
11. Provide additional support for individuals in the hospital. CLASS participants may have lengthy hospital stays and require attendant care during their stay. If needed, the attendant care should be a waiver benefit.

## **IDD SRAC Recommendations Related to H.B. 4533 STAR+PLUS Pilot Program**

### **Background**

In 2019 through H.B. 4533, 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 SP3W when designing pilot criteria.

People with IDD and related conditions receive most HCBS LTSS through 1915(c) IDD waiver programs or ICF/IID. While the acute care services for these programs have been carved into managed care since 2015, however, these LTSS services are carved out of managed care and administered through traditional FFS Medicaid. The SP3 was to test the delivery of LTSS through a single, coordinated managed care system. A comprehensive evaluation of the pilot was required to inform the state's determination whether to transition all or some LTSS services from IDD waivers and ICF/IIDs to managed care. Due to the complexities of operations unique to each individual waiver program requirements and varying numbers of enrollees in each IDD waiver, the risk of moving each individual IDD waiver and operating those four waivers differently in managed care would be complex, administratively burdensome and very difficult to navigate for individuals and families. It is crucial to develop and test a model that meets the needs of persons with IDD currently in the IDD waivers in order to facilitate an opportunity and maximize the potential for successful program transitions.

Over the past four years, HHSC worked extensively with the IDD SRAC, SP3W, and stakeholders to develop STAR+PLUS Pilot Program. HHSC made the decision to use

the 1115 waiver and a 1915(i), which the IDD SRAC supports to allow for flexibility through the 1915(i). However, during the 88th legislative session, funds for the pilot were not approved. Concerns were cited regarding possible uncontrolled growth should the pilot, if successful, become a permanent program in the future.

To address the concerns that allow for the ability to manage the number of people in the pilot/program and allow for management of benefits some changes may be needed to support the pilot and the future program.

Effective June 1, 2023, the SP3W was disbanded by HHSC due to the lack of appropriations. The IDD SRAC will continue to make recommendations, collaborate and coordinate with HHSC on possible changes to the any future pilot design and implementation of other critical system reforms for IDD services.

In the interim, below are recommendations related to the pilot that the IDD SRAC contends are critical to fulfillment of Chapter 534, Texas Government Code. The recommendations pertain to pilot development and implementation, IDD Assessment Process, Pilot Evaluation and Pilot Goals for Measuring Quality and Testing Innovative Payment Methodologies.

## **Development, Funding and Implementation**

### **Recommendations**

1. Adhere to the pilot structure specified in H.B. 4533, using one waiver (rather than four) based on an institutional level of care. This allows HHSC to continue to work on the structure already developed over the last four years which simplifies eligibility, the waiver program, and benefits into one pilot program. We do not recommend moving the current IDD waivers into managed care as four individual programs.
2. Test and evaluate the model before determination of the transition of all or some of the LTSS of the IDD waivers and ICF/IDD into managed care. A successful transition requires identification of and resolution to unintended consequences that may result during the pilot period.
3. Prohibit the acceleration of the timeline for IDD waivers and ICF/IID transitions established in H.B. 4533. This is necessary to address the uniqueness of each program, do no harm to individuals currently receiving services and support the potential success of moving some or all of the programs into managed care.

4. Collaborate and coordinate closely between IDD SRAC and HHSC and, as appropriate, the legislature to refine the provisions of Chapter 534, Texas Government Code prior to the 89th Texas Legislative Session. This includes address any future concerns and developing a successful managed care model that provides the most appropriate services necessary for this population to have quality of life and to successfully live their lives in communities where they are supported by program services if statutory changes are needed.
5. Appropriate funds in accordance with the IDD SRAC recommendations specified in the 2022 Annual Report regarding operations, benefits, eligibility, and program evaluation to the extent possible contingent on any necessary statutory system redesign modifications.

## Funding

1. The Texas Legislature fully fund the proposed SP3 benefits recommended by the IDD SRAC TMC Subcommittee and approved by the IDD SRAC. When determining the cost for SP3, the Legislature must take into consideration the current utilization of the population currently in STAR+PLUS. IDD SRAC TMC Subcommittee added the following benefits beyond those specified in legislation and believes they are key to a well-designed program for persons with intellectual disabilities and those with similar functional needs, such as:
  - A. Behavioral health crisis intervention services (specified in H.B. 4533),
  - B. Enhanced behavioral support specialty (specified in H.B. 4533),
  - C. Enhanced behavioral family/caregiver coaching services,
  - D. Enhanced behavioral extended substance use disorder services,
  - E. Enhanced behavioral peer supports,
  - F. Enhanced behavioral therapeutic in-home respite,
  - G. Enhanced behavioral therapeutic out of home respite,
  - H. Specialized therapies,
  - I. Orientation and mobility,
  - J. Intervenor support for participants with visual/auditory challenges,
  - K. Assisted living with modifications (specified in H.B. 4533 without modifications), and
  - L. Adult foster care with modifications (specified in H.B. 4533).

2. The STAR+PLUS Pilot includes a unique population in the pilot such as persons with IDD, those with head injuries, adult autism, and persons with similar functional needs. We strongly encourage the Legislature to fully fund all populations to test the model.
3. The Texas Legislature fund a sustainability or transition plan for continuation or discontinuing services once the pilot ends.
4. The Texas Legislature fund administrative duties to include:
  - A. Any additional IT programming costs should be included in the pilot to assure access to electronic records, eligibility information, and data sharing.
  - B. Texas HHSC staff need to implement and oversee the pilot.
  - C. Fund for the evaluation of the pilot to ensure we have adequate data to assess the pilot. Measures should include evaluation for all populations including specific for those assessed and confirmed with IDD and those other populations.
  - D. Dedicated staff to provide increased education and outreach and ongoing support to members automatically enrolled in the pilot to ensure no negative impacts in participation.
5. Texas Legislature fund training for pilot members, providers, and others impacted by the pilot understanding the benefits and the pilot through HHSC, MCOs, and LIDDAs.
6. The Texas Legislature fully fund targeted case management services provided by the LIDDAs and paid to the LIDDAs by MCOs for their services and for delivery of comprehensive services for comprehensive service providers.
7. Ensure payment for funding incentives to comprehensive services providers to provide feedback on member progress on goals and objectives.
8. If there are savings associated with the managed care model and enhanced federal match for services provided in the pilot should be reinvested into community based LTSS services.
9. Fund continuous eligibility for the length of the pilot should be included in funding.

10. Ensure the most effective and efficient use of Medicaid resources that is not limited to cost of care and cost savings, a tenet of Chapter 534, Texas Government Code.
11. HHSC should ensure that any additional funding through the APRA funds for CDS are processed through the FMSAs for notice, acceptance, and payment for their employers to provide to their employees.

## **Operations**

The Pilot Program must develop processes to:

1. Ensure the state has sufficient and valid information to inform whether and how to implement additional stages of the IDD LTSS system redesign consistent with Chapter 534, Texas Government Code.
2. Ensure and evaluate the best possible outcomes, identified separately for each population in the pilot, for individuals with ID, DD, brain injury, autism, and those with similar functional needs in accordance with the system redesign goals specified in Chapter 534, Texas Government Code,
3. Ensure development of a system redesign in coordination with and including input from all affected stakeholders.
4. Ensure access to the workforce necessary to implement all aspects of the pilot to include attendants, direct care workers, employment services, day hab, complex care staffing and supports, and licensed professionals.

## **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 SP3W 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 SP3 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:

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

Over the past two years, HHSC worked extensively with the IDD SRAC, SP3W, and stakeholders to develop SP3 criteria. These activities led to the development of the following IDD SRAC recommendations.

## **Recommendations**

1. HHSC should determine SP3 eligibility by needs-based criteria. To qualify for the pilot, a person must meet all of the following requirements:
  - 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 from table 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:
  - A. STAR+PLUS Pilot Target Group A criteria:
    - a. People who have a diagnosis:
      - (1) ID
      - (2) Autism
      - (3) TBI
      - (4) Acquired brain injury (ABI)
    - b. A condition on the Texas HHSC Approved Diagnostic Codes for Persons with Related Conditions List.

B. STAR+PLUS Pilot Target Group B criteria:

- a. 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 SP3 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 must allow pilot participants to transition to a 1915(c) IDD waiver if their slots become available through state interest list or requested through Diversion during pilot operation.
7. Ensure we are tracking Pilot populations and sub-populations individually as Group A and Group B specifically.

## Continuous Eligibility

### Background

Section 534.104(k), Government Code, requires HHSC, in consultation and collaboration with the IDD SRAC and SP3W, to develop and implement a process to ensure pilot participants remain eligible for Medicaid for 12 consecutive months during the pilot. The majority of the pilot population are SSI recipients and do not have another type of assistance to transfer to if SSI eligibility is lost. HHSC explored all systems, and at this time there are no systems solutions for the pilot participants to maintain 12-months continuous eligibility.

### Recommendations

1. IDD SRAC and SP3W recommend participants in the pilot have 12 months of continuous eligibility. Based on the research described above, HHSC in consultation with IDD SRAC and SP3W will focus on training and coordination with pilot MCOs, providers, and participants to meet the intent of this requirement to maintain 12-months of continuous eligibility for as many pilot participants as possible.

2. IDD SRAC and SP3W recommend HHSC continues to consider additional options to ensure pilot participants remain Medicaid eligible including assessing the feasibility of having a designated point of contact to address eligibility issues that arise during the pilot.

## 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, SP3W, and stakeholders to develop STAR+PLUS Pilot Program benefits. HHSC made the decision to use the 1115 waiver and a 1915(i), which the IDD SRAC TMC Subcommittee supports to use allow for flexibility through the 1915(i). Below are the recommendations for benefits approved by the SP3W and the IDD SRAC.

### Recommendations

1. The IDD SRAC and SP3W approved the following benefits to 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). These include the following:
  - A. Current State Plan LTSS Services (Reference Section: 1143.1.2 Long-term Services and Support Listing)
    - a. Day Activity & Health Services
    - b. Personal Assistance Services (PAS)  
CFC (PAS, Emergency Response Services, Support Management, Habilitation)
  - B. Current STAR+PLUS HCBS Services (Reference Section: 1143.2 Services Available to STAR+PLUS Home and Community Based Services Program Members)
    - a. Adaptive Aids & Medical Supplies

- b. Adult Foster Care adding modification
  - c. Assisted Living
  - d. Audiology (Limited)
  - e. Auditory Integration Training/Auditory Enhancement Training
  - f. Cognitive Rehabilitation Therapy
  - g. Dental Treatment
  - h. Emergency Response (for Medicaid Assistance Only (MAO) members)
  - i. Employment Assistance (EA)with modifications career planning
  - j. Financial Management Services
  - k. Home Delivered Meals
  - l. Minor Home Modifications
  - m. Nursing Services
  - n. Occupational Therapy (OT)
  - o. Personal Assistance Service (for MAO members)
  - p. Protective Supervision
  - q. Physical Therapy (PT)
  - r. Respite
  - s. Speech
  - t. Support Consultation
  - u. Supported Employment (SE) Services
  - v. Transition Assistance Services
- C. New HCBS Services for STAR+PLUS Pilot referenced in statute
- a. Behavioral Support Services
  - b. Behavioral Health (BH) Crisis Intervention Service
  - c. Enhanced Behavioral Supports
    - (1) Enhanced In-Home Respite Services (EIHRS)
    - (2) Enhanced Out of Home Respite Services (EOHRS)
    - (3) Behavioral Support Specialty Services

- (4) Individual/Family /Caregiver Coaching to include training, education and Peer Supports
  - (5) Peer Supports
- d. IDD Enhanced Extended Substance Use Disorder Services (SUDS)
- e. Community support transportation
- f. Day Habilitation
- g. Enhanced Medical Supports
- h. Innovative Technology including remote monitoring
- D. New Recommendations allowed under statute and approved by IDD SRAC - HCBS Services
  - a. Community Integrations Supports
  - b. See Enhanced BH and SUDS above
  - c. Specialized Therapies:
    - (1) Massage; Recreational;
    - (2) Music;
    - (3) Art;
    - (4) Aquatic;
    - (5) Hippotherapy;
    - (6) Therapeutic Horseback Riding.
  - d. Dietary Services
  - e. Intervener/interpreter

## **Improve the IDD Assessment Process**

The 88th Legislature did not provide funding for the implementation of the SP3. In the event that SP3 is funded and implemented in the future, the data collected from piloting the InterRAI ID and CAP would help SP3W and HHSC in the planning and funding of the SP3 implementation.

Any changes in assessment of individual needs and in receiving services should be consistent and involve stakeholder input in the development, implementation and evaluation of effectiveness. This may include using additional InterRAI modules and other evidence-based assessment tools.

## Recommendations

1. Coordinate with SP3W and IDD SRAC, once to determine the necessary and allowable revisions to the InterRAI ID and CAP Assessments and other assessment tools in order to determine each individual's needs and appropriate resources to meet those needs.
2. Require an evaluation of the accuracy and reliability of the InterRAI Intellectual Disability Assessment and Collaborative Action Plan and submit a written report to the IDD SRAC and SP3W.
3. Must commit to reevaluating the adequacy and use of the InterRAI-ID and CAP tools and resource algorithm at a minimum of annually with SP3W and IDD SRAC.
4. For the purposes of evaluation to inform the IDD system redesign, ensure that the STAR+PLUS Pilot assessment process and tools identify and distinguish pilot participants with IDD from pilot participants with functional needs similar to IDD.
5. Focus on meeting the actual, individualized needs of the person(s) participating in the STAR+PLUS Pilot without the use of tiers, caps, thresholds, or levels of need to determine approval of the person-centered service plan.
6. Require stakeholder input from SP3W, IDD SRAC, and representatives across all LTSS community programs prior to the continuation of the InterRAI ID and CAP in the pilot or expansion to other HHSC programs.
7. Ensure any algorithm is comprehensively tested for the InterRAI ID and CAP accurately assesses the support needs of the intended population for SP3 or other programs prior to use.

## Pilot Program Evaluation

### Background

The SP3 includes the requirement for an evaluation of the results of the pilot. IDD SRAC and SP3W have provided feedback and recommendations for the evaluation over the past year. The comprehensive analysis, due by September 1, 2026, will include:

- Analyze the experiences and outcomes of system changes.

- Include feedback on the pilot based on personal experiences of pilot participants, families, and providers.
- Include recommendations on:
  - ▶ A system of programs and services for consideration by the Legislature;
  - ▶ Necessary statutory changes; and
  - ▶ Whether to implement the pilot statewide under STAR+PLUS for eligible members.

## 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:
  - A. Review plans of care based on individual identified needs and desires.
  - B. Ensure that the plan of care is flexible and that related LTSS can change as an individual's needs or goals change over time or satisfaction with services change. Goal setting and goal evaluation process should be organic.
  - C. Compare services was on plan with services delivered, and if not delivered and reason delivery did not occur, including lack of access to a provider and overall service utilization.
  - D. Collect and review gaps and delays in services due to workforce shortages including length of times without authorized services and potentially preventable events, including hospital and institutional admissions and readmissions; ER visits; potentially preventable complications; and death.
  - E. Identify services provided by one or more providers, such as behavior supports, PT, OT, which may be provided by non-licensed individuals that reinforce therapy according to the plan of care.
  - F. Within the IDD system, including ICF/IID, 1915(c) waivers, and the STAR+PLUS HCBS waiver, publish deficiencies 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 including network adequacy for community attendants and direct service workers.
  - A. Collect data on service delays and gaps related to administrative issues caused by Case Manager/Service Coordinator, DSAs, FMSA, and HHSC for timely access.
  - B. Attendant turnover caused by late payments made to workers by FMSA.
  - C. Attendant turnover based upon providers leaving the workforce.
3. 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 versus Medicaid coverage.
4. Establish and publish a dashboard to track data elements on the HHSC website.
  - A. 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 implementation.
  - B. Ensure that state leaders have accurate, reliable data to use in development of policy and critical decisions that impact people with IDD conditions. Expand data collection for people who have private insurance or Medicare to improve the evaluation and decision making.
  - C. Examine results for missing data to identify persons without data for key acute care indicators including maximum distance or travel time to a provider, urgent care, PCP, such as annual check-ups, vaccines, etc. Present findings by entity (MCO only, private insurance + 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 strategies to mitigate health care risks and to improve

the person's health and wellness. For example: examine key indicators for healthcare such as well checkups.

5. Identify individuals with IDD and, separately, each other eligible group, by ensuring State designated identifier codes within managed care for each population. Ensure an identifier within each group (risk group or some type of indicator).
6. 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 NCI to obtain participant experience. Pilot measures should include sufficient NCI IPS and IDD measures.
7. Ensure the committee will receive and review the results quarterly with HHSC to determine if the pre and post pilot and quarterly data are valid and can be used as baseline data for future considerations regarding managed care and fee for service systems that support individuals with IDD. 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 quarterly;
  - 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). This should be considered for pilot evaluation and beyond the pilot.

## **STAR+PLUS Pilot Program Workgroup Quality Subcommittee**

Chapter 534.105(a) of the statute charges the advisory committee and the pilot program workgroup to identify measurable goals to be achieved by the pilot program using appropriate survey products such as the NCI, The National Quality Forum (NQF) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS). The SP3W Quality Subcommittee was charged with the development of recommendations for the measurable goals. SP3W and IDD SRAC adopted the Quality Subcommittee's recommendations for measurable goals on November 18, 2021.

In addition, the statute requires that the pilot program be designed to test innovative payment rates and methodologies for the provision of LTSS. The SP3W Quality Subcommittee was charged with the development of recommendations for how alternative payment methodologies could support the pilot program quality goals. SP3W and IDD SRAC adopted the Quality Subcommittee's recommendations for APMs on February 24, 2022.

The adopted recommendations, in addition to the Quality recommendations by Institute for Child Health Policy (IHP), an external contractor engaged by HHSC, should be considered in any future managed care pilot.

The Subcommittee's recommendations are based on:

1. The need to have an evidence-based product to assess the quality and outcomes of services provided to individuals with IDD and similar conditions;
2. Discussion with Ms. Vegas, NCI Director, and her colleagues, which clarified that collection of data for this pilot population using the IDD-In-Person surveys instruments are possible. In addition, NCI offers the option of adding 10 state- specific questions;
3. No appearance of conflict between statute requirements assigned to IHP and the use of NCI IDD-In-Person and Adult Family surveys, which the Subcommittee visualizes as a supplement to the requirements charged to IHP. (The subcommittee understands that upon further discussions, including those with IHP, the need for the NCI survey may be redundant.)

Regardless of the survey tool or content adopted for the pilot, the subcommittee recommends early surveying to identify a baseline, to be followed up later in the program to measure quality in the individual and family/caregiver experience for those participating in the program. It could also be helpful to compare pilot survey results similar to survey results from other STAR+PLUS programs. We recommend inclusion of the NCI IDD In-Person Survey and the Adult Family Survey in obtaining a baseline and evaluation, including pre- and post-test measures.

Utilize IDD SRAC Principles, Definitions and Criteria for MCOs Participating in STAR+PLUS Pilot submitted by March 29, 2021 and adopted by SA and Quality subcommittees.

## **Guiding Principles**

- Collaboration and coordination across entities.
- Avoidance of conflicts of interest.
- PCP and service delivery.
- Emphasis on informed choice, self-determination, and consumer-directed options.
- Non-discriminatory practices in access and serving participants.
- Inclusion of quality measures for health and social determinants specific to pilot population.
- Ensure participants are served in the most integrated settings with access to and support for active and social engagement, as desired by the participant.
- Ensure a network of Qualified Providers including significant traditional providers, comprehensive service providers, and including the incorporation of existing qualified providers as MCO network providers to the extent possible.

Quality strategies that include evaluation development and implementation of a comprehensive quality strategy that is transparent, integrated across programs and services, and appropriately tailored to address the needs of the LTSS populations served.

- Consider NCI – IDD In-Person and Adult Family Surveys for the STAR+PLUS Pilot.

# Alternative Payment Methodologies Recommendations

## Adopted by SP3W and IDD SRAC on February 24, 2022

The Alternative Payment Methodologies recommendation(s) are limited by the structure of the APM used today. We strongly advocate for the development of more functionality within the system to allow consideration of other Alternative Payment models in the future including, but not limited to, Bundled Payments.

1. Enhance Incentive Payments for the completion of Reporting Data Elements and meeting Predetermined Outcomes/ Quality Metrics with the condition that it captures data elements to allow for the implementation of future Alternative Payment Models (i.e., Bundled Payments).
2. The APM system must:
  - A. Ensure that any incentive payment is in addition to the base rate for services be standardized and simple to administrate.
  - B. Provide flexibility for the MCO and the Contractor develop Enhanced Incentive Payments in addition to the provision of Base Incentive payments.
  - C. Focus on quality outcomes for those participating in the pilot and include administrative measures as well as outcomes measures.
  - D. Include measures, outcomes and metrics collected and measured consistently.
  - E. Ensure the system does not have a financial downside to the participating provider.
  - F. Address the goals of the pilot, including incentivizing services in the most integrated setting.
  - G. Capture utilization of services for future consideration for a bundled payment model.
  - H. Incentivize capturing data for the provision of LTSS, Medical, including Durable Medical Equipment, Behavioral Health, and other services outlined in the person- centered plan.
  - I. Provide the CSP with the training from HHSC and MCOs and support needed for the provider to enter the information electronically and

- understand how the information is being used to measure outcomes for the person.
- J. Ensure HHSC is prepared to move in a timely fashion to inform and assist providers in becoming an eligible LTSS Medicaid Provider and obtaining the Texas Provider Identifier number.
  - K. Require MCOs to prepare to move in a timely fashion to assist CSP with the approval of credentials, contracting as well as training and support needed for the provider to enter the information electronically and understand how the information is being used to measure outcomes for the person.
  - L. Ensure Measures and Metrics are consistent with the External Quality Review Organization Evaluation Plan.
  - M. Preserve the right to develop and review specific measures and metrics utilized in the pilot.

# **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 eligible individuals 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 2022, an average of 549,157 individuals were enrolled in STAR+PLUS each month. Of that total, approximately 18,312 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 acute health 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 and 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 four Medicaid MCOs contracted to operate the STAR+PLUS program. These adults continue to receive LTSS services through FFS.

## STAR Kids

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.

In fiscal year 2022 an average of 169,349 eligible children and young adults were enrolled in STAR Kids each month. Of that total, an average of 4,218 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 LTSS and Comprehensive Care Program services, such as private duty

nursing and personal care services, through one of nine Medicaid MCOs contracted to operate 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. 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 2022, an average of 46,161 children and young adults were enrolled in STAR Health each month. Of that total, approximately 209 were enrolled in an IDD waiver or community-based ICF/IID each month.

## **Community First Choice (CFC)**

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.<sup>16</sup> Federal law allows the CFC option under Section 1915(k) of the Social Security Act, and CFC services are offered in Texas as a Medicaid state plan benefit. 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. CFC services are available in managed care and FFS programs. Persons with IDD who are enrolled in a managed care program receive their CFC through managed care unless they are also enrolled in an FFS waiver program. Those enrolled in an FFS waiver receive their CFC through FFS, delivered by their waiver provider.

## **CFC Eligibility**

Individuals may be eligible for CFC services if they:

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<sup>16</sup> Meeting an institutional level of care means needing the level of care provided in a nursing facility, ICF/IID, or Institution for Mental Disease.

- Are eligible for Medicaid;
- Meet criteria for an institutional level of care<sup>17</sup>; and
- Have functional needs that can be addressed by CFC services.

## **CFC 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:

- Personal assistance services (PAS)<sup>18</sup>
- Habilitation (HAB)<sup>19</sup>
- Emergency response services<sup>20</sup>
- Support management<sup>21</sup>

## **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 do not have to 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. As of August 2022, a total of 137,905 individuals were receiving SSI (making them eligible for Medicaid) and also on the HCS, TxHmL, CLASS, and/or DBMD interest lists. These numbers are duplicated because individuals may be on multiple interest lists at any given time. 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.

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<sup>17</sup> Meeting an institutional level of care means needing the level of care provided in a nursing facility, ICF/IID, or Institution for Mental Disease.

<sup>18</sup> PAS is assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

<sup>19</sup> HAB is the acquisition, maintenance, and enhancement of skills necessary to accomplish ADLs and IADLS and health related tasks based on the individual's person-centered plan.

<sup>20</sup> Emergency response systems are backup systems and supports as defined in 42 CFR §441.505; limited to electronic devices (emergency call button).

<sup>21</sup> Support management is voluntary training on how to select, manage and dismiss attendants.

In fiscal year 2022, there was an average of 35,344 non-waiver recipients receiving CFC services each month through STAR+PLUS.

In fiscal year 2022, there were an average of 2,711 non-waiver recipients under 21 years of age enrolled in STAR, STAR Kids, STAR Health, STAR+PLUS or the Dual Demonstration who received CFC services each month. An average of 35,520 non-waiver recipients 21 years and older enrolled in STAR, STAR Kids, STAR Health, STAR+PLUS or the Dual Demonstration<sup>22</sup> received CFC services each month. These individuals meet at least one of the eligibility criteria for institutional services: nursing facility, ICF/IID, or Institution for Mental Disease. The table below shows the average monthly enrollment for non-waiver recipients by age group, and CFC services provided in state fiscal year 2022.

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 during the PHE. This policy expires March 31, 2025.

**Table 1: Average Monthly Enrollment for Non-Waiver Recipients by Age Group, and CFC Services Provided in Fiscal Year 2022**

Program	Age Group	Average Monthly Program Enrollment	Average Monthly Individuals Using CFC Services
STAR	0-20	N/A	985
STAR Kids	0-20	154,379	1,629
STAR Kids	21+	25	12
STAR Health	0-20	46,161	98
STAR Health	21+	70	1
STAR+PLUS	0-20	4	0
STAR+PLUS	21+	445,166	35,344
Dual Demonstration	21+	35,653	164

Source: Quality Assurance and Improvement (QAI) Datamart and Analytical Data Store (ADS) Datamart

## 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

<sup>22</sup> Dual Demonstration means the Texas Dual Eligibles Integrated Care Demonstration Project, which uses a service delivery model for Dual Eligibles that combines Medicare and Medicaid services under the same health plan.

Medicaid managed care by providing HCBS as an alternative to residing in a nursing facility. Although CFC services are a Medicaid state plan benefit, individuals enrolled in 1915(c) waivers such as HCS and TxHmL receive their CFC services from their waiver provider. STAR+PLUS HCBS and MDCP enrollees receive CFC services from an MCO-contracted providers. 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/IID. As outlined in the table below, an average of 39,923 individuals with IDD were enrolled in the four IDD waiver programs each month during fiscal year 2022.

CFC services were utilized at the highest rate by all ages in CLASS, with an average of approximately 5,453 individuals in CLASS receiving CFC services each month out of the total 10,615 individuals each month across all four waiver programs.

**Table 2: 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 2022**

Age Group	Average Monthly Individuals Enrolled in IDD Waivers	Average Monthly Individuals Using CFC Services
0-20	3,971	2,026
21+	35,952	8,589
<b>All Ages Unduplicated</b>	<b>39,923</b>	<b>10,615</b>

Source: QAI Datamart and ADS Datamart

**Table 3: Average Monthly Enrollment in CLASS by Age Group, and CFC Services Provided by Age Group to Individuals Enrolled in CLASS in Fiscal Year 2022**

Age Group <sup>23</sup>	Average Monthly Individuals Enrolled in CLASS Waiver <sup>24</sup>	Average Monthly Individuals Using CFC Services <sup>25</sup>
0-20	1,343	1,053
21+	4,732	4,419
<b>All Ages Unduplicated<sup>26</sup></b>	<b>6074</b>	<b>5,453</b>

Source: QAI Datamart

**Table 4: Average Monthly Enrollment in DBMD by Age Group, and CFC Services Provided by Age Group to Individuals Enrolled in DBMD in Fiscal Year 2022**

Age Group	Average Monthly Individuals Enrolled in DBMD Waiver	Average Monthly Individuals Using CFC Services
0-20	120	62
21+	204	108
<b>All Ages Unduplicated<sup>27</sup></b>	<b>324</b>	<b>170</b>

Source: QAI Datamart

**Table 5: Average Monthly Enrollment in HCS by Age Group, and CFC Services Provided by Age Group to Individuals Enrolled in HCS in Fiscal Year 2022**

Age Group	Average Monthly Individuals Enrolled in HCS	Average Monthly Individuals Using CFC Services
0-20	1,799	428
21+	27,764	2,320
<b>All Ages Unduplicated<sup>28</sup></b>	<b>29,563</b>	<b>2,743</b>

Source: QAI Datamart

<sup>23</sup> An individual was counted as under 21 through the end of the month of their 21st birthday.

**Table 3: Average Monthly Enrollment in TxHmL by Age Group, and CFC Services Provided by Age Group to Individuals Enrolled in TxHmL in Fiscal Year 2022**

Age Group	Average Monthly Individuals Enrolled in TxHmL Waiver	Average Monthly Individuals Using CFC Services
0-20	709	483
21+	3,252	1,742
<b>All Ages Unduplicated<sup>29</sup></b>	<b>3,961</b>	<b>2,220</b>

Source: QAI Datamart

## Nursing Facility Level of Care

MDCP is a 1915(c) waiver providing HCBS as an alternative to a nursing facility for children and young adults in the STAR Kids or STAR Health programs. 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 provides HCBS to children as an alternative to an institution for mental disease.

As indicated in the table below, an average of 55,174 individuals received CFC services each month in fiscal year 2022 across MDCP, YES, STAR+PLUS HCBS, and Dual Demonstration HCBS.

<sup>24</sup> 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.

<sup>25</sup> CFC utilization counts for CLASS, DBMD, HCS, and TxHmL based on LTSS FFS claims. All counts are unduplicated by client Medicaid number.

<sup>26</sup> Members may be represented in multiple rows due to aging into a different program or other program changes, however totals represent unduplicated member counts. Note: there is a rounding error because the information is a result of rounding averages that were also rounded.

<sup>27</sup> Members may be represented in multiple rows due to aging into a different program or other program changes, however totals represent unduplicated member counts. Note: there is a rounding error because the information is a result of rounding averages that were also rounded.

<sup>28</sup> Members may be represented in multiple rows due to aging into a different program or other program changes, however totals represent unduplicated member counts. Note: there is a rounding error because the information is a result of rounding averages that were also rounded.

<sup>29</sup> Members may be represented in multiple rows due to aging into a different program or other program changes, however totals represent unduplicated member counts.

**Table 4: 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 2022**

<b>Program</b>	<b>Age Group<sup>30</sup></b>	<b>Average Monthly Enrollment<sup>31</sup></b>	<b>Average monthly Individuals Utilizing CFC Services<sup>32</sup></b>
<b>MDCP</b>	0-20	5885	3,278
<b>YES</b>	0-20	1,305	111
<b>STAR+PLUS HCBS</b>	21+	57,248	48,274
<b>Dual Demonstration HCBS</b>	21+	4,168	3,511
<b>All Waivers Unduplicated<sup>33</sup>, Ages 0-20</b>	0-20	7,190	3,389
<b>All Waivers Unduplicated<sup>34</sup>, Ages 21+</b>	21+	61,416	51,785
<b>All Waivers Unduplicated<sup>35</sup>, All Ages</b>	All ages	68,606	55,174

**Source: QAI Datamart and ADS Datamart**

<sup>30</sup>An individual was counted as under 21 through the end of the month of their 21st birthday.

<sup>31</sup>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.

<sup>32</sup>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.

<sup>33</sup>Members may be represented in multiple rows due to aging into a different program or other program changes, however totals represent unduplicated member counts.

<sup>34</sup>Members may be represented in multiple rows due to aging into a different program or other program changes, however totals represent unduplicated member counts.

<sup>35</sup>Members may be represented in multiple rows due to aging into a different program or other program changes, however totals represent unduplicated member counts.

# **Appendix C. Related State and Federal Legislation**

## **State Legislation**

The 88th Texas Legislature passed several pieces of legislation that will impact services and programs for individuals with IDD.

### **House Bill 4696**

H.B. 4696 clarifies HHSC, DFPS, and provider responsibilities and processes for investigations of certain cases of abuse, neglect, and exploitation. For purposes of reporting abuse, neglect, and exploitation, H.B. 4696 clarifies the provider types that must be reported to HHSC rather than DFPS. Finally, this bill directs HHS to develop and implement a system to track reports and investigations of abuse and neglect.

### **House Bill 1009**

H.B. 1009 requires a Medicaid provider to review state and federal criminal history record information and obtain electronic updates from the Department of Public Safety of arrests and convictions for each residential caregiver the provider employs or contracts with to provide community-based residential care services to Medicaid recipient and prohibits an individual who has been convicted of a certain offense from being employed by or contracted as a residential caregiver or otherwise provide direct care to a Medicaid recipient with an IDD.

The Medicaid provider must immediately suspend upon notice of the reportable conduct finding, the employment or contract of a residential caregiver who HHSC finds has engaged in reportable conduct. The suspension must remain in place while the individual exhausts any applicable appeals process, including informal and formal appeals, pending a final decision by an administrative law judge. HHSC must take disciplinary action against a Medicaid provider that does not comply with this requirement.

### **House Bill 4169**

H.B. 4169 impacts three of HHSC's IDD waiver programs - HCS, TxHmL, and DBMD – by adding prevocational services to these waiver programs, either as part of an

existing service called individualized skills and socialization, or as a new stand-alone waiver service. The bill requires HHSC to establish clearly stated, service-related performance standards for providers of prevocational services.

## **General Appropriations Act**

The 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023 included wage increases for community attendants and providers of private duty nursing. Rider 29 allocates funding to change the DBMD case management rate from hourly to monthly. Finally, as noted earlier in this report, the SP3 initiative redesigning IDD services delivered through managed care was not funded.

## **Federal Legislation**

### **American Rescue Plan Act (ARPA) of 2021**

ARPA was signed into law on March 11, 2021. Section 9817 of ARPA provides states with a time-limited 10 percent enhanced Federal Medical Assistance Percentage (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, 2021. 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. To ensure continued approval from CMS, HHSC sends the spending plan to CMS on a quarterly basis and the narrative portion describing updates and progress in implementation biannually. As of July 26, 2023, HHSC has decided to continue maintenance of effort in order to maintain its ability to receive the enhanced FMAP until March 31, 2025. On September 21, 2023, HHSC submitted a request to the Legislative Budget Board and Governor's Office to request approval

to continue compliance with maintenance of effort required by the ARPA and to continue projects that did not complete timely. This includes some technology improvements as well as to continue funding for Individualized Skills and Socialization and waiver slots.

## **Families First Coronavirus Response Act**

The Families First Coronavirus Response Act (FFCRA)(Public Law No: 116-127), effective on March 18, 2020, addressed the economic impact of PHE. FFCRA allowed for continuous Medicaid eligibility for anyone eligible March 1, 2020, or later through the end of the PHE addition and established a temporary 6.2 percent enhancement in FMAP funding to help provide services to an increased number of eligible Medicaid enrollees throughout the PHE period. In accordance with federal law, continuous Medicaid coverage ended on March 31, 2023.