



# **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 2022**



**TEXAS**  
Health and Human  
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# Executive Summary

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

Chapter 534 directs the 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 and 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.

Over the past nine years, HHSC has made substantial progress on the IDD system redesign, including increasing access to services and preventing institutionalization for individuals with IDD, and standardizing and making the complaint process more efficient. Other milestones are described in the 2021 Implementation of Acute Care Services and Long-Term Services and Supports System Redesign for Individuals with an Intellectual or Developmental Disability<sup>1</sup>.

In addition, 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. At the time of this report, the design includes the eligibility criteria, contractual requirements, designated service area, and evaluation protocols for the SP3.

In 2022, HHSC published the Statewide IDD Strategic Plan<sup>2</sup> and migrated the Home and Community-based services (HCS) and Texas Home Living (TxHmL) Program forms and claims processing function from the legacy mainframe system to modern web-based systems.

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<sup>1</sup> <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2021/sb7-report-imp-ac-s-ltss-system-redesign-iid-sept-2021.pdf>

<sup>2</sup> <https://www.hhs.texas.gov/sites/default/files/documents/statewide-idd-strategic-plan-jan-13-2022.pdf>

# Introduction

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

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

Further, Section 534.112, added by 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. The SP3 will implement in phases, beginning September 1, 2023, and operate for at least two years. The SP3 evaluation report will be included as part of the annual report required by Section 534.054 and must include:

- An assessment of the effect of the SP3 on elements of the system such as access and quality, person-centeredness, integration, employment, appeals, self-direction, and attendant workforce;
- Benefits of providing STAR+PLUS Medicaid managed care services to persons based on functional needs as required in the SP3 including feedback based on the personal experiences of the SP3 participants (e.g., individuals and families served and providers);
- Recommendations about a system of programs and services for consideration by the Legislature, including recommendations for needed statutory changes and whether to transition the SP3 to a statewide program under STAR+PLUS;
- An analysis of the experience and outcomes of the following systems changes:
  - Comprehensive assessment instrument under Section 533A.0335, Texas Government Code,
  - 21st Century Cures Act,<sup>3</sup>

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<sup>3</sup> <https://www.congress.gov/114/plaws/publ255/PLAW-114publ255.pdf>

- ▶ Implementation of Home and Community-Based Services (HCBS) settings rules,<sup>4</sup>
- ▶ Provision of CFC attendant and habilitation services required under Section 534.152, Texas Government Code.

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<sup>4</sup> <https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider>

# Background

Texas Government Code, Section 534.051<sup>5</sup> 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>6</sup> directs the following activities related to the SP3:

- Development and implementation of a 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 a 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 two<sup>7</sup> includes development and implementation of a plan to transition all or a portion of services 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 will be used to inform stage two. The program transitions in stage two are staggered beginning with Texas Home Living (TxHmL) by September 1, 2027, Community Living Assistance and Support Services (CLASS) by September 1, 2029, and non-residential Home and Community-based Services (HCS) and Deaf Blind with Multiple Disabilities (DBMD) services by September 1, 2031.

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<sup>5</sup> <https://statutes.capitol.texas.gov/Docs/GV/htm/GV.534.htm#534.051>

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

<sup>7</sup> Texas Government Code, Chapter 534, SUBCHAPTER E:  
<https://statutes.capitol.texas.gov/Docs/GV/htm/GV.534.htm>

HHSC must conduct a second SP3 to test the feasibility and cost efficiency of transitioning HCS and DBMD residential services and community-based ICF/IID services to managed care.



# 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 finalize key design elements of the SP3 and begin work to operationalize these decisions. HHSC's implementation and planning efforts to date for the SP3 include:

- 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 as of the writing of this report 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 Collaborative Action Plan as the functional needs-based assessment and the My Life Plan (MLP) 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 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.

- ▶ HHSC plans to pursue an 1115 waiver amendment using the parameters similar to the 1915(i)-authority based on communications with CMS and statutory direction for the SP3.
- Completed a dental study required by H.B. 4533 to inform dental benefits for SP3 participants.

The SP3 implementation start date remains September 1, 2023; however, the SP3 is dependent on the operational start date for the STAR+PLUS program, currently under procurement. The current operational start date for STAR+PLUS is February 2024. Current information on the STAR+PLUS procurement can be found here: <https://www.hhs.texas.gov/business/contracting-hhs/procurement-opportunities>.

The implementation of SP3 will occur in three phases, and all phases include ongoing stakeholder collaboration. Examples of activities for each phase are provided below.

- Phase I activities were completed in June 2022, with input from the IDD SRAC, SP3W, and CMS. Phase I activities include developing needs-based eligibility criteria and target groups; establishing possible service areas; selecting tools used for assessment and PCP; developing the service array and service descriptions; exploring alternative payment methodologies; establishing roles and responsibilities for service coordination and providers; and modifying CDS to increase access and use.
- Phase II activities are scheduled to complete by September 1, 2023. Phase II activities include finalizing policy, rules, and federal authority; conducting outreach and education for participants and providers; facilitating member selection of participating SP3 Managed Care Organizations (MCO); and performing readiness activities and system changes.
- Phase III activities are scheduled to complete by February 2024. Phase III activities include finalizing systems updates, completing trader partner testing and readiness; and initiating assessment, service planning, and service delivery for SP3 participants.

The SP3 provides an opportunity to focus on quality metrics by requiring identification and tracking of measurable goals using national core indicators (NCI), the National Quality Forum LTSS measures, and other appropriate Consumer Assessment of Healthcare Providers and Systems measures. HHSC and the SP3W Quality Subcommittee collaborate on this effort.

## **Information Technology Modernization**

An exceptional item for Information Technology (IT) 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. A second deployment, continuing the transition of IDD Waivers programs (HCS and TxHmL) into managed care is planned for summer of 2023.

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

## **Employment First**

Senate Bill (S.B.) 50, 87th Legislature, Regular Session, 2021 requires HHSC to develop a uniform process to assess competitive and integrated employment goals and opportunities available to people in waiver programs for individuals with IDD and STAR+PLUS HCBS; and use those identified goals and opportunities to direct plans of care. HHSC is currently developing the uniform process for assessing employment goals and using goals in the service planning process. In partnership with Texas Workforce Commission (TWC), HHSC is also collecting 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. Additionally, HHSC is developing a rules project to accomplish provisions of the bill relating to the employment initiative.

## **Critical Incident Management System**

CMS released guidance in 2014 related to participant safeguards within managed care long-term services and supports (MLTSS) and health and welfare assurances within 1915(c) waivers that, (a) need critical incident management systems (CIMS) and (b) must include safeguards to prevent abuse, neglect, and exploitation (ANE). In addition to ANE reporting, other critical incidents such as law enforcement involvement, emergency room visits, and deaths are reported as critical incidents.

The CIMS design gives one place for Community Living Assistance and Support Services, Home and Community-based Services, DBMD, and TxHmL, STAR+PLUS Home and Community Based Services and STAR Kids Medically Dependent Children Program waiver providers to enter critical incident data. LIDDAs will also enter critical incident data related to General Revenue (GR) services into the CIMS. The CIMS allows HHSC to monitor, track, and trend critical incidents, including, but not limited to ANE.

The CIMS was implemented on July 25, 2022. Fee for service (FFS) waiver providers were first to adopt the system with MLTSS waiver providers added later in fiscal year 2023. MLTSS waiver providers currently report critical incidents into an MLTSS specific reporting system. HHSC is giving FFS waiver providers a 90-day grace period to adopt the system.

## **Study on High Behavioral and High Medical Needs in the HCS Waiver Program**

The 2022-23 General Appropriations Act S.B. 1, 87th Legislature, Regular Session, 2021 (Article II, Health and Human Services Commission), Rider 38 requires HHSC to conduct a study<sup>8</sup> on the provision of services under the HCS waiver program to individuals with an IDD who have high behavioral needs or high medical needs. To comply, HHSC used existing HCS policies related to high behavioral and high medical needs and available administrative data as a framework to define the scope of high behavioral and high medical needs. In addition, HHSC took into consideration stakeholder feedback and modified the definitions for high behavioral and medical needs as a result. HHSC defined four indicators of high behavioral needs and three indicators of high medical needs. Using the defined indicators, HHSC identified 591 individuals in the HCS Program who met the criteria for high behavioral needs and 2,971 who met the criteria for high medical needs for fiscal year 2021.

## **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 (IL) questionnaire with certain minimum information. HHSC will implement this project by:

- Updating Community Services Interest List (CSIL) application and Questionnaire for LTSS Waiver Program Interest Lists, form 8577, with revised questionnaire elements.

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<sup>8</sup> <https://www.hhs.texas.gov/sites/default/files/documents/study-hcs-waiver-program.pdf>

- 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 list(s).
- Creating an annual IDD SRAC report with active/inactive statistics.

HHSC began meeting with external stakeholders to review proposed changes to the questionnaire and will begin collaboration with the IDD SRAC in December 2022.

# Effects on the System

## Complaints, Appeals, and Fair Hearings

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

## Complaints Data Trending and Analysis Initiative

HHSC has identified opportunities to improve the member and provider managed care complaints process and data collection for all members including members who have IDD. A cross divisional workgroup was formed in July 2018 to address this effort. Activities are in line with the 85th Legislature, General Appropriations Act, Regular Session, 2017, Article II, Rider 61 report recommendations regarding strengthening oversight of the Texas Medicaid program. Changes are also aligned with the 86th Legislature, Regular Session, 2019, H.B. 4533 requirements on grievances.

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

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

## 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>9</sup> Individuals in

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<sup>9</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

STAR+PLUS, STAR Kids, and STAR Health, or their LAR, may file an appeal with their MCO if they are dissatisfied with an adverse benefit determination taken by the MCO.

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

Table 1 below shows the average monthly number of individuals in an IDD waiver or ICF/IID compared to the number of complaints received in state fiscal year (FY) 2021 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 FY 2021 regarding Acute Care.**

Managed Care Program	Average Monthly Number of Individuals Receiving Services who were in an IDD Waiver or ICF/IID	Number of Complaints Received by Members in an IDD Waiver or ICF/IID in FY 2021
STAR+PLUS	18,204	130
STAR Kids	5,215	55
STAR Health	152	7
<b>Total</b>	<b>23,571</b>	<b>192</b>

Source: TexConnect – MCO self-reported data

The top three reasons for complaints from members in an IDD waiver or ICF/IID in FY 2021 were access to care, claims/payment, and quality of care. All reasons for complaints in FY 2021 from members in an IDD waiver are listed below.

- Access to Care
- Claims/Payment
- Customer Service

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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.

- Electronic Visit Verification (EVV)
- Medical Transportation
- Policies/Procedures
- Prescription Services
- Provider Contracting
- Quality of Care
- Value-Added Services

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

**Table 2. Number of MCO Internal Appeals Upheld, Overturned, or Withdrawn for Recipients in an IDD Waiver or ICF/IID Enrolled in STAR+PLUS, STAR Kids, and STAR Health in FY 2021**

Program	Total Number of Appeals Filed	Number of Appeals Upheld by MCO <sup>10</sup>	Number of Appeals Overturned by MCO <sup>11</sup>	Number of Appeals Withdrawn by Member
<b>STAR+PLUS</b>	358	202	148	7
<b>STAR Kids</b>	204	118	127	9
<b>STAR Health</b>	31	8	23	0
<b>Total</b>	<b>593</b>	<b>328</b>	<b>298</b>	<b>16</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 2021 for members enrolled in an IDD waiver or ICF/IID related to reduction or denial of Durable Medical Equipment (DME), medical necessity, and Private Duty Nursing. All reasons for State Fair Hearings in 2021 for members enrolled in an IDD waiver related to reduction or denial of services and supports are listed below.

- DME
- Genetic Testing
- Medical Necessity

<sup>10</sup> Indicates that the MCO investigated, reviewed, and ruled in favor of the adverse benefit determination taken by the MCO.

<sup>11</sup> Indicates that the MCO investigated, reviewed, and overturned the adverse benefit determination taken by the MCO.



- Pharmacy
- Prior Authorization
- Private Duty Nursing
- Therapy – Treatment
- Transportation

## Office of the Ombudsman

The Office of the Ombudsman received 54 complaints, four substantiated<sup>12</sup> and 50 unsubstantiated<sup>13</sup> or unable to substantiate<sup>14</sup> in FY 2021 for STAR+PLUS, STAR Kids, and STAR Health members enrolled in an IDD waiver. Access to care and quality of care were the primary general complaint categories. All general complaint categories received are listed below.

- Access to Care (31)
- Claims/Payment (3)
- Member Enrollment (3)
- Policies/Procedures (1)
- Prescription Services (5)
- Quality of Care (6)
- Therapy (3)
- Transportation Issues (2)

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<sup>12</sup> Substantiated complaint--A complaint for which research clearly indicates HHS policy was violated or HHS expectations were not met.

<sup>13</sup> Unsubstantiated complaint--A complaint for which research clearly indicates HHS policy was not violated or HHS expectations were met.

<sup>14</sup> Unable to substantiate complaint--A complaint for which research does not clearly indicate HHS policy was violated or HHS expectations were not met.

# Initiatives to Improve Access and Outcomes

For details on past HHSC initiatives to improve access and outcome, see the 2021 Implementation of Acute Care Services and LongTerm Services and Supports System Redesign for Individuals with an Intellectual or Developmental Disability<sup>15</sup>.

## Person-Centered Planning

Federal rules for Medicaid HCBS, including CFC, require person-centered service planning, also referred to as PCP. Using a PCP process, a service plan and objectives are developed based on a person's preferences, strengths, and clinical and support needs.

To comply with federal and state regulations, HHSC requires people who facilitate person-centered service plans for CFC and HCBS to complete training within six months of hire. The state and its partners, including LIDDAs, The University of Texas Center for Disability Studies, and The Learning Community for Person-Centered Practices, have been working to build the infrastructure to train and certify more Person-Centered Thinking (PCT) trainers. In addition, HHSC established a PCP Steering Committee to ensure person-centered thinking, planning, and practice occurs throughout the HHSC system.

In 2022, HHSC aligned PCP efforts within the Office of Disability Services Coordination for systemic integration of PCP values and initiatives. The National Center on Advancement of Person-Centered Practices and Systems (NCAPPS) Technical Assistance grant acted as a springboard to activities such as development of the MLP and the Employment Crosswalk.

At the time of this report, HHSC is conducting an environmental scan, i.e. tracking trends, of PCP initiatives and best practices at an agency, state and national level to inform future efforts.

By December 2022, HHSC will integrate the MLP framework in a PCP organization and system in the SP3. At the end of the SP3, HHS 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.

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<sup>15</sup> chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2021/sb7-report-imp-acsltss-system-redesign-iid-sept-2021.pdf

## 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 collected inputs 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 with a volunteer sample. Phase 1 was completed on August 31, 2017.
- Phase 2 included the evaluation and comparison of the InterRAI with the currently used assessment, the Inventory for Client and Agency Planning (ICAP). Phase 2 was completed in December 2018, with the final report received in late February 2019.
- Phase 3 involves the development of a resource allocation algorithm, and statewide rollout of the InterRAI ID assessment instrument. , 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 algorithm is expected to be completed in December 2022, however statewide implementation requires legislative direction.

## 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 must comply with these rules by March 17, 2023, which includes a one-year extension due to the federal coronavirus disease (COVID-19) public health emergency (PHE) declaration.

HHSC is promulgating rules for Medicaid IDD waiver programs in order to comply with the HCBS Settings Rule. After posting for informal public comment, reviewing and finalizing the proposed rules, HHSC staff is scheduled to submit the formal posting for public comment in the Texas Register in September 2022. All public comments will be considered before sending the rules to the Texas Register for adoption which is scheduled for late December 2022 for the HCS and TxHmL HCBS Settings rules and late January 2023 for the CLASS and DBMD HCBS Settings rules.

CMS 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

Texas submitted an initial statewide transition plan (STP) to CMS in 2014 and updated the plan with feedback from CMS. HHSC submitted the most recent version of the STP to CMS in April 2022.

CMS presumes some settings have qualities that are institutional or isolating in nature. CMS requires states to submit evidence demonstrating these settings are able to overcome the presumption and meet all requirements of the HCBS settings rule. These settings must go through a heightened scrutiny review by CMS. At the time of this report, HHSC is working with MCOs to complete the heightened scrutiny process for all assisted living facilities (ALF) that serve individuals in the STAR+PLUS HCBS waiver. HHSC has ongoing communication with CMS which will then select a sample of ALFs to review. If CMS approves the ALFs, they are an approved HCBS service setting and may continue to be a residential setting within the STAR+PLUS HCBS waiver. If CMS does not approve an ALF under the heightened scrutiny process, HHSC may be required to work with MCOs to revise how ALF services are provided in order to secure CMS approval for these settings.

## **Transition of Day Habilitation Services**

As part of HHSC's plan to achieve compliance with the HCBS settings rule, HHSC will replace 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. The new, more integrated service is called individualized skills and socialization.

In 2021, to help achieve this goal, the Texas Legislature provided HHSC the authority to transfer funds in Goal A of the budget for the implementation of individualized skills and socialization (2022-23 General Appropriations Act, S.B. 1, 87th Texas Legislature, Regular Session, 2021- Article II, HHSC, Rider 23). The Legislature appropriated approximately \$1.7 million to fund an individualized skills and socialization provider registry, to ensure ongoing monitoring and oversight of individualized skills and socialization providers. To ensure timely implementation of individualized skills and socialization services, HHSC will require an individualized skills and socialization provider to be licensed rather than registered. Providers will receive a day activity and health services facility license with a special designation for individualized skills and socialization.

As outlined in the Transition of Day Habilitation Services plan, HHSC is currently undertaking efforts to replace day habilitation with individualized skills and socialization, which will include an on-site (center-based) component and an off-site (community-based) component. An in-home (home-based) component is included in the HCS and TxHmL programs only. Individualized skills and socialization will also include off-site staff ratios to allow staff to provide more individual attention to program participants.

## **IDD Strategic Plan**

Texas developed a Statewide IDD Strategic Plan to increase awareness of the IDD population and gaps in policy, services, and funding which must be addressed to ensure optimal care is provided.

The first version and foundation of the plan was published in February 2019. This plan included the following:

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

In a subsequent version of the IDD Strategic Plan released in 2022, stakeholders further explored community needs and collaborated to develop a comprehensive list of recommendations across state agencies aimed to meet the needs and close the gaps identified. The final Statewide IDD Strategic Plan<sup>16</sup> was published in January 2022. The plan includes the following:

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

Following the publication of the strategic plan, HHSC is reviewing the recommendations to identify strategies that align with the agency's strategic and operational goals and determine next steps. The Statewide IDD Strategic Plan was also shared with other state agencies to review recommendations that are outside HHSC's scope.

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<sup>16</sup> <https://www.hhs.texas.gov/reports/2022/01/statewide-intellectual-developmental-disabilities-strategic-plan-2022>

# Promoting Independence and Preventing Institutionalization

## Money Follows the Person Demonstration

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's MFPD funding and the program through September 30, 2025.

Many of the MFPD-funded projects in Texas designed to promote independence for individuals with IDD are outlined in Texas's *Promoting Independence Plan*,<sup>18</sup> in response to the U.S. Supreme Court ruling in *Olmstead v. Zimring*. Some of the projects are highlighted below.

MFPD-funded projects include:

- Integrated and competitive employment initiatives designed to increase the number of persons with developmental disabilities (DD) in integrated employment. This includes funding for: in-person trainings and webinars sharing Employment First (EF) principles; employment recruitment coordinators who work to promote hiring people with DD; EF coordinators to promote employment in the general workforce; apprenticeship pilot programs; an EF website; web-based trainings; and videos, and other communication tools including, a guide, brochure, and magnet promoting hiring people with disabilities. MFP funds were also used to sponsor a pilot project which utilized electronic tablets with

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<sup>17</sup><https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/promoting-independence/money-follows-person-demonstration-project>

<sup>18</sup> [2020 Revised Texas Promoting Independence Plan](#)

interactive technology to help people reduce their dependency on in-person job coaching. This approach helps to increase a person's control of their job training and supports successful transitions for people in all settings.

- Transition Support Teams help community providers and LIDDAs deliver adequate support to individuals with significant medical, behavioral, and psychiatric challenges transitioning from institutional settings or who are at risk of admission to an institution. Eight LIDDAs and community provider consultative support teams provide educational activities and materials, technical assistance, and consultative case reviews.
- The LIDDA Enhanced Community Coordination (ECC) service coordinators provide intense monitoring and flexible support to individuals to support success in the community. The ECC service coordinator ensures individuals are linked to critical services and receive person-centered services for up to one year following a transition or diversion. From September 1, 2020, through August 31, 2021, 2,280 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 relocation process and planning. They serve as a resource for personal support teams to help identify services and supports for individuals in the community, to identify obstacles to community transition, and to develop strategies to mitigate barriers for transitioning. The continuity of services specialist monitors the final community living discharge plan and post-move support to assure quality of services and make suggestions for improvement.

In 2022, MFPD funds were also used to sponsor provider fairs designed to educate individuals and their families and guardians on options for receiving services in the community.

- 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 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. Priority for available units will be designated for individuals transitioning into their communities from nursing facilities or ICFs/IID.
- 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 PRA operates in select areas of the state and serves the following target populations:

- ▶ Persons with disabilities exiting institutions (e.g., nursing facilities and ICF/IID), who are eligible to receive LTSS through a Medicaid waiver.
  - ▶ Persons with SMI who are eligible to receive services through HHSC; and
  - ▶ Youth or young adults with disabilities exiting Department of Family and Protective Services (DFPS) foster care.
- The direct service workforce (DSW) development project supports the implementation of a multi-year strategic plan to improve recruitment and retention of direct service workers. DSW recruitment and retention sustainability projects are key to building an infrastructure to support transitions to the community. The goals and objectives in this project build on previous MFPD projects and contribute to capacity building within HCBS by researching potential long-term strategies and building federal, state, regional and local partnerships to enhance recruitment and retention of the direct care workforce which provide necessary support for people receiving services in the community. The project funds two contracted positions to assist with project deliverables from the DSW Taskforce. The taskforce—comprised of attendants, advocates, providers, TWC, Texas Higher Education Coordinating Board, and several local workforce development boards—is responsible for exploring the applicability of non-wage based long-term recruitment and retention strategies and providing continuous feedback on the implementation of the strategic plan. All project objectives meet two primary goals:
    - ▶ Goal 1: Enhance Workforce Development; and
    - ▶ Goal 2: Improve Data.

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

Initially, the 84th Legislature, Regular Session, 2015 allocated \$18.6 million, which increased by \$10 million over subsequent sessions for crisis intervention and crisis respite services. A total of \$28.6 million was allocated to provide crisis intervention and crisis respite support to individuals with IDD who have behavioral health or mental health support needs. All 39 LIDDAs statewide provide crisis intervention and crisis respite services to support individuals to maintain independent lives in the community, and to avoid unnecessary institutionalization. From September 1, 2020 to August 31, 2021:

- 3,927 individuals were provided therapeutic supports for successful community integration through crisis intervention services,

- 775 individuals were diverted from institutionalization or hospitalization by receiving crisis respite services:
- 682 of which utilized IDD Crisis Respite; and
- 93 utilized Mental Health Crisis Respite services.

# IDD System Redesign Advisory Committee

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

- Transition to Managed Care (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 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 to inform 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 2021, 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 FFS or managed care) for legislative and HHSC consideration. The recommendations address a host of suggested service improvements to:

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

# Challenges and Areas for Further Consideration

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

## Attendant Workforce

A successful community-based long-term support system is contingent upon a stable and trained workforce. The current demand for personal care aides (PCAs) in Texas and nationwide exceeds supply, and this gap is projected to grow substantially over the coming decades.

The 2020-21 General Appropriations Act, H.B. 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 157) directs HHSC to develop strategies to recruit, retain, and ensure adequate access to the services of community attendants. The work of Rider 157 resulted in the Community Attendant Workforce Strategic Plan<sup>19</sup> 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, described above.

In May 2021, HHSC implemented ARPA HCBS Provider Retention payments, providing funds to agencies and CDS employers to support direct care staff recruitment and retention efforts. HHSC is providing time-limited reimbursement increases to strengthen and stabilize the HCBS workforce. Temporary rate increases will be made on eligible HCBS service claims with dates of service between March 1, 2022 and August 31, 2022.

## Interest List

As of April 2022, the unduplicated count of individuals on all Texas Medicaid waiver interest lists was 166,313. Texas' combined waiver interest lists increased from 78,626 unduplicated individuals in 2010 to 166,313 in 2022 (111.5 percent).

Interest list reduction is a high concern of stakeholders, advisory committees, and individuals who continue to request full funding of the six interest lists.

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<sup>19</sup> <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/rider-157-ca-workforce-dev-strat-plan-nov-2020.pdf>

The 2020-21 General Appropriations Act, H.B. 1, 86th Legislature, Regular Session, 2019 (Article II, Health and Human Services Commission [HHSC], Rider 42) required a Medicaid Waiver Programs Interest List Study be conducted in efforts to reduce the interest list. Suggested strategies in the report to address the length of the interest lists include:

- Addressing gaps in real-time information about the needs of individuals currently on waiver interests lists to better understand and manage timely access to services thereby addressing risks to health and safety or institutionalization.
- Prioritizing certain populations and individuals with the highest level of service needs, similar to what other states have implemented.
- Considering any interest list reduction allocations and targeting additional funding for priority populations.

## **Individuals with High Medical Needs**

Stakeholders continue to voice concerns through IDD SRAC meetings and stakeholder engagement meetings with HHSC about individuals in the HCS Program who reside in host homes, have high medical needs, and “age out” of certain services, particularly private duty nursing, at age 21. Stakeholders believe the current nursing billing requirements in HCS prevent medically complex adults from receiving the level of nursing required to support the host home providers and as a result, these individuals must either transition into institutions or move from HCS into the STAR+PLUS HCBS program. Stakeholders feel both options are detrimental to the health and well-being of these individuals and have requested that HHSC address rules, policies, and billing requirements so individuals can remain in the HCS Program.

Residential and nursing services are available for medically complex adults with intellectual or IDD in both the HCS and STAR+PLUS HCBS programs. While there are some similarities across the two programs, key differences include the type of residential service available, the maximum number of people served in residential settings, the approach to habilitation, rates for residential services, the approach used for monitoring and oversight of residential providers, the scope of allowable nursing tasks and activities, and the overall cost cap for the respective waiver programs.

HHSC is exploring options for better serving medically complex adults with IDD to ensure they can safely remain in community-based settings and have their needs met.

## Community First Choice

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.

## Non-Medical Drivers of Health

Non-medical drivers of health, previously referred to as social determinants of health, are factors that can influence overall health and the ability to access healthcare and services. Homelessness, lack of transportation, unemployment, food insecurity, and other socioeconomic or environmental factors can pose challenges to obtaining needed medical services and LTSS. Individuals with IDD often face greater challenges when health-related social needs are unmet.

HHSC partners with MCOs, local agencies, and state and national organizations to review existing evidence-based practices around value-based payment models, quality measures, program effectiveness and funding sources to address non-medical drivers of health in Texas Medicaid and Children's Health Insurance Program (CHIP). Further information is needed to understand how financial incentives can support screening tools for non-medical drivers of health that providers and MCOs can use to screen for health-related social needs; encouraging collaboration with community agencies to address these health-related social needs; and an increased focus on aging populations and regions where additional resources to address non-medical drivers of health are most needed.

An internal workgroup consisting of subject matter experts from across HHS was created in April 2020 to share best practices and updates on projects related to non-medical drivers of health and to foster cross-collaborative opportunities for peer review and feedback on developing projects. The agency is assessing potential policies or programs to improve health outcomes for Texans, including solutions to barriers preventing adequate access to health care and LTSS.

## COVID-19

In response to the COVID-19 PHE, HHSC initiated and secured a number of system changes and flexibilities to allow for safer delivery of services, such as allowing virtual assessments and service coordination, telehealth delivery of some LTSS, and allowing family members to provide services in lieu of staff coming into the home from the outside. HHSC also collaborated with other state agencies and community providers to facilitate access to personal protective equipment (PPE) and vaccine administration for people who otherwise may not have access.

H.B. 4, 87th Legislature, Regular Session, 2021, required HHSC to assess the clinical and cost-effectiveness of making the telehealth and telemedicine flexibilities allowed during the COVID-19 PHE available permanently. After analyzing services, HHSC determined certain Medicaid state plan and waiver services are appropriate to be delivered using telehealth and/or audio-only communication on a permanent basis. At the time of this report, rule and policy changes for the implementation<sup>20</sup> of H.B. 4 is ongoing and will be completed by early 2023.

HHSC has made significant progress on the IDD system redesign. The past year has been heavily focused on the development of the SP3 in collaboration with the IDD SRAC and SP3W. 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 work with stakeholders to improve programs and services for Texans with IDD.

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<sup>20</sup> <https://www.hhs.texas.gov/services/health/medicaid-chip/provider-information/medicaid-chip-teleservices>

# List of Acronyms

Acronym	Full Name
ABI	Acquired Brain Injury
ADL	Activity of Daily Living
ADS	Analytical Data Store
ALF	Assisted Living Facility
APM	Alternative Payment Model
ARPA	American Rescue Plan Act
ASD	Autism Spectrum Disorder
BH	Behavioral Health
CARES	Coronavirus Aid, Relief, and Economic Security
CAP	Collaborative 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 Systems
CLASS	Community Living Assistance and Support Services
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
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
DME	Durable Medical Equipment
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
FY	Fiscal Year
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
ICAP	Inventory for Client and Agency Planning



<b>Acronym</b>	<b>Full Name</b>
ICF	Intermediate Care Facility
ICF/IID	Intermediate Care Facility for an Individual with an Intellectual Disability
IDD	Intellectual and Developmental Disabilities
IDD SRAC	Intellectual and Developmental Disabilities System Redesign Advisory Committee
InterRAI ID	International Resident Assessment Instrument Intellectual Disability Assessment
IT	Information Technology
ITP	Individual Transportation Participant
LAR	Legally Authorized Representative
LIDDA	Local Intellectual and Developmental Disability Authority
LON	Level of Need
LTSS	Long-Term Services and Supports
MAO	Medicaid Assistance Only
MCO	Managed Care Organization
MDCP	Medically Dependent Children Program
MFPD	Money Follows the Person Demonstration
MLP	My Life Plan
MMIS	Medicaid Management Information System
NCAPPS	National Center on Advancement of Person-Centered Practices and Systems
NCI	National Core Indicator
NEMT	Non-Emergency Medical Transportation
OT	Occupational Therapy
PAS	Personal Assistance Services
PCA	Personal Care Aide
PCP	Person-Centered Planning
PCT	Person-Centered Thinking
PHE	Public Health Emergency
PPE	Personal Protective Equipment
PRA	Project Rental Assistance
PT	Physical Therapy
QAI	Quality Assurance and Improvement
SE	Supported Employment
SP3	STAR+PLUS Pilot Program
SP3W	STAR+PLUS Pilot Program Workgroup
SSI	Supplemental Security Income
SSLC	State Supported Living Center
STP	Statewide Transition Plan
SUD	Substance Use Disorder
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

<b>Acronym</b>	<b>Full Name</b>
UR	Utilization Review
VR	Vocational Rehabilitation

# **Appendix A: IDD System Redesign Advisory Committee Recommendations<sup>21</sup>**

## **Transition to Managed Care Subcommittee**

### **H.B. 4533 Pilot STAR+PLUS Pilot Program Development and Funding and Implementation**

#### **Background**

The STAR+PLUS Pilot Program (SP3) will move into procurement and operations in 2022 through 2024, with an expected implementation date of February 2024. This will be the first model of its kind in the United States combining populations based on need rather than discreet diagnosis. Also unique is the population being tested which will be current STAR+PLUS members not on IDD waivers. The new pilot will require IT changes, HHSC dedicated staff, contracts with MCOs, new benefits to align with the needs of the population, training, and outreach.

#### **Recommendations**

To ensure that the pilot is adequately funded and operational the IDD SRAC TMC subcommittee has the following recommendations:

#### **Funding**

1. The Texas Legislature fully fund the proposed STAR+PLUS Pilot benefits recommended by the TMC and approved by the IDD SRAC. When determining the cost for the STAR+PLUS Pilot, the Legislature must take into consideration the current utilization of the population currently in STAR+PLUS. TMC 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:
  - Behavioral health crisis intervention services (specified in H.B. 4533),
  - Enhanced behavioral support specialty (specified in H.B. 4533),
  - Enhanced behavioral family/caregiver coaching services,
  - Enhanced behavioral extended substance use disorder services,
  - Enhanced behavioral peer supports,

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<sup>21</sup> Recommendations were drafted and adopted by the IDD SRAC. HHSC made minor non-substantive edits to address formatting and grammar.

- Enhanced behavioral therapeutic in-home respite,
  - Enhanced behavioral therapeutic out of home respite,
  - Specialized therapies,
  - Orientation and mobility,
  - Intervenor support for participants with visual/auditory challenges,
  - Assisted living with modifications (specified in H.B. 4533 without modifications), and
  - 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:
    - Any additional IT programming costs should be included in the pilot to assure access to electronic records, eligibility information, and data sharing.
    - Texas HHSC staff need to implement and oversee the pilot.
    - Funding 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.
    - 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. Funding 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 STAR+PLUS Pilot will test the delivery of LTSS through a single, coordinated managed care system. A

comprehensive evaluation of the pilot will help inform the state’s plan to transition LTSS services from IDD waivers and ICF/IIDs to managed care.

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

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

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

## Recommendations

1. HHSC should determine STAR+PLUS Pilot eligibility by needs-based criteria. To qualify for the pilot, a person must meet all of the following requirements:
  - 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 1 below).
  - C. Demonstrate a need for at least one pilot service.
  - D. Have substantial functional limitations in three or more areas of the following major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.
2. Recommended target groups should include:

**Table 1. STAR+PLUS Pilot Target Groups**

Target Group	Criteria
<b>Group A</b>	<p>People who have a diagnosis:</p> <ul style="list-style-type: none"><li>• ID</li><li>• Autism</li><li>• TBI</li><li>• Acquired brain injury (ABI)</li></ul> <p>A condition on the Texas HHSC Approved Diagnostic Codes for Persons with Related Conditions List</p>

Target Group	Criteria
<b>Group B</b>	People enrolled in STAR+PLUS HCBS with a diagnosis listed in Group A who could benefit from pilot services not available through STAR+PLUS HCBS

3. Enrollment should be open for a limited time to ensure a statistically viable and consistent population.
4. HHSC will automatically enroll STAR+PLUS Pilot eligible persons in the pilot but give them the ability to opt out.
5. HHSC should develop informational materials to help pilot participants make an informed choice to stay in the pilot or opt out.
6. HHSC 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 Supplemental Security Income (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 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:

**Table 2: STAR+PLUS Pilot Benefits**

<b>Current State Plan LTSS Services -</b> <u>Reference Section:</u> 1143.1.2 Long-term Services and Support Listing	<ul style="list-style-type: none"><li>• Day Activity &amp; Health Services</li><li>• Personal Assistance Services (PAS)</li><li>• CFC (PAS; Emergency Response Services; Support Management; Habilitation)</li></ul>
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<p><b>Current STAR+PLUS HCBS Services</b></p> <p><u>Reference Section:</u>1143.2 Services Available to STAR+PLUS Home and Community Based Services Program Members</p>	<ul style="list-style-type: none"> <li>• Adaptive Aids &amp; Medical Supplies</li> <li>• Adult Foster Care adding modification</li> <li>• Assisted Living</li> <li>• Audiology (Limited)</li> <li>• Auditory Integration Training/Auditory Enhancement Training</li> <li>• Cognitive Rehabilitation Therapy</li> <li>• Dental Treatment</li> <li>• Emergency Response (for Medicaid Assistance Only (MAO) members)</li> <li>• Employment Assistance (EA)with modifications career planning</li> <li>• Financial Management Services</li> <li>• Home Delivered Meals</li> <li>• Minor Home Modifications</li> <li>• Nursing Services</li> <li>• Occupational Therapy (OT)</li> <li>• Personal Assistance Service (for MAO members)</li> <li>• Protective Supervision</li> <li>• Physical Therapy (PT)</li> <li>• Respite</li> <li>• Speech</li> <li>• Support Consultation</li> <li>• Supported Employment (SE) Services</li> <li>• Transition Assistance Services</li> </ul>
<p><b>New HCBS Services for STAR+PLUS Pilot referenced in statute</b></p>	<ul style="list-style-type: none"> <li>• Behavioral Support Services</li> <li>• Behavioral Health (BH) Crisis Intervention Service</li> <li>• Enhanced Behavioral Supports <ul style="list-style-type: none"> <li>◦ Enhanced In-Home Respite Services (EIHRS)</li> <li>◦ Enhanced Out of Home Respite Services (EOHRS)</li> <li>◦ Behavioral Support Specialty Services</li> <li>◦ Individual/Family /Caregiver Coaching to include training, education and Peer Supports</li> <li>◦ Peer Supports</li> </ul> </li> <li>• IDD Enhanced Extended Substance Use Disorder Services (SUDS)</li> <li>• Community support transportation</li> <li>• Day Habilitation</li> <li>• Enhanced Medical Supports</li> <li>• Innovative Technology including remote monitoring</li> </ul>
<p><b>New Recommendations allowed under statute and approved by IDD SRAC - HCBS Services</b></p>	<ul style="list-style-type: none"> <li>• Community Integrations Supports</li> <li>• See Enhanced BH and SUDS above</li> <li>• Specialized Therapies – Massage; Recreational; Music; Art; Aquatic; Hippotherapy; Therapeutic Horseback Riding.</li> <li>• Dietary Services</li> <li>• Intervener/interpreter</li> </ul>

# 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 3. Requirements for Accessing Dental Services by Waiver or Program**

<b>Waiver or ICF/IID Program</b>	<b>Benefit Limit</b>	<b>Unique Rules</b>
<b>HCS</b>	\$2000	Specific dental limit. Built into initial and renewal plan of care based on need.
<b>TxHmL</b>	\$1000	Specific dental limit. Built into initial and renewal plan of care based on need.
<b>CLASS</b>	\$10,000	Combined with adaptive aids. Approvals required and not built into initial or renewal plan of care.
<b>DBMD</b>	\$2500 & \$2,000 for Dental Sedation	Approvals required and not built into initial or renewal plan of care.
<b>ICF/IID</b>	Traditional Medicaid <sup>22</sup>	Discussed at the annual staffing and recommendations for 3 months, 6 months or annual dental care based on need. There are follow-up meetings and appointments based on what was recommended in the staffing.
<b>STAR+PLUS</b>	\$5000	Specific dental limit. Built into initial and renewal plan of care.

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

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<sup>22</sup> See July 7, 2014, Information Letter 14-37 Re: Exceptions to Managed Care Expansion: <https://www.dads.state.tx.us/providers/communications/2014/letters/IL201>

and clear guidance from HHSC. This includes explaining how a dental value-added benefit impacts limits and processes in each of the programs. To streamline the requirements and to allow easy access to dental services for this population, the IDD SRAC has the following recommendations.

## **Recommendations**

1. For each HCBS waiver, include in the person's yearly plan of care the amount of services needed and available funds for dental for the year. Educate participants about their benefit.
2. For TxHmL and HCS, HHSC should expand the approved list of covered Adaptive Aids to include dentures and implants with prior approval from HHSC and reflect the benefit change in all waiver renewals. More guidance is needed concerning use of implants and dentures to individuals.
3. 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.
4. Allow for the utilization of dental benefits across two service plan years.
5. 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.
6. 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.
7. For any prior authorizations needed for dental services reviewed by HHSC, HHSC will provide a response within three business days of receipt of the treatment plan.
8. 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.

9. 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.
10. 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.
11. HHSC and the Higher Education Coordinating Board shall work to build access to services for this population by working with dental schools across Texas.
12. 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.
13. For those dental Individual Plan of Care (IPC)s requiring Utilization Review (UR), ensure strong and clear communication between the client's Service Planning Team, Direct Services Agency, 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.
14. 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 TMC which provided more guidance for persons with IDD. The brochure will be distributed by HHSC. The IDD SRAC TMC has some additional recommendations for consideration including:

## **Recommendations**

1. 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.
2. Monitor call center hold times for NEMT to assure timely access to Medicaid transportation benefits and assure that MCOs provide reports quarterly to HHSC. HHSC should consider increased hours for access to call centers beyond standard workday hours. 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.
3. Standardize and simplify NEMT applications for Individual Transportation Participants (ITP), who provide mileage-reimbursement transportation services to Medicaid recipients. The applications and requirements for ITPs should be the same across all Medicaid programs and MCOs to reduce barriers for Medicaid recipients who use NEMT mileage reimbursement benefits. Doing so would require TMHP and MCOs to automatically transfer NEMT data for ITP drivers when Medicaid recipients change MCOs or switch to or from an MCO to Traditional Medicaid to avoid delays in access to NEMT mileage reimbursement services for Medicaid recipients. ITP drivers should not be required to complete new ITP applications if they have already been approved as ITP drivers by another MCO or by Traditional Medicaid, to reduce barriers for Medicaid recipients who use NEMT mileage reimbursement benefits.
4. Develop 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 Housing Transition Specialist as a Medicaid Waiver Benefit

## Background

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

- Educate a potential housing applicant on community living options, property availability, and the application process.
- 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.

The IDD SRAC approved adding a benefit for a housing support for persons in the pilot and was part of the enacting legislation. 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 transition specialist available in the pilot:

1. Fund the Housing Transition Specialist benefit to assist persons with IDD to transition to the most integrated, appropriate housing for the person.

2. Fully fund the Housing Transition 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.

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.

## **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.

## **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.

## **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 will be 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 Financial Management Services Agencies (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.

## **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 to account for hours approved in each pay period and the hours actually paid by the FMSA.

## **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 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 physicians 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. Texas may need creative solutions to look at solutions to provider individuals on Medicaid with complex conditions better primary and specialty care.

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 are becoming available for use of telemedicine for not only primary and specialty care, but also for behavioral health and certain LTSS. Below are some solutions to address access.

## **Recommendations**

### **Funding**

- Provide additional funding to expand physician and specialty capacity for persons with intellectual and developmental disabilities.
- Continue funding the current comprehensive care clinics and transition clinics and expand these clinics throughout the state of Texas. Direct HHSC to determine qualification standards for comprehensive and transition clinics. 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 contract with Medicaid MCOs. Funding should be sufficient to provide access to persons with IDD and ensure the expertise to treat complex conditions for persons with multiple conditions.
- 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 diminishes 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.
- 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. Consider funding for broadband access or technology needed to participate in telemedicine and telehealth.

## **LTSS Telehealth Access**

For appropriate tasks, direct support workers should be able to provide care via telehealth 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. Currently this has been added to the STAR+PLUS pilot but should be considered in other programs.
- When determined medically appropriate and when licensure doesn't 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 better data sharing between the MCOs, LIDDAs and Comprehensive Service Providers to provide better integrated care.

## **System Changes**

- Maximize use of medical training programs to increase access to care.
- 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).
- Evaluate best value when contracting with MCOs, not limited to cost of care and cost savings, to incorporate holistic, person-centered care that:
  - ▶ Delivers Person-Centered Service Coordination that connects participants to the care they need,
  - ▶ Ensures participants have timely access to the services they need,
  - ▶ Encourages providers to participate in the Medicaid program,

- ▶ Ensures a sustainable Medicaid program by incentivizing value in the service delivery model and optimizing resources, and
- ▶ Uses data, technology, and reporting to facilitate and demonstrate strong performance and oversight.

## Identify and Develop Acute Health Care Initiatives

### Background

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

According to a November 2017 Policy Data Brief Titled Health and Healthcare Access among Adults with Autism Spectrum Disorder (ASD) and 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.). 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, regarding coordination of benefits, and S.B. 1648 , 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 to changes to be implemented due to recent legislation, 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. To encourage health and wellness that may result in reduction of obesity rates, which are not always due to low physical activity levels, develop and implement easily understandable, targeted health promotion policies and practices that focus on nutrition and healthy lifestyle.
8. Analyze data and, if needed, expand data collection to include access, availability, experience, utilization, and the results of health care activities (outcomes) and patient perception of care including use of NCI health and wellness data for individuals with ASD, ID, and other developmental disabilities in order to identify health care initiatives. Provide separate results for persons with private insurance and those with dual Medicaid/Medicare coverage.
9. Use MCO encounters and other HHSC data regarding hospitalizations, ER visits and other physical and behavioral health related factors that may lead to institutionalization in nursing facilities, ICF/IID, SSLCs, State Hospitals and other long-term care institutions information to identify and address health initiatives to prevent admissions and facilitate returning to the community for individuals with IDD.

- 10.Track and report quarterly to 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.Implement certain innovative practices learned during the COVID-19 PHE that increased timely access to services and are agreed to by the individual. Survey individuals and families to understand the impact of COVID-19 and COVID-19 policies during the PHE.
- 12.Services defined during the pilot program benefit design process should be incorporated into current waivers.
- 13.Consider use of focused telemedicine for urgent care and behavioral health needs for persons with IDD performed by physicians experienced with the population.

## **Monitor Quality on Acute and LTSS Benefits**

### **Background**

At this time, HHSC is not able to review and analyze quality metrics specific to the total population of individuals with IDD in the STAR Health, STAR Kids, and STAR+PLUS programs.

People with IDD, TBI, ABI, and those with similar functional needs are supported through a variety of managed care and non-managed care programs. Without a code, risk group, or other flag identifying an individual as a person with IDD in the managed care and non-managed care data systems, data for individuals with IDD, related conditions, TBI, ABI, and other populations cannot be disaggregated from totals. This concern and related recommendations apply to the STAR+PLUS Pilot Program and to other HHSC programs. At this time, individuals with IDD are unable to be disaggregated from total populations within STAR Health, STAR Kids, and STAR+PLUS acute care services and from STAR+PLUS HCBS LTSS services. Some individuals in STAR+PLUS are not identified as having an IDD condition. HHSC, in collaboration with the MCOs, is only able to pull metrics specific to a single sub-set of individuals with IDD diagnosis. Those who are currently supported through an IDD waiver and who will not be in the pilot program. The other populations of people with IDD conditions supported in managed care, including those not currently supported on an IDD waiver and those currently receiving STAR+PLUS HCBS Waiver services, have no state designed identifier.

## Recommendations

IDD SRAC strongly recommends HHSC and the MCOs work together to create a risk group or an identifier of eligibility in the 834 enrollment file to allow for tracking of access, quality and other metrics separately to each eligible population, including:

- Persons with IDD,
- Persons with related conditions who were not already identified,
- Persons with TBI and ABI, and
- Other persons with similar functional needs.

## Improve the IDD Assessment Process

### Background

S.B. 7, 83<sup>rd</sup> 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. In April 2015, legacy DADS determined it would pilot the InterRAI ID.

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

Recognizing the anticipated timeline for completion of the InterRAI Pilot is 2022, with an indefinite period of time needed after completion of the pilot to develop a resource allocation algorithm if HHSC chooses to implement the InterRAI, the IDD SRAC strongly recommends HHSC work on dual tracks, to improve and modify use of the ICAP at present, while also preparing for the future where the InterRAI may be in place. HHSC announced, during the December 2021 joint meeting of the SP3W and the IDD SRAC, the intent to use the InterRAI ID and Collaborative Action Plans (CAP) in the STAR+PLUS Pilot to determine service needs of pilot participants, those with IDD and those with similar functional needs. HHSC identified that the Related Condition Eligibility Screening Instrument as the screening tool to determine eligibility for the STAR+PLUS Pilot Program in absence of an existing diagnosis or eligibility assessment. The InterRAI ID Assessment tool is to be used to determine strengths



and support needs for the people eligible to participate in the STAR+PLUS pilot program.

## Recommendations

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

1. Implement person-centered, individualized, and comprehensive training and assessments
  - A. 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.
  - B. Allow and encourage using a variety of evidence-based, empirically-valid tools as necessary to accurately identify needs.
  - C. Must coordinate with SP3W and IDD SRAC, once research is completed to determine the necessary and allowable revisions to the InterRAI ID Assessment tool in order to determine each individual's needs and appropriate resources to meet those needs.
  - D. Level of support needed to live inclusively in the community.
  - E. Self-direction (ability to participate in the planning and directing services).
  - F. Preferences, long term goals, and life plan.
2. Expand or enhance assessment tools and resource algorithms that account for high support needs and changes in conditions across the life continuum of the individual, whether physical, medical, behavioral, or psychosocial.
  - A. Ensure high quality services that align resources with assessed needs and preferences (adjust rates that support quality).
  - B. Ensure that assessment goals and related LTSS services can change over time as an individual's initial goals are met or as their needs change.
3. Must ensure that other assessments used in conjunction with the InterRAI ID Assessment are not duplicative and do not create an unnecessary burden on individuals and families.
4. Must commit to reevaluating the adequacy and use of the InterRAI-ID tool at regular intervals with the SP3W and IDD SRAC.
5. Develop and implement flexibility across programs and settings for service planning and resource allocation based on assessed needs, including for, but not

limited to, individuals transitioning to community settings from institutional settings who may need higher levels of support during periods of transition.

6. Ensure continuity and integrity of services for transitions across programs, settings, and changes in needs over time.
7. Acknowledgment of the important role an individual's natural supports can play and a willingness to provide justified family support services, such as additional respite or in-home supports, at the level necessary to support an individual to remain at home or in the community.
8. Ensure individuals receive the amount, type, and duration of services needed without requiring natural supports beyond those voluntarily provided.
9. Increase and improve training for assessment personnel to ensure assessments and staff appropriately address cultural, language, communication, learning differences, and needs of children and adults and their families.
10. 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.
11. Increase and enhance mental health screening to obtain baseline information and identify needs including trauma informed care strategies.
12. During any system redesign that implements new or modified assessments, ensure people obtain and maintain their necessary services with no significant reductions according to assessed needs both new and continuing as needs and goals change over time.
13. Maintain continuity and level of care when an individual moves across service or geographic areas.
14. Coordinate with and include joint recommendations from the pilot program workgroup for assessment recommendations to be utilized in the pilot.
15. 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.
16. HHSC must develop resource allocation to be used with the InterRAI that:
  - A. Establishes criteria for who may administer the InterRAI.
  - B. Provides standardized training for accurate and consistent completion administration of the InterRAI.
  - C. Focuses on meeting the actual, individualized needs of the person(s) participating in the pilot without the use of tiers, caps of or levels of need to determine authorization of services.

- D. Determines the frequency and indications for interval assessment, if any, with which all assessment tools and service planning forms will be utilized.
- E. Requires an evaluation of the accuracy and reliability of the InterRAI Intellectual Disability Assessment and submit a written report to the IDD SRAC and SP3W.
- F. Requires stakeholder input from the SP3W, the IDD SRAC, and representatives across all LTSS community programs prior to the continuation of the InterRAI ID in the pilot or expansion to other HHSC programs.
- G. Although an algorithm is not expected prior to implementation of the STAR+PLUS Pilot, HHSC must ensure any algorithm developed for the InterRAI ID accurately assesses the support needs of the intended population prior to its use in other programs.

## **Pilot Program Evaluation**

### **Background**

The STAR+PLUS pilot program 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, Direct Service Agencies (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**

### **Recommendations**

**Adopted by the STAR+PLUS Pilot Program Workgroup and IDD SRAC  
November 18, 2021**

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).

HHSC has informed the Quality Subcommittee and the STAR+PLUS Pilot Program Workgroup that an external contractor, Institute for Child Health Policy (ICHP), has been engaged to implement this requirement of the statute.

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 ICHP and the use of NCI IDD-In-Person and Adult Family surveys, which the Subcommittee visualizes as a supplement to the requirements charged to ICHP. (The subcommittee understands that upon further discussions, including those with ICHP, 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.
- Ensuring 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 the STAR+PLUS Pilot Program Workgroup and IDD SRAC on February 24, 2022**

The Alternative Payment Methodologies recommendation(s) are limited by the structure of the Alternative Payment Methodology (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:

- Ensure that any incentive payment is in addition to the base rate for services be standardized and simple to administrate.
- Provide flexibility for the MCO and the Contractor develop Enhanced Incentive Payments in addition to the provision of Base Incentive payments.
- Focus on quality outcomes for those participating in the pilot and include Administrative measures as well as Outcomes measures.
- Include measures, outcomes and metrics collected and measured consistently.
- Ensure the system does not have a financial downside to the participating provider.
- Addresses the goals of the pilot, including incentivizing services in the most integrated setting.
- Capture utilization of services for future consideration for a bundled payment model.
- Incentivizes capturing data for the provision of LTSS, Medical, including Durable Medical Equipment, Behavioral Health, and other services outlined in the person-centered plan.
- Provide the Comprehensive Service Provider (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.
- 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.
- 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.
- Ensure Measures and Metrics are consistent with the External Quality Review Organization Evaluation Plan.



- Preserves the right to develop and review specific measures and metrics utilized in the pilot.

## **Data Collection and Utilization**

Require and fund the use of electronic documentation by long-term care service providers and improve communications with MCOs, participants and providers:

- Develop the capability to electronically maintain health and life records for all individuals served in LTSS programs that are interoperable with related systems.
- Provide life records to participants, MCOs, and all parties involved and be on a shared platform.
- 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.
- Implement additional communications options for LTSS program participants and providers such as texts, phone, telecommunications, and other evolving means of engaging and expanding contacts, consistent with S.B. 1911, 87th Legislature, 2021.

## **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, Texas Education Agency (TEA), TWC, comprehensive providers and persons with IDD, and families.
2. Explore options for leadership roles to develop and operationalize regional partnerships including persons with lived experience.
3. Initiate regional partnerships prior to the STAR+PLUS Pilot Program to best support the goals of the pilot. Target implementation in the region selected for the pilot.
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. Pursue public-private partnerships to develop cross-system collaborations and innovative funding options to offer people with disabilities meaningful access to the same opportunities as their peers without disabilities.
6. Increase use of the regional education service centers' statewide networks to develop and provide innovative leadership development, training, and support for education for both professionals and families.
7. Increase regional and statewide resources and personnel to develop and implement inclusive competitive and integrated employment programs for students.

## **Day Habilitation and Employment Services Subcommittee**

### **Identify Employment and/or Meaningful Day Goals**

#### **Background**

There is currently no standardization in person-centered service planning across programs. Employment and meaningful day activity goals are not consistently addressed in assessment tools across programs. In addition, the external assessment conducted by HHSC in compliance with the federal HCBS regulation indicated that exploring and obtaining employment is an interest of a significant number of individuals receiving HCS services and employment goals should be addressed to implement S.B. 1226, 83<sup>rd</sup> Legislature, 2013.

## Recommendations

1. Require a person-centered plan for all individuals that addresses competitive, integrated employment and other meaningful day activity goals.
  - A. Include self-advocates in the discovery process by the development of a Peer Support Model benefit to assist individuals in identifying their meaningful day.
    - a. 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.
  - C. The service planning discovery tool currently in development should include a specific module on employment.
2. HHSC will be required to provide training in the principles of EF, waiver employment program services, steps to become an Employment Services Provider (ESP) 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, day habilitation providers and DSAs.
  - A. Improve electronic communication channels between TWC and LTSS providers and MCOs.
  - B. Require HHSC staff and LTSS providers to be trained in the implementation of what is required from TWC-VRS to obtain employment services to ensure it is never a barrier to pursuing employment goals.
  - C. Provide training that is affordable, accessible and available across Texas for all IDD LTSS providers and day habilitation providers to become successful ESPs (as the ESPs in TWC) in order to have a "pool" of providers for EA and SE services and to easily transition employment services from TWC to the waiver services.
  - D. Require TWC staff to notify HHSC staff when there is an ESP contract open enrollment period. HHSC will inform TWC who their contact person is. HHSC staff then will distribute this information to all LTSS providers and encourage them to enroll as ESPs.

- E. Encourage HHSC staff and LTSS providers to register to receive notifications on TWC website to be informed of information related to vocational rehab.
  - F. Allow the open enrollment period for ESPs contracts to be available year-round.
  - G. Examine the current state contracts for training providers of EA and SE to reduce the overall time required for them to qualify as a credentialed provider.
3. Include TWC 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.
  4. Promote awareness of employment supports through all means: case management, service coordination, PCP, assessments, reviews, etc.
  5. Explore HHSC regulatory staff reviewing for compliance to Department of Labor standards for all sheltered based employment services paying less than minimum wages.
  6. Explore additional strategies to increase competitive integrated employment as per the Texas EF policy.
  7. Increase additional strategies that lead to skill development to increase competitive employment.

## **Increase Utilization of Employment Services**

### **Background**

Despite the passage of S.B. 1226 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 LTSS providers to contract with a network of EA and SE providers who meet quality standards to provide SE and EA services in order to meet the

needs of the participants, including ESPs. The recommended Quality Standards include:

- A. The ESP must have a discovery process in place that supports the individual to identify their employment capacities, abilities, and preferences. EA services used for discovery must reflect one-on-one interaction, business exploration and job training. EA services are expected to lead to competitive, integrated employment and to transition to SE Services.
  - B. For all individuals receiving EA services, individual employment plans must be reviewed by the service planning team every six months to discuss and remove any barriers to competitive, integrated employment.
  - C. The 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 matches the individual to a job that reflects their employment capacities, abilities, and preferences to a full or part-time job in the community paying minimum wage or better.
2. Develop and facilitate regularly scheduled regional and/or local collaboration on employment issues, including state agencies that provide employment services (MCOs, 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 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).
  3. Require contractors and subcontractors to comply with EF policies by ensuring the primary goal is competitive integrated employment as outlined in the Government Code, 531.02447.
  4. Expand the definition of EA services to include providing a person-centered, comprehensive employment plan with support services needed. This could be similar to the Employment Plan used by TWC. This service would 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 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.
6. Add SSA benefits counseling as a service in all LTSS waivers to promote competitive, integrated employment by not only increasing awareness of work incentives and providing accurate information, but by also assisting with, applying for and implementing work incentives that allow individuals who work to continue their Medicaid eligibility. The SSA benefits counseling will be provided by certified social security benefits counselors or those who are Work Incentive Practitioner-Credentialed. This will ensure participants understand that their Medicaid waiver pilot benefits will be preserved after obtaining employment.
  - A. Increase the number of certified social security benefits counselors by providing the necessary training in SS benefits. Currently there are less than 30 state certified benefits counselors in Texas.
7. 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.
8. 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.
9. Establish a transportation benefit to allow flexibility to include the use of taxis, bus passes, and ride shares and allow this to be billable through EA and SE services when it is employment related transportation.

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

### **Background**

Currently, individuals with IDD receiving day habilitation services do not have full access to the greater community through their HCBS services. Service delivery design and reimbursement rates are barriers to individualized, integrated community

participation, making person-centered plans and implementation plans hard to fully implement.

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

## **Recommendations**

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

## **HCBS Settings Rules Background**

### **Background**

HCBS Settings Rule: Residential Remediation Plan for Texas HCBS STP

Effective March 17, 2014, CMS issued a rule under which states must provide home and community-based LTSS in a manner that meets new requirements by March 17, 2023. The rule requires states to ensure that all settings in which HCBS is provided comply with the federal requirements that individuals are integrated in and have full access to their communities, including engagement in community life, integrated work environments, and control of personal resources.

The rule also includes a number of requirements for increasing self-determination and person-centeredness in the planning for and delivery of HCBS. Each state that has HCBS is required to file a STP with CMS. The Texas STP includes timeframes and milestones for state actions, including assessment of the state's current compliance and, at a high level, planned steps for remediation.

Settings that are considered by CMS to presumably have the qualities of an institution have the effect of isolating individuals. If a state considers a setting presumed institutional to be integrated in the community the State should, per CMS strong encouragement, make an in-person site visit to observe the individuals' life experience and to ensure that the setting supports the inclusion of individuals in the general community. The expectation for HCBS-funded services is that people in the setting participate in community activities beyond those that involve only people with disabilities. Requests for review of a setting presumed institutional, known as "heightened scrutiny," must be submitted to CMS for additional review and approval through their heightened scrutiny process.

Assessment results indicated that individuals receiving HCBS need more resources in order to maximize their participation in the community and comply with CMS requirements. To achieve this HHSC created a new service focused on community participation: Individualized Skills and Socialization. Though the new service initially included a new fee to support community participation and new options for non-medical transportation, the funds appropriated by the 87th Legislature and subsequent plan HHSC has proposed now excludes these benefits. Moreover, there is concern that the funds appropriated will not be sufficient to successfully implement this new service.

For purposes of this proposal, references to residential provider include HCS three- and four-person homes; HCS host home/companion care; and DBMD assisted living facilities and one- to three-person homes.

In addition to new or significantly modified service definitions, assessment results indicate a need to clarify expectations of how existing services are delivered. Some providers have already incorporated these items into regular practice; for others, the modified services may necessitate a change. These include:



- Residential Staff Scheduling;
- Person-centered Service Delivery;
- Choice of Staff;
- Privacy;
- Standardized Residential Lease and individual renter's rights;
- Choice of Home;
- Employment; and
- Subsidized Residential Lease.

## Recommendations

1. 1. To ensure successful implementation of the HCBS Settings requirements:
  - A. Fund all aspects of assessment, remediation, onsite heightened scrutiny and ongoing monitoring needed to become fully compliant with the HCBS rule. This includes funding to ensure successful implementation by providers.
  - B. Examine the adequacy of the current proposed rates for the new Individualized Skills and Socialization service.
  - C. Ensure full funding is allocated for providers of Individualized Skills and Socialization including:
    - a. Cost of transportation under the new Individualized Skills and Socialization service.
    - b. Immediate add-on support to address higher costs to recruit and retain direct care workers, higher costs of products and services and to off-set cost of inflation.

NOTE: See also related recommendations of the Day Habilitation/Employment Services Subcommittee. See also recommendations from SA on workforce shortage issues.
2. To ensure services for persons with IDD do not trigger or re-traumatize individuals, revise the name of Individualized Skills and Socialization (ISS) to Meaningful Day and Individualized Supports. In school settings, children with disabilities experience higher instances of discipline, including in-school suspension often called ISS.

# 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

### Background: Initial Access to IDD Medicaid Waivers

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 March 31, 2022, the IDD Medicaid-waiver interest list included the following number of persons on the list: 78,265 for CLASS; 1,239 for DBMD; 108,838 for HCS; 96,895 for TxHmL; 19,723 for STAR+PLUS Waiver; and 7,651 for Medically Dependent Children Program (MDCP)<sup>23</sup>. In comparison, as of March 31, 2022, the following number of persons were enrolled in these waiver programs: 6,021 in CLASS; 313 in DBMD; 29,665 in HCS; 3,965 in TxHmL; 62,738 in STAR+PLUS HCBS; and 5,689 in MDCP.

The Texas Legislature funds IDD waivers to support children and adults by diverting funds from admissions to facilities, or transitioning from facilities, as part of its commitment to the Olmstead decision, the Texas Promoting Independence Plan and permanency planning for children. In 2021, the 87th Legislature funded new waivers slots for 1,549 persons on the interest lists to enroll during the 2022-2023 biennium. However, the 86th and 87th Legislatures did not appropriate funds for Promoting Independence waiver slots, which are slots to prevent unnecessary institutionalization. With no Promoting Independence slots during the 2021-2021 and 2022-2023 biennium, 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.

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<sup>23</sup> <https://www.hhs.texas.gov/sites/default/files/documents/house-hhs-committee-1115-waiver-may-5-2022.pdf>

The tables below outline the Texas Legislature funding for waiver services: HCS and other waiver appropriations for fiscal year 2014 through fiscal year 2023, the attrition for HCS waiver slot utilization for the 2020-2021 biennium, and interest list counts by years on the list.

**Table 1. HCS Targeted Group Appropriated Slots by Biennium**

<b>HCS Targeted Group</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>Crisis Diversion</b> <sup>24</sup>	To prevent institutionalization/crisis	300	400	0	0	0
<b>Nursing Facility Diversion</b> <sup>25</sup>	For persons with IDD diverted from nursing facility admission	150	600	150	0	0
<b>Nursing Facility Transition</b>	For persons with IDD moving from nursing facilities	360	700	150	0	0
<b>Child Protective Services Aging Out</b>	For children aging out of foster care	192	216	110	0	0
<b>Nursing Facility Transition for Children</b> <sup>26</sup>	For children moving from nursing facilities	0	20	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
<b>DFPS General Residential Operation (GROs)</b>	For children moving out of a DFPS GRO	25	25	0	0	0
<b>State Hospital (MDU)</b>	For persons moving out of state hospitals	0	120	0	0	0
<b>HCS Interest List Reduction</b>	Statewide interest list reduction	1,324	2,134	0	1,320	542
<b>TxHmL Interest List Reduction</b>	Statewide interest list reduction	3,000 <sup>27</sup>	0	0	0	471
<b>Total</b>		<b>5,451</b>	<b>4,295</b>	<b>735</b>	<b>1,320</b>	<b>1,013</b>

<sup>24</sup> Crisis Diversion was known as SSLC Diversion in FY14-15 and FY16-17.

<sup>25</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>26</sup> None specified in appropriations, but HHSC historically provides about 20 slots per biennium to help transition children from nursing facilities

<sup>27</sup> FY14-15 HHSC (Prior to Transformation DADS) used resource allocation to designate 125 slots for the purpose of diverting admission to nursing facilities via the TxHmL waiver

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

<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>CLASS Interest List Reduction</b>	Statewide interest list reduction	712	752	0	240	381
<b>DBMD Interest List Reduction</b>	Statewide interest list reduction	100	50	0	8	6
<b>MDCP Interest List Reduction</b>	Statewide interest list reduction	120	104	0	60	42
<b>STAR+PLUS HCBS Interest List Reduction</b>	Statewide interest list reduction	490	0	0	0	107
<b>Total</b>		<b>1,422</b>	<b>906</b>	<b>0</b>	<b>308</b>	<b>536</b>

**Table 3. HCS Attrition Slot Utilization for the 2020-2021 Biennium<sup>28</sup>**

<b>Attrition Target Group</b>	<b>Purpose</b>	<b>2020-21 Appropriated Slots</b>	<b>FY 2020-21 Total Released<sup>29</sup></b>	<b>FY 2020-21 Total Enrollment</b>	<b>FY 2020-21 Total Pending Enrollment</b>
<b>Crisis Diversion</b>	To prevent institutionalization/crisis	0	770	650	39
<b>Nursing Facility Diversion</b>	For persons with IDD diverted from nursing facility admission	0	265	214	11
<b>Nursing Facility Transition</b>	For persons with IDD moving from nursing facilities	0	346	151	39
<b>Child Protective Services Aging Out</b>	For children aging out of foster care	0	190	167	6
<b>Nursing Facility Transition for Children</b>	For children (age 21 or younger) moving from nursing facilities	0	13	10	3
<b>Large or Medium ICFs-IID</b>	For persons moving out of an ICF-IID, including SSLC	0	125	105	5
<b>Total</b>		<b>0</b>	<b>1709</b>	<b>1297</b>	<b>103</b>

<sup>28</sup> Table 3 data is for September 1, 2019, through January 31, 2022, tracked in HHSC monthly slot reports. HHSC continues to track issued slots across fiscal years.

<sup>29</sup> Attrition slots require input from HHSC Budget to determine if resources are available and to what capacity for the specified point in time.

**Table 4. March 2022 Interest List Counts, by Years on List<sup>30</sup>**

Years On List	CLASS Count	CLASS %	DBMD Count	DBMD %	HCS Count	HCS %	MDCP Count	MDCP %	STAR+ Count	STAR+ %	TxHmL Count	TxHmL %
0-1	5130	6.6%	258	20.8%	5465	5.0%	2321	30.3%	19261	97.7%	5388	5.6%
-2	3817	4.9%	270	21.8%	6138	5.6%	1884	24.6%	438	2.2%	6128	6.3%
2-3	6022	7.7%	274	22.1%	8304	7.6%	3349	43.8%	6	0.0%	8407	8.7%
3-4	5879	7.5%	174	14.0%	8281	7.6%	96	1.3%	10	0.1%	8385	8.7%
4-5	6230	8.0%	130	10.5%	8377	7.7%	1	0.0%	-	-	8535	8.8%
5-6	5859	7.5%	133	10.7%	8647	7.9%	-	-	8	0.0%	8801	9.1%
6-7	5375	6.9%	-	-	7963	7.3%	-	-	-	-	7942	8.2%
7-8	4576	5.8%	-	-	6844	6.3%	-	-	-	-	6675	6.9%
8-9	4804	6.1%	-	-	6695	6.2%	-	-	-	-	6821	7.0%
9-10	4917	6.3%	-	-	7648	7.0%	-	-	-	-	7713	8.0%
10-11	5777	7.4%	-	-	7518	6.9%	-	-	-	-	7437	7.7%
11-12	6809	8.7%	-	-	7842	7.2%	-	-	-	-	7635	7.9%
12-13	6156	7.9%	-	-	7410	6.8%	-	-	-	-	7026	7.3%
13-14	5523	7.1%	-	-	5779	5.3%	-	-	-	-	2	0.0%
14-15	1388	1.8%	-	-	4775	4.4%	-	-	-	-	-	-
15-16	3	0.0%	-	-	1142	1.0%	-	-	-	-	-	-
16-17	-	-	-	-	9	0.0%	-	-	-	-	-	-
17-18	-	-	-	-	1	0.0%	-	-	-	-	-	-
Totals	78265	100%	1239	100%	108838	100%	7651	100%	19723	100%	96895	100%

<sup>30</sup> Senate Bill 1, 87<sup>th</sup> 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>

## Recommendations for Initial Access to IDD Waivers

1. Fully fund interest list reduction to serve all individuals currently on the interest lists no later than August 31, 2033. At a minimum, fully fund 10 percent interest list reduction per year. Additionally, future funding considerations should ensure no individual is on an interest list for more than 10 years and should take into account population growth and increased needs. To better address reasonable promptness, the committee recommends:
  - A. Accessing funds through all available federal initiatives, to include MFP 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 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 and have access to needed services.
4. Provide outreach and training on how to access 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.
5. 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 LTSS services are carved into managed care over the next decade, ensure access for recipients with SSI who qualify for IDD waiver through a no-interest list policy.
6. Implement the strategies recommended by the IDD SRAC as outlined in the Medicaid Waiver Programs Interest List Study, Appendix C (Rider 42) to reform the state system for interest list management. Prioritize funding to address gaps



in real time information about the needs of individuals currently on waiver interest lists to better understand and manage timely access to 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.

7. 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.
8. Implement sub-strategies and potential actions, included in the Texas Statewide Intellectual and Developmental Disabilities Strategic Plan, for expanding "Individual Services to Support Diversion, Transition, and Interest List Enrollments."<sup>31</sup>
9. 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.
10. 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.
11. Explore ways to streamline and simplify the diversion processes for accessing waivers. Consider flexibilities for expediting the Determination of ID.

## Improving Access through System Reform

### Background

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

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<sup>31</sup> <https://www.hhs.texas.gov/sites/default/files/documents/statewide-idd-strategic-plan-jan-13-2022.pdf>, p.A-4.

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.

## **Recommendations for Improving Access through System Reform**

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:

1. Provide comprehensive data at least quarterly to the IDD SRAC and the public regarding the requests for waivers, and enrollments by slot type, and the interest lists by waiver type. In addition, provide data on institutional census, admission and discharge of persons with IDD including SSLCs, ICFs, General Residential Operations (GROs) and Nursing Facilities (NFs). Data should include the numbers of persons active and inactive by waiver type on the interest lists, and the numbers of persons inactivated by quarter.
2. Improve interest list data and tracking across programs, including STAR+PLUS, serving persons with IDD, including the number of persons on the interest list who are receiving institutional services by institutional type and waiver interest list.
3. Provide choice of the most appropriate waiver when a person in a SSLC or other institutional setting, is transitioning to the community and would qualify for the DBMD or HCS waiver.
4. In conjunction and coordination with Regional Collaboratives, implement a well-coordinated transition and referral process when persons experience a transition in care. The transition processes should identify problems and explore options through local, state and Medicaid resources. Transitions in care may include changes in caregivers, MCOs, provider agencies, or care settings.
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 procedures are operationalized for obtaining authorization for IDD Medicaid waiver services and other non-waiver services under the Medicaid medical assistance program, including procedures for appealing denials of service that take into account physical, intellectual, behavioral and sensory barriers and providing feedback on development of the new Independent Review Organization, including outreach and education.
8. 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.
9. Ensure compliance with policies that require that a child or youth receiving Medicaid services has access to the most appropriate, comprehensive waiver service as adults, based on that person's needs and preferences when the person ages out of and loses eligibility for Medicaid State Plan or Medicaid waiver services for children. In addition, processes should ensure that families have access to education and resource information to successfully support their family member transitioning to adult services.
10. Ensure children receive access to adult benefits for which they may be eligible, including SSI, Medicaid, and other benefits before aging out of services. Assist families to access adult benefits in a timely manner.
11. Establish the family support necessary to maintain a person's living arrangement with a family for children and, if desired, for adults with IDD.
12. 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.
13. 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.
14. 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*<sup>32</sup> (First Edition Updated: 2/10/2009), 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.

15. 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.
16. 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.
17. Monitor the implementation and impact of managed care, new policies, and initiatives required by the 87th Texas Legislature.
18. Identify state agency staff to assist persons to understand, maintain, and manage their Medicaid benefits. Implement improvements to ensure a streamlined process for Medicaid eligibility for IDD Waiver applicants.

# **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, 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 move forward with 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 is still pending approval by CMS. Meanwhile, it is hard to find nurses and attendants due to rates, billing restrictions and very limited use of nurse delegation.

IDD SRAC recommendations for the SP3 include 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 the SP3. Access must include employment services and/or meaningful day supports.

Currently, HHSC is undergoing a study as required in Rider 38. Rider 38 requires 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 must define 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 must also identify the number of individuals with IDD enrolled in the program who have the highest behavioral and medical needs. A report<sup>33</sup> on the

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<sup>33</sup> <https://www.hhs.texas.gov/sites/default/files/documents/study-hcs-waiver-program.pdf>

results of the study is due to the Legislature on September 1, 2022. HHSC is receiving input on the methodology and scope of the study from SRAC and other stakeholders. HHSC reports that the goal is to provide continuity of care and prevent institutionalization. IDD SRAC stakeholders made recommendations in their discussions with HHSC, to include a request that HHSC improve its data systems to 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 need, and 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 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 is planning to pilot a new assessment tool to use with the STAR+PLUS Pilot Program, the pilot will not be in place until September 1, 2023, at the earliest. The InterRAI is 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. Assess and address the whole person. Fully assess need, including medical and behavioral, at enrollment and identify an appropriate Level of Need (LON), not dependent on temporary “bumps” for medical and behavioral supports.
2. For new HCS waiver enrollments, HHSC should collaborate with LIDDAs, providers, and MCOs to establish the initial LON for the first 12 months.

3. For enrollments and changes in condition, HHSC must promptly consider all medical and psychiatric history and hospitalization to establish an accurate LON.
4. 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 afforded to providers only.
5. 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.
6. 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.
7. Add higher level of services with higher total cost allowance for persons with the most complex needs in Medicaid, including in managed care and the SP3. The increased level should include enhanced rates for Direct Service Workers.
8. Develop a high medical LON (similar to LON 9 for behavior supports in in CLASS, DBMD, HCS, and TxHmL).
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.

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

1. Ensure adequate resources, to include technical assistance, for providers to meet complex needs. 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. Train LIDDAs and providers to improve documentation for justification for services through all service coordination entities.
5. 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.
6. 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.
7. Improve and streamline the SSLC transition process and create successful and timely continuity of necessary supports and services.
8. Implement a medically fragile policy within the STAR+PLUS HCBS program to eliminate the cost cap when justified without further delay in fiscal year 2022.

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

1. Ensure enhanced rates in IDD waiver programs to address provider capacity to meet needs of individuals with complex needs.
2. 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.



3. Streamline access to GR and other additional funds for those who exceed the cost cap for Medicaid waivers, including in managed care and the SP3. Modify eligibility for GR funds to remove the institutional bias and use language consistent with maintaining services in the most integrated setting.
4. At a minimum, increase the cost cap in DBMD and CLASS consistent with the average costs in small ICFs.
5. Enhance capacity of crisis respite and long-term stabilization as a measure to prevent hospitalization and/or institutionalization across all waiver programs and in non-waiver services for all persons with IDD.
6. Ensure access to protective supervision /personal assistance services across all waiver programs. Reinstate access to protective supervision in the HCS waiver.
7. Create high needs services, such as enhanced behavioral and medical supports and enhanced case management, that support advanced direct service professional training, supervision and compensation when supporting persons with high medical, behavioral, physical, or psychiatric needs.
8. 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 Day Habilitation 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 day habilitation services. However, in CFC, the rate is the same regardless of the person's LON. A flat rate that does not recognize individual needs limits the individual/ family's options to obtain services that best meet their needs. Ensure rate enhancement is included for CFC services provided through all waivers and non-waiver CFC services and all service models (CDS and Agency options).
9. 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.

10. Providing 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.
11. 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. Evaluation and assessment 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; and
  - 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.

## **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 also, demonstrate that payment is both justified and

sufficient to meet medical or behavior acuity (high needs) of individuals and prevent institutionalization. Enforcement actions should 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. Ensuring that provider payments are justified, sufficient 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.
2. Implementing 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. Providing funds to expand programs and create new comprehensive IDD waiver benefits, concurrent with testing new benefits in the SP3.
4. Funding overnight supports and/or protective supervision across all HCBS waivers.
5. Implementing 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 CLASS and DBMD waivers.
6. Implementing a program for medically fragile individuals in the 1115 STAR+PLUS program.
7. Updating the 2020-21 General Appropriations Act H.B. 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC), Rider 25, Waiver Program Cost Limits, to include consideration of services "in the most integrated setting appropriate for the individual." NOTE: The current assessment to allow an individual to exceed their Medicaid Waiver individual cost limit is solely based on health and safety needs.
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;
  - B. Higher rates for direct support staff serving individuals with complex behavior needs;

- C. Enhanced payments for high medical needs across IDD programs for the most medically involved individuals at risk of institutionalization or hospitalization;
- D. Training of IDD providers;
- E. Training and on-site consultation from highly trained clinical staff;
- F. Training and consultation for behavioral health systems in the specialized needs of the IDD population; and
- G. 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 while the term attendant is typically used in all other programs. While these terms may be used interchangeably, HHSC staff currently do not.

Though this chronic staffing shortage existed long before the pandemic (see Note below) the 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. NOTE: See [\*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. It 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.]

While efforts over the years to address this problem 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.”

[[\*Community Attendant Workforce Development Strategic Plan, November 2020\*](#) – Rider 157, 86th Legislature]. Funds to increase wage rates in Medicaid programs which have the lowest wage rates have been minimal.

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.

Though the COVID-19 PHE exacerbated the workforce crisis, now that the PHE is waning, providers, families, and individuals who rely on this critical service (some, if not many, 24 hours a day) continue experiencing great difficulty with recruiting and retaining a stable workforce. This is due to the conservative Medicaid service rates which significantly limit the ability of providers 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.

Providers of IDD services must also compete with the higher wages and robust benefits paid to direct care workers in the SSLCs, and the sign-on bonuses SSLCs are offering. According to HHSC's website and advertisements across the state, DSWs may qualify for \$2,500 hiring bonuses.

NOTE: Other reports detailing the crisis in Texas and across the nation are:

[The Case for Inclusion 2022 - Blazing Trails to Sustainability for Community Disability Services \(prepared by United Cerebral Palsy and ANCOR Foundation\);](#)

[University of Minnesota, Institute on Community Integration – Policy Research Briefs on Direct Care Worker and Attendant Wages;](#)

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

## **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 program. 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 services, the health and safety of individuals will be at risk and providers will be at risk for adverse enforcement actions. The issue is further exacerbated for Medicaid providers who operate in cities in which there is a SSLC. In addition to the sign-on bonuses SSLCs are offering to attract direct care workers, they are also offering sign-on bonuses nurses: new registered nurses can qualify for \$5,000 bonuses,

eligible LVN new hires can receive \$3,500 and, in a State Hospital, PNAs may qualify for \$2,500 hiring bonuses.

## **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), those funds are no longer effective in recruiting and retaining DCWs.

Though one-time funds to offer recruitment and retention payments to direct care workers, attendants and nurses are being made available through the ARPA of 2021, the funds will not be sufficient to stabilize the crisis on a long-term basis. In addition, for persons using the CDS option, ARPA funds must be disbursed through the FMSA, not the employer of record, for management of administrative functions and accounting purposes.

## **Recommendations**

While some hypothesize that the market will correct itself at the end of the PHE, 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 and ensure persons receive the services and supports they need and at the levels they need, meaningful funding strategies to address the workforce crisis across all Medicaid-funded programs and services must be developed and pursued. Though not inclusive, following are recommended actions and strategies:

1. Make funding to address the workforce crisis the top priority in HHSC's fiscal year 2024-2025 Legislative Appropriations Request.
2. Request funds to increase the median or average wage rate of attendants and direct care workers to at least \$15/hour across all Medicaid programs using direct care workers/attendants.

3. 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.
4. Set 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 hospitals.
5. Prior to the Texas 88th 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.
6. 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.
7. 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.

## **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 Habilitation (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 persons with IDD. More emphasis should be given to provide education to attendants doing the day- to-day work with members, so they are successful in helping members learn skills.
5. An inconsistent assessment process for all populations, and a lack of an assessment process for all life areas.

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

## **Recommendations**

1. Increase awareness of CFC through a concerted, statewide outreach effort.
  - 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 transportation and respite services.
3. 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.

4. 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.
5. Establish a clear and streamlined funding mechanism and payment rate for the LIDDAs to perform eligibility determinations and CFC functional assessments for persons with IDD. This includes funding mechanisms and rates for CFC eligibility and/or assessments for persons with IDD who receive CFC in non-waiver programs such as STAR+PLUS, STAR Kids and STAR Health.
6. 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.
7. Allow flexibility within the CFC benefit, utilization policies, and PCP such as:
  - A. Allowing two or more persons to receive CFC services from the same direct service worker at the same time;
  - B. Allowing 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. Allowing persons to more easily change service delivery models between agency option and CDS option; and
  - D. Allowing families to use paid support to prevent being overburdened by their family member's care needs.
8. 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.

9. Require HHSC to recognize that a person remains eligible when eligibility was determined by a Determination of Intellectual Disability (DID) assessment completed after age 18. The requirement for a DID update should only apply to a person whose eligibility was determined by a DID completed prior to the 18th birthday, or if there are significant changes in the person's functioning.
10. Request HHSC to improve, revise and further develop the CFC assessment tool and processes in consultation and coordination with the IDD SRAC. In addition, consider revisions to the instructions and directions to assessors, to include training requirements for assessors on the use of the tool and technical assistance on the development of justification for identified services.

## **Impact of COVID-19**

### **Background**

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

- Directs HHSC to ensure individuals, who receive services through Medicaid, CHIP, and other public benefits programs, have the option to receive certain services using telecommunications or information technology, to the extent permitted by federal law if determined cost-effective and clinically effective by HHSC. This provision applies to all services delivery models, inclusive of the managed care delivery model. Covered services include the following: preventative health and wellness services, case management services, including targeted case management; behavioral health services, occupational, physical, and speech therapy services; nutritional counseling services; and assessment services, including nursing services under certain Section 1915(c) waiver programs (HCS, TxHmL, CLASS, and DBMD).
- Allows Medicaid MCOs to reimburse for home telemonitoring services as defined in Government Code Section 531.02164.

- Requires HHSC to implement a system that ensures behavioral health services may be provided using an audio-only platform in Medicaid, CHIP, and other public benefits programs administered by HHSC or another health and human services agency and allow HHSC to authorize the provision of other services using an audio-only platform.

During the PHE, HHSC, 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 to Gain Efficiencies in the Medicaid and CHIP Programs**

1. Allow qualified individuals living in the same household as a person receiving waiver services to be providers of CFC services. NOTE: Currently, this is not allowed in TxHmL and HCS programs. This change would keep individuals safe by limiting the number of people coming into the home as well as assist with the recruitment and retention of direct service providers. Qualified individuals are age 18 or older, meet all required screening requirements, and provide CFC services to adult persons with IDD. Parents of minor children and spouses are not eligible providers.
2. Allow for individuals in different waivers to share attendants when deemed appropriate in accordance with the person-centered plan and ensure flexibility in rates when an attendant is supporting more than one person.
3. Add PPE, 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.
4. 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.
5. Allow health plans to develop and provide services that address social determinants of health experienced by Medicaid eligible persons. During this

crisis, health plans have been asked to support food, housing, and other social determinants of health services.

6. 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.
7. Explore opportunities for their DSWs/ attendants to work remotely, virtually or off-site to the extent allowed by federal regulations. 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.

## **Recommendations to Guide Future 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 an emergency or disaster, allow CDS employers of record to be the providers of CFC services, unless the individual is their own CDS employer of record. Currently, this is not allowed in the CDS option. This change would keep individuals safe by limiting the number of people coming into the home as well as assist with the recruitment and retention of direct service providers. NOTE: CDS employers of record are age 18 or older, meet all required screening requirements, and provide CFC services to adult persons with IDD. Parents of minor children and spouses are not eligible to be CDS employers of record.
3. Allow flexibilities for the new employee training requirements for family members of the individuals receiving services during an emergency or disaster. These would be the same flexibilities in place for all programs in regard to the crisis. Flexibilities may include allowance for a 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 the PHE by the period of time necessary to ensure uninterrupted waiver services and Medicaid eligibility. Apply these actions during the PHE while HHSC is processing the backlog of cases, and at the conclusion of a PHE. 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 during and beyond the COVID-19 PHE. HHSC should allow for modifications to CPR training and certification requirements in all Medicaid waivers to allow for easier onboarding of new employees and easier recertification of existing employees during a public health emergency.
7. Disallow the reduction in waiver eligibilities, services or budgets if persons are temporarily under-utilizing the services in their plans due to emergencies or pandemics.
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 during local, regional, or statewide disasters.
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.

# **Appendix B: Historical IDD System Redesign Implementation Activities**

## **STAR+PLUS Transition**

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

In fiscal year 2021, an average of 534,514 individuals were enrolled in STAR+PLUS each month. Of that total, approximately 18,204 individuals were also enrolled in an IDD waiver or ICF/IID each month.

## **Eligibility**

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

- Participate in the CLASS, HCS, TxHmL, or DBMD waiver programs; or
- Are in a community-based ICF/IID and not a SSLC; and
- Do not receive Medicare Part B, in addition to Medicaid benefits. Individuals who receive Medicare Part B 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 Transition**

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



package of acute health care benefits, along with LTSS (for those who are not receiving LTSS through an IDD waiver program). In alignment with the requirements in Texas Government Code, Section 534.051, STAR Kids provides person-centered service coordination for children with disabilities and their families to support their needs related to health and independent living.<sup>34</sup>

In fiscal year 2021, an average of 169,057 eligible children and young adults were enrolled in STAR Kids each month. Of that total, an average of 5,215 eligible children and young adults were enrolled in an IDD waiver or community-based ICF/IID each month.

## Eligibility

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

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

## Services

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

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<sup>34</sup> <https://hhs.texas.gov/services/health/medicaid-chip/programs/star-kids>

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

## **STAR Health**

STAR Health is the Medicaid managed care program for children and young adults in DFPS conservatorship and children and young adults who are transitioning out of conservatorship.<sup>35</sup> 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 2021, an average of 43,469 children and young adults were enrolled in STAR Health each month. Of that total, approximately 152 were enrolled in an IDD waiver or community-based ICF/IID each month.

## **Community First Choice**

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

## **Eligibility**

Individuals may be eligible for CFC services if they:

- Are eligible for Medicaid;
- Meet criteria for an institutional level of care;<sup>36</sup> and
- Have functional needs that can be addressed by CFC services.

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<sup>35</sup> [https://www.dfps.state.tx.us/Child\\_Protection/Medical\\_Services/](https://www.dfps.state.tx.us/Child_Protection/Medical_Services/)

<sup>36</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.

## Services

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

- PAS
- HAB
- Emergency response services
- Support management

## CFC for Non-Waiver Recipients

CFC provides an opportunity for people with IDD who are not currently receiving services in an IDD waiver to receive personal assistance and habilitation services. Eligible Medicaid beneficiaries no longer must wait to receive these services through the waiver programs, which have interest lists with wait times ranging from one to 16 years depending on the waiver program. In FY 2021, a total of 148,167 individuals were concurrently enrolled in Medicaid and on the HCS, TxHmL, CLASS, and/or DBMD interest lists.<sup>37</sup>

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

MCOs began using new procedure code combinations for STAR+PLUS PAS and CFC services on September 1, 2019. Due to this change, HHSC anticipates improved CFC reporting accuracy in the future. This more accurate reporting reflects a higher number of people receiving CFC services in managed care. In fiscal year 2020, there was an average of 1,963 non-waiver recipients receiving CFC services each month through STAR+PLUS. In fiscal year 2021, there was an average of 90,056 non-waiver recipients receiving CFC services each month through STAR+PLUS.

In fiscal year 2021, there were an average of 95,600 non-waiver recipients receiving CFC services each month through STAR, STAR Kids, STAR Health,

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<sup>37</sup> Unduplicated total of individuals on HCS, TxHmL, CLASS and DBMD interest lists in fiscal year 2021 with concurrent Medicaid eligibility in TIERS.

STAR+PLUS and the Dual Demonstration.<sup>38</sup> These individuals meet at least one of the eligibility criteria for institutional services: nursing facility, ICF/IID, or Institution for Mental Disease. Table 1 below shows the average monthly enrollment for non-waiver recipients by age group, and CFC services provided in state fiscal year 2021.

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

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

**Table 1. Average Monthly Enrollment for Non-Waiver Recipients by Age Group, and CFC Services Provided in FY 2021<sup>39</sup>**

<b>Program</b>	<b>Age Group<sup>40</sup></b>	<b>Average Monthly Program Enrollment<sup>41</sup></b>	<b>Average Monthly Individuals Using CFC Services<sup>42</sup></b>
<b>STAR<sup>43</sup></b>	0-20	N/A	999
<b>STAR Kids</b>	0-20	154,379	3,544
<b>STAR Kids</b>	21+	2,589	65
<b>STAR Health</b>	0-20	43,256	509

<sup>38</sup> The Dual Eligible Integrated Care Demonstration Project, or Dual Demonstration, is a fully integrated managed care model for individuals age 21 and older who are dually eligible for Medicare and Medicaid and required to be enrolled in the STAR+PLUS program. This capitated model involves a three-party contract between an MCO with an existing STAR+PLUS contract, HHSC, and CMS for the provision of the full array of Medicaid and Medicare services. The Dual Demonstration operates in six Texas counties.

<sup>39</sup> Beginning September 1, 2019, new codes were used by MCOs, that improved CFC reporting accuracy.

<sup>40</sup> An individual was counted as under 21 through the end of the month of their 21st birthday.

<sup>41</sup> The average enrollment column does not include members concurrently enrolled in a waiver, ICF/IID, or nursing facility. The STAR Kids, STAR Health, STAR+PLUS, and Dual Demonstration average enrollment numbers do not match the numbers in the body of the text because earlier enrollment numbers represent the entire managed care program, including members in nursing facilities, ICFs/IID, or receiving services through a waiver.

<sup>42</sup> CFC utilization counts for all managed care programs (excluding STAR) based on encounter records from the TMHP Vision 21 Enc. Best Picture universe. All counts are unduplicated by client Medicaid number.

<sup>43</sup> CFC utilization counts for STAR based on acute care FFS claims (CFC is carved out of managed care for children in STAR). All counts are unduplicated by client Medicaid number. Further, all STAR participants are not eligible for CFC. For all other programs represented in the report, all clients under each program are potentially eligible for CFC services.

<b>Program</b>	<b>Age Group<sup>40</sup></b>	<b>Average Monthly Program Enrollment<sup>41</sup></b>	<b>Average Monthly Individuals Using CFC Services<sup>42</sup></b>
<b>STAR Health</b>	21+	213	1
<b>STAR+PLUS</b>	0-20	0	0
<b>STAR+PLUS</b>	21+	427,153	90,056
<b>Dual Demonstration</b>	21+	38,533	8
<b>All Programs Unduplicated<sup>44</sup>, Ages 0-20</b>	<b>0-20</b>	<b>197,635</b>	<b>4,053</b>
<b>All Programs Unduplicated<sup>45</sup>, Ages 21+</b>	<b>21+</b>	<b>470,174</b>	<b>90,555</b>

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 Medicaid managed care by providing acute health care and LTSS, including HCBS, as an alternative to residing in a nursing facility. Individuals in Texas receive CFC services through both 1915(c) waivers and the STAR+PLUS HCBS program.<sup>46</sup> CFC for waiver recipients is presented below based on the type of institutional level of care.

### Intermediate Care Facility – Level of Care

The HCS, TxHmL, CLASS, and DBMD waivers provide HCBS as an alternative to residing in an ICF. As outlined in Table 2, an average of 39,380 individuals with IDD were enrolled in the four IDD waiver programs each month during fiscal year 2021, with nearly three-quarters of the individuals served enrolled in HCS.

CFC services were utilized at the highest rate by all ages in CLASS, with an average of approximately 5,011 individuals in CLASS receiving CFC services each month out of the total 10,493 individuals each month across all four waiver programs.

<sup>44</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>45</sup> Ibid.

<sup>46</sup> Due to CFC federal income limitations, not all people enrolled in STAR+PLUS HCBS are eligible to receive CFC services. However, the STAR+PLUS HCBS program offers PAS and emergency response services for those persons not eligible for CFC.

**Table 2. Average Monthly Enrollment in CLASS by Age Group, and CFC Services Provided by Age Group to Individuals Enrolled in an IDD Waiver in FY 2021**

<b>Age Group<sup>47</sup></b>	<b>Average Monthly Individuals Enrolled in IDD Waivers<sup>48</sup></b>	<b>Average Monthly Individuals Using CFC Services <sup>49</sup></b>
<b>0-20</b>	1,220	967
<b>21+</b>	4,304	4,061
<b>All Ages Unduplicated<sup>50</sup></b>	<b>5,526</b>	<b>5,011</b>

Source: QAI Datamart

**Table 3. Average Monthly Enrollment in DBMD by Age Group, and CFC Services Provided by Age Group to Individuals Enrolled in an IDD Waiver in FY 2021**

<b>Age Group</b>	<b>Average Monthly Individuals Enrolled in IDD Waivers</b>	<b>Average Monthly Individuals Using CFC Services</b>
<b>0-20</b>	138	76
<b>21+</b>	205	103
<b>All Ages Unduplicated<sup>51</sup></b>	<b>343</b>	<b>179</b>

Source: QAI Datamart

**Table 4. Average Monthly Enrollment in HCS by Age Group, and CFC Services Provided by Age Group to Individuals Enrolled in an IDD Waiver in FY 2021**

<b>Age Group</b>	<b>Average Monthly Individuals Enrolled in IDD Waivers</b>	<b>Average Monthly Individuals Using CFC Services</b>
<b>0-20</b>	1,807	462
<b>21+</b>	26,763	2,131
<b>All Ages Unduplicated<sup>52</sup></b>	<b>28,570</b>	<b>2,587</b>

Source: QAI Datamart

**Table 5. Average Monthly Enrollment in TxHmL by Age Group, and CFC Services Provided by Age Group to Individuals Enrolled in an IDD Waiver in FY 2021**

<b>Age Group</b>	<b>Average Monthly Individuals Enrolled in IDD Waivers</b>	<b>Average Monthly Individuals Using CFC Services</b>
<b>0-20</b>	923	625
<b>21+</b>	4,019	2,106

<sup>47</sup> An individual was counted as under 21 through the end of the month of their 21st birthday.

<sup>48</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>49</sup> CFC utilization counts for CLASS, DBMD, HCS, and TxHmL based on LTSS FFS claims. All counts are unduplicated by client Medicaid number.

<sup>50</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>51</sup> Ibid

<sup>52</sup> Ibid

Age Group	Average Monthly Individuals Enrolled in IDD Waivers	Average Monthly Individuals Using CFC Services
<b>All Ages Unduplicated<sup>53</sup></b>	<b>4,942</b>	<b>2,725</b>

Source: QAI Datamart

**Table 6. Average Monthly Enrollment in All Waivers Combined by Age Group, and CFC Services Provided by Age Group to Individuals Enrolled in an IDD Waiver in FY 2021**

Age Group	Average Monthly Individuals Enrolled in IDD Waivers	Average Monthly Individuals Using CFC Services
<b>0-20</b>	4,088	2,130
<b>21+</b>	35,292	8,401
<b>All Ages Unduplicated<sup>54</sup></b>	<b>39,380</b>	<b>10,493</b>

Source: QAI Datamart and ADS 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. 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 Table 7, an average of 57,670 individuals received CFC services each month in fiscal year 2021 across MDCP, YES, STAR+PLUS HCBS, and Dual Demonstration HCBS.

<sup>53</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>54</sup> Ibid

**Table 7. Average Monthly Enrollment in LOC Nursing Facility & IMD Waivers by Age Group, and CFC Services Provided by Age Group to Individuals Enrolled in FY 2021**

<b>Program</b>	<b>Age Group<sup>55</sup></b>	<b>Average Monthly Enrollment<sup>56</sup></b>	<b>Average monthly Individuals Utilizing CFC Services<sup>57</sup></b>
<b>MDCP</b>	0-20	6,290	3,610
<b>YES</b>	0-20	1,528	149
<b>STAR+PLUS HCBS</b>	21+	59,123	50,073
<b>Dual Demonstration HCBS</b>	21+	4,531	3,838
<b>All Waivers Unduplicated<sup>58</sup>, Ages 0-20</b>	<b>0-20</b>	<b>7,818</b>	<b>3,759</b>
<b>All Waivers Unduplicated<sup>59</sup>, Ages 21+</b>	<b>21+</b>	<b>63,654</b>	<b>53,911</b>
<b>All Waivers Unduplicated<sup>60</sup>, All Ages</b>	<b>All ages</b>	<b>71,472</b>	<b>57,670</b>

Source: QAI Datamart and ADS Datamart

## CFC for All Programs

In fiscal year 2021, an average of 162,764 individuals used CFC services each month for all programs including waiver and non-waiver recipients. Of the 162,764 individuals, 9,942 were 20 years old or younger and 152,867 were 21 years old or older.

<sup>55</sup> An individual was counted as under 21 through the end of the month of their 21st birthday.

<sup>56</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>57</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>58</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>59</sup> Ibid.

<sup>60</sup> Ibid.



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

## **State Legislation**

### **Rider 42 Interest List Study**

2020-21 General Appropriations Act, H.B. 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 42), directs HHSC to work in consultation and collaboration with the IDD SRAC to conduct a study<sup>61</sup> of the interest lists and develop strategies to eliminate the interest lists for STAR+PLUS HCBS and the HCS, CLASS, DBMD, MDCP, and TxHmL waivers.

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

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

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

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<sup>61</sup> <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/medicaid-waiver-programs-interest-list-study-sept-2020.pdf>

in an individual being removed from the interest list and the individual will retain their original placement on the interest list.

- S.B. 1648, 87th Legislature, Regular Session, 2021 requires HHSC, in consultation with the IDD SRAC and STAR Kids Managed Care Advisory Committee, to study the feasibility of creating an online portal for individuals to request to be placed and check the individual's placement on a Medicaid waiver program interest list. As part of the study, HHSC is directed to determine the most appropriate and cost-effective automated method for determining the LON of an individual seeking services through a Medicaid waiver program. HHSC is directed to prepare and submit a report not later than January 1, 2023, to the governor, lieutenant governor, the speaker of the house of representatives and the standing legislative committees with primary jurisdiction over health and human services summarizing HHSC's findings and conclusions from the study. S.B. 1648 also directs HHSC to develop a protocol in the Office of the Ombudsman to improve the capture and updating of contact information for an individual who contacts the office regarding Medicaid waiver programs or services.
- The 2022-2023 General Appropriations Act, 87th Legislature, Rider 41 allocated funds to revise the Questionnaire for LTSS Waiver Program Interest Lists and administer the revised questionnaire to all individuals on the waiver interest lists. Rider 41 also directs HHSC to use funds appropriated for revision and administration of the questionnaire to evaluate the use of available technology to create a "no-wrong-door" approach, allowing individuals access to an online portal for requesting interest list placement and providing current interest list questionnaire information.

## **Senate Bill 50: Employment Initiative**

S.B. 50, 87th Legislature, Regular Session, 2021 bolsters the state's EF policy, set forth in Section 531.02448, Government Code. S.B. 50 requires HHSC to develop a uniform process to assess competitive and integrated employment goals and opportunities available to people in the IDD waivers and STAR+PLUS HCBS, and to use those identified goals and opportunities to direct plans of care.

S.B. 50 also requires HHSC to identify strategies to increase the number of people receiving employment services through waiver programs and TWC programs, set targeted increases in those numbers, and report on the progress and status every two years to the governor and legislature.

## **House Bill 4: Telehealth Access**

H.B. 4, 87th Legislature, Regular Session, 2021 requires HHSC ensure Medicaid recipients and other individuals receiving benefits under a public benefits program administered by HHSC have the option to receive services as telemedicine medical services, telehealth services, or otherwise using telecommunications or information technology, to the extent that it is cost-effective and clinically effective, as determined by HHSC.

At the direction of H.B. 4, HHSC conducted analysis of the various services provided in the IDD waivers. As a result, policy was drafted providing specific guidance regarding service delivery options in the different waiver populations for these services. For policy that was otherwise ambiguous, this clarified when and which telehealth options should be considered appropriate and for whom depending on what service was being delivered. Implementation efforts are ongoing, taking into consideration when the PHE may end. Some of the policy changes have been added to the HCBS settings rules project for timely enactment. Other aspects of the H.B.4 requirements are being codified through handbook revisions.

## **Rider 38: Study on High Behavioral and High Medical Needs in the HCS Waiver Program**

Rider 38 requires HHSC to conduct a study on the provision of services under the HCS waiver program to individuals who have high behavioral or high medical needs. Rider 38 directs HHSC to define the scope of high behavioral and high medical needs for which an individual with an intellectual or developmental disability may require enhanced services and service coordination under the waiver program; and identify the number of individuals in the HCS with the highest behavioral and medical needs.

In conducting the study, HHSC used existing HCS policies related to high behavioral and high medical needs and available administrative data as a framework to define the scope of high behavioral and high medical needs and to identify the number of individuals with the highest behavioral and medical needs in the HCS Program. HHSC also solicited and received external stakeholder feedback for the study.

Due to limitations identified with the scopes used to define high medical needs, HHSC recommended initiatives for future consideration to improve the process for identifying individuals with high medical needs.

## **Federal Legislation**

### **American Rescue Plan Act of 2021**

ARPA was signed into law on March 11, 2021. Section 9817 of ARPA provides states with a time-limited 10 percent enhanced FMAP for Medicaid HCBS as well as a number of state plan services. The enhanced FMAP must be used to supplement, rather than supplant, enhancements to a state's HCBS programs and services. States can claim the enhanced FMAP during the period beginning April 1, 2021 and ending on March 31, 2022. To claim the funds, states must submit a spending plan to CMS with an accompanying narrative that attests the state meets maintenance of effort requirements and a commitment to supplement rather than supplant state funds and explain how the state intends to sustain the activities beyond March 31, 2024.

HHSC submitted a proposal for expending the enhanced FMAP funding on July 12, 2021.<sup>62</sup> 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.

## **COVID-19**

### **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 COVID-19. FFCRA allowed for continuous Medicaid eligibility for anyone eligible March 1, 2020 or later through the end of the COVID-19 PHE. In addition, it has established a temporary 6.2percent enhancement in FMAP funding to help provide services to an increased number of eligible Medicaid enrollees throughout the COVID-19 PHE.

### **CARES Act**

The Coronavirus Aid, Relief, and Economic Security Act (CARES) passed in March 2020. Overseen by the Federal Health Resources and Services Administration

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<sup>62</sup> <https://www.hhs.texas.gov/sites/default/files/documents/govdelivery/arpa-hcbs-funding-plan.pdf>

(HRSA), the CARES Act provided funding between March 2020 and December 2021 to assist uninsured or underinsured Texans needing COVID-19 testing, vaccines, and treatment. It also provided funding for all types of healthcare providers impacted by COVID-19.