

Part III. Benefits

Chapter 7: Long-Term Services and Supports

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Overview

Medicaid covers a broad range of long-term services and supports (LTSS). LTSS enable people age 65 and over and those with physical, psychological, intellectual, or developmental disabilities to experience dignified, independent, and productive lives in safe living environments through a continuum of services and supports ranging from in-home and community-based services to institutional services. The demand for LTSS in Texas continually grows and is influenced by the aging of the population, medical advances allowing people with significant disabilities to live longer and healthier lives, and other trends such as co-occurring behavioral health needs. The population of people age 65 and older is projected to increase from 3.5 million in 2017 to 7.6 million in 2040. The percentage

of the total population that is 65 years of age or older is projected to increase from 12 percent in 2017 to 17 percent in 2040.¹ LTSS accounted for approximately 31 percent of all Texas Medicaid services expenditures in state fiscal year 2015.

LTSS, in contrast to medical care, are meant to support an individual with ongoing, day-to-day activities, rather than treat or cure a disease or condition. Individuals receiving LTSS often need assistance performing activities of daily living (ADLs) such as eating, bathing, or grooming, or other life activities such as housekeeping, working, or pursuing hobbies. Some LTSS are performed by licensed medical professionals such as nurses or therapists, while others are provided by direct care

¹ Texas Demographic Center/Office of the State Demographer at the University of Texas at San Antonio

staff without medical training. These services may be provided in an institution such as a nursing facility (NF) or intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID), in the individual's own home or family home, an assisted living facility, or in other settings like day activity and health services (DAHS) centers. LTSS in Texas are provided through both traditional fee-for-service (FFS) and managed care.

Who Receives LTSS

Older Individuals and Individuals with Physical Disabilities

LTSS for people age 65 and older and those with physical disabilities include both NF services for people whose medical conditions require the skills of a licensed nurse on a regular basis, and home and community-based services (HCBS) to help people maintain their independence and prevent institutionalization.

People with Intellectual and Developmental Disabilities

LTSS for people with intellectual and developmental disabilities (IDD) include both institutional residential services in an ICF/IID and HCBS, which may include residential services such as a group home, for

individuals who qualify for an ICF/IID level of care.

Where Individuals Receive LTSS

Institutional Care

Institutional settings for LTSS in Texas include NFs, ICFs/IID, and state supported living centers (SSLCs). The Department of Aging and Disability Services (DADS) regulates these facilities.² NFs provide services for individuals whose medical conditions require the skills of a licensed nurse on a regular basis. ICFs/IID provide LTSS for persons with an intellectual disability or related condition requiring residential, medical, and habilitative services.

Home and Community-Based Services

Federal law allows states to apply for waivers exempting them from certain Medicaid requirements. One of these, referred to as a 1915(c) waiver after the particular section of the Social Security Act it waives, allows states to provide HCBS to individuals who qualify for institutional care based on need in order to maximize independence and prevent institutionalization. The

² This function will transfer to the Health and Human Services Commission on September 1, 2017.

Medicaid 1915(c) waiver programs include:

- Community Living Assistance and Support Services (CLASS);
- Deaf-Blind with Multiple Disabilities (DBMD);
- Home and Community-based Services (HCS);
- Medically Dependent Children Program (MDCP);
- Texas Home Living (TxHmL); and
- Youth Empowerment Services (YES).

Home and community-based waivers allow the state to provide a broader array of services to specific individuals. Examples of waiver services provided include nursing, personal assistance services (PAS), habilitation, minor home modifications, dental services, respite, therapies, adaptive aids, medical supplies, and emergency response services. According to federal rules, home and community-based waivers cannot cost more than institutional care would have cost for the group served by the waiver. Because of funding limitations, the number of individuals wanting to receive waiver services generally exceeds the number of individuals the state can serve through a waiver. Most home and community-based waiver programs have interest lists for people who wish to enroll. These interest lists have grown despite

significant increases in waiver funding by the Legislature.

Home and community-based LTSS can also be provided under the authority of an 1115 waiver, also named for the section of the Social Security Act it waives. The STAR+PLUS HCBS program is operated under such a waiver and allows Texas to provide community-based services to adults as an alternative to NF care (see **Appendix F, Texas Medicaid Waivers**).

Recent Initiatives

Community First Choice

S.B. 7, 83rd Legislature, Regular Session, 2013, directed the Health and Human Services Commission (HHSC) to implement the most cost-effective option for delivering basic attendant care and habilitation to Medicaid-eligible individuals. HHSC used existing program infrastructure to implement Community First Choice (CFC), a federal option for the delivery of services to assist with ADLs on June 1, 2015. Individuals in the home and community-based waivers who previously received a CFC-like service continue to receive the services as CFC state plan services, but they are delivered by their waiver providers. In this way, the state implemented CFC as seamlessly as possible for individuals who were already receiving services.

The state receives an additional six percent federal match for funds spent on CFC services.

To be eligible for CFC, an individual must be Medicaid-eligible and require the level of care provided in a hospital or NF, an ICF/IID, or a psychiatric hospital.³ An individual must have a documented need for CFC services. Individuals can receive CFC services and keep their spot on an interest list or continue to receive services in a waiver program.

The following services are provided through CFC:

- PAS – Hands-on assistance with ADLs, like eating and bathing; instrumental activities of daily living (IADLs), like cleaning and grocery shopping; and health-related tasks delegated by a nurse, like medication administration and special feeding protocols.
- Habilitation – Assistance learning, maintaining, and enhancing the skills necessary for the individual to perform his or her own ADLs and IADLs. This can include hands-on assistance. Habilitation also includes teaching an individual skills related to money management, socialization, personal decision-making,

and integrating in the greater community.

- Emergency response services – A service for individuals who would otherwise require extensive routine supervision and who live alone, are alone for large parts of the day, and do not have regular caregivers for extended periods of time.
- Support Management – A voluntary service for individuals who want to learn how to better communicate their preferences and needs to their provider, including selecting, training, and dismissing an attendant.

As described in the Service Delivery Options section at the end of this chapter, CFC services are available through the traditional agency model, the consumer-directed services model (CDS), and the service responsibility option (SRO), and are provided in both FFS and managed care. CFC services must be provided in community-based settings, and are required to be delivered through a person-centered planning framework. Providers include licensed home and community support services agencies and certified waiver providers.

Balancing Incentive Program

The federal Balancing Incentive Program (BIP) authorized \$3 billion for states through September 2015

³Called an institution for mental disease (IMD) in federal rules, IMD services are limited to individuals under age 21 or over age 64.

to increase access to community-based LTSS. States spending 25-50 percent of Medicaid LTSS funding on community LTSS were eligible for a 2 percent increase in federal matching funds on certain community LTSS expenditures through September 2015, provided they made three structural changes to increase community LTSS:

- No Wrong Door/Single Entry Point System – establish a statewide coordinated system that provides information, application assistance, referrals, and eligibility determinations.
- Core Standardized Assessment Instrument(s) – ensure standardized assessment instruments are used in a uniform manner throughout the state to determine eligibility, identify needs, and inform care planning. Assessment instruments must address ADLs, medical diagnoses, cognitive functioning, and behavior concerns.
- Conflict-Free Case Management – ensure separation of case management and eligibility determination from service provision (e.g., through administrative separation of services and enhanced state oversight).

By September 2015, participating states were required to fully implement the three structural

changes and achieve at least a 50 percent benchmark of Medicaid community LTSS expenditures. In October 2012, Texas began participating in BIP, receiving a total grant award of \$283.5 million. Texas structural changes included:

- Expanding Aging and Disability Resource Center (ADRC) coverage statewide;
- Establishing a toll-free number to provide individuals with information about and access to services;
- Integrating a basic screening tool into the Your Texas Benefits self-service web portal to direct individuals to the services that best meet their needs; and
- Enhancing certain LTSS assessment instruments.

Other activities funded through BIP to increase access to community services included:

- Additional community-based waiver slots;
- CFC services;
- Specialized therapies for individuals with acquired brain injury and targeted case management in several waiver programs; and
- A base wage increase to improve recruitment and retention of direct service workers.

As of September 2015, Texas spent 56.3 percent of Medicaid LTSS funds on community LTSS.

CMS Regulations on HCBS Settings and Person-Centered Planning

In March 2014, the Centers for Medicare & Medicaid Services (CMS) issued a new rule for the delivery of Medicaid HCBS. The purpose of the rule is to ensure individuals receive services in fully integrated settings. Services cannot be provided in a setting that is institutional in nature or has the effect of isolating individuals from the greater community. The rule requires all HCBS settings meet certain standards, including:

- Integration in and support for full access to the greater community;
- Providing opportunities to work in integrated settings;
- Is selected by the individual from among setting options;
- Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Provides opportunities for individuals to control their own schedules and activities; and
- Allows for choice regarding services and who provides them.

All HCBS must comply with the new settings rule by March 2019.

The HCBS rule also requires that people receiving HCBS have a person-centered service plan. As

such, the rule outlines the required contents of a plan. Person-centered service plans document service options that take into account an individual's strengths, goals, and preferences as well as needs.

Prescribed Pediatric Extended Care Centers

S.B. 492, 83rd Legislature, Regular Session, 2013, directed DADS to create a new licensure category and HHSC to establish a new Medicaid benefit for Prescribed Pediatric Extended Care Centers (PPECC).

A PPECC provides non-residential, facility-based care during the day as an alternative to private duty nursing (PDN) for individuals under age 21 who are medically or technologically dependent. When prescribed by a physician, the child or young adult can attend a PPECC up to a maximum of 12 hours per day to receive medical, nursing, psychosocial, therapeutic, and developmental services appropriate to their medical condition and developmental status. Per S.B. 492, the payment rate for PPECCs must not exceed 70 percent of the average hourly rate for PDN. PPECCs became a Medicaid benefit effective November 1, 2016.

Licensure requirements were amended by H.B. 2340, 84th Texas Legislature, Regular Session, 2015. H.B. 2340 requires DADS to

create three licensure categories: temporary, initial, and renewal. PPECCs must be licensed by DADS in order to enroll as a Medicaid provider.⁴

Electronic Visit Verification

Electronic visit verification (EVV) is a telephone and computer-based system that verifies individuals receive the authorized service visits for which the state is billed. EVV electronically logs the precise time a visit begins and ends using an individual's home landline telephone or a small alternate device. As of June 1, 2015, EVV is required by state rule for attendant services in certain FFS and managed care home and community-based programs, including CFC and some waivers. EVV is optional for members who have selected the CDS delivery option.

Since April 1, 2016, all Medicaid providers required to use EVV who fail to achieve and maintain an EVV compliance score of at least 75 percent per review period (90 percent starting April 1, 2017) may be subject to the corrective action plan process, liquidated damages, and the imposition of contract actions (including contract termination).

⁴ This function will transfer to HHSC on September 1, 2017.

IDD Managed Care Pilot

S.B. 7, 83rd Legislature, Regular Session, 2013, authorized HHSC and DADS to develop and implement a pilot program to test one or more service delivery models involving a capitation-based managed care strategy to deliver Medicaid LTSS to individuals with IDD. H.B. 3523, 84th Legislature, Regular Session, 2015, requires the pilot to be implemented by September 1, 2017. The pilot may operate for up to 24 months.

Per the legislation, the pilot must be voluntary and pilot participants may come from community-based ICFs/IID or the CLASS, DBMD, HCS, and TxHmL programs. HHSC determined the pilot will not include ICFs/IID or the TxHmL waiver program. HHSC was not appropriated any new or additional funds for the pilot program, so no new waiver slots are available for the pilot.

The legislation allows the pilot to be operated by managed care organizations (MCOs) or private LTSS service providers that meet requirements around offering managed care services.

The pilot must be designed to:

- Increase access to LTSS;
- Improve quality of acute care services and LTSS;
- Promote meaningful outcomes by using person-centered planning, individualized budgeting, and

self-determination, and promote community inclusion and customized, integrated, competitive employment;

- Promote integrated service coordination of acute care services and LTSS;
- Promote efficiency and the best use of funding;
- Promote the placement of an individual in housing that is the least restrictive setting appropriate to the individual's needs;
- Promote employment assistance and supported employment;
- Provide fair hearing and appeals processes in accordance with applicable federal law; and
- Promote sufficient flexibility to achieve the goals through the pilot program.

Services for People Age 65 and Older or with Physical Disabilities

LTSS for people age 65 and older or with physical disabilities include HCBS and NF services. If eligible for Medicaid, individuals may receive an array of services, from non-skilled personal care to skilled nursing services.

In addition to the growth of the population age 65 and older, the number of Texans age 5 and older with a physical disability is projected

to increase from 1.7 million in 2015 to 3.6 million in 2040.⁵

Community Services and Supports: Medicaid State Plan Services

Medicaid state plan community-based programs provide Medicaid-covered services in homes and other community settings, enabling people age 65 and older and those with physical disabilities who can be served at home or in the community to maintain their independence and prevent institutionalization. These state plan services are PAS, community attendant services (CAS), personal care services (PCS), and DAHS. CFC, discussed earlier in this chapter, is also a state plan community-based benefit.

Personal Assistance Services

PAS is a Medicaid community-based entitlement service delivered through several programs, including STAR+PLUS and traditional FFS Medicaid, where it is known as Primary Home Care. Being an entitlement means the state must provide PAS to all individuals who request services and are determined eligible. PAS is a non-technical, non-skilled service that includes

⁵Texas Demographic Center/Office of the State Demographer at the University of Texas at San Antonio; U.S. Census Bureau's 2015 American Community Survey (Texas Public Use Sample)

attendant care for individuals with an approved medical need for assistance with personal care tasks. PAS is available to eligible adults whose health conditions create limitations in their ability to perform ADLs as determined by a health care practitioner. Covered services include an escort to obtain a medical diagnosis or treatment or both, home management assistance such as laundry and housekeeping, and PCS such as bathing, dressing, grooming, and preparing meals. PAS can be the critical factor in keeping individuals in their own homes and out of institutions.

Community Attendant Services

The CAS program is an entitlement program that provides personal care without other Medicaid benefits to individuals whose income is too high to qualify for Medicaid, but who meet the higher NF income limit, which is 300 percent of the Supplemental Security Income (SSI) federal benefit rate (FBR). CAS is a non-technical, non-skilled service providing in-home attendant services to individuals with an approved medical need for assistance with personal care tasks. CAS is available to eligible adults and children whose health conditions create limitations in their ability to perform ADLs as determined by a health care practitioner. Covered services include an escort on trips to obtain a medical diagnosis or treatment or both, assistance with

home management such as laundry and housekeeping and PCS such as bathing, dressing, grooming and preparing meals. In state fiscal year 2015, the CAS program served an average of 52,640 individuals per month, with an annual expenditure of \$611.5 million all funds.

Personal Care Services

PCS is a Medicaid benefit through which individuals receive assistance with ADLs and IADLs. To receive PCS, an individual must:

- Be under 21 years of age and have Medicaid;
- Have a disability, physical or mental illness, or a health problem that lasts for a long time;
- Have a Practitioner Statement of Need signed by a practitioner (physician, advanced practice registered nurse, or physician assistant);
- Need help with ADLs and IADLs based on an assessment; and
- Have a reason why his or her guardian cannot provide the necessary assistance.

In state fiscal year 2015, the average number of children and young adults served by non-waiver, community-based entitlement programs offering PCS was 61,031 per month with an annual expenditure of \$601.3 million all funds.

Day Activity and Health Services

DAHS provides up to 10 hours of services per day, Monday through Friday, to individuals residing in the community as an alternative to placement in NFs or other institutions. Services are designed to address the physical, mental, medical, and social needs of individuals and include nursing and personal care; noon meals and snacks; transportation; and social, educational, and recreational activities. The individual must have a medical diagnosis and a physician's order for care or supervision by a licensed nurse, a functional limitation related to the medical diagnosis, and the need for assistance with one or more personal care tasks. In state fiscal year 2015, DAHS facilities provided services to a monthly average of 1,207 individuals with an annual expenditure of \$7.9 million all funds.

Community Services and Supports: Non-State Plan Models

STAR+PLUS

The Medicaid STAR+PLUS program provides primary, acute care, behavioral health care, pharmacy services, and LTSS for individuals who are age 65 or older or have a disability. LTSS include services such as attendant care and DAHS. In

addition, STAR+PLUS members who do not have Medicare are eligible for unlimited prescriptions. The program operates statewide under the authority of the 1115 Transformation Waiver. Services are delivered through five MCOs under contract with HHSC. Individuals have the choice of at least two STAR+PLUS MCOs in each service area and have the option to change plans.

The STAR+PLUS program serves adults with SSI, SSI-related Medicaid, and those who qualify for Medicaid because they meet medical necessity criteria for NF services and, as a result, receive services through the STAR+PLUS HCBS Program (also called the STAR+PLUS HCBS waiver). If eligible for STAR+PLUS, adults are required to participate in the program.

STAR+PLUS enrollees who are eligible for both Medicaid and Medicare receive LTSS through STAR+PLUS and most acute care services through Medicare.

The STAR+PLUS program provides only acute care services to non-dual eligible members receiving services from an ICF/IID or a 1915(c) waiver program for individuals with IDD (HCS, CLASS, TxHmL, DBMD). Adults in an IDD waiver or residing in an ICF/IID are required to participate in STAR+PLUS for acute care services only. All dual eligible individuals who are currently living in an ICF/IID or receiving IDD waiver services and

individuals residing in an SSLC are excluded from participation in the STAR+PLUS program.

Adults with disabilities may be in the Health Insurance Premium Program (HIPP) and enrolled in STAR+PLUS at the same time. HHSC will expand STAR+PLUS to include women in the Medicaid for Breast and Cervical Cancer program in September 2017. These women will be assigned a service coordinator when they enroll in STAR+PLUS.

STAR+PLUS program members have access to a primary care provider (PCP) who knows their health care needs and can coordinate their care through a medical home. STAR+PLUS also offers services not available in traditional FFS, such as value-added or case-by-case services. STAR+PLUS members with complex medical conditions are assigned a service coordinator who is responsible for coordinating acute care and LTSS. The service coordinator develops an individual service plan with the member, the individual's family members, and providers and can authorize certain services. A STAR+PLUS member who is not assigned a service coordinator can call the MCO and ask for one.

STAR+PLUS HCBS Program

STAR+PLUS HCBS is part of the larger STAR+PLUS program. STAR+PLUS HCBS provides LTSS to clients who are elderly or who

have disabilities as a cost-effective alternative to living in a NF. Services included are nursing, PAS, adaptive aids, medical supplies, and minor home modifications to make members' homes more accessible. To be eligible for STAR+PLUS HCBS, a member must be age 21 or older, meet income and resource requirements for Medicaid NF care, and receive a determination from HHSC that they meet the medical necessity criteria to be in a NF.

STAR Kids

STAR Kids is the managed care program that provides acute care and LTSS benefits to children and young adults ages 20 and younger with disabilities. STAR Kids was implemented on November 1, 2016 and operates statewide under the authority of the 1115 Transformation Waiver. Services are delivered through MCOs. Children, young adults, and their families have the choice of at least two STAR Kids health plans in each service area and have the option to change plans.

Children and young adults ages 20 and younger who either receive SSI or SSI-related Medicaid or are enrolled in MDCP receive all of their Medicaid services through the STAR Kids program. Children and youth who get services through the Medicaid Buy-In Program for Workers with Disabilities or the Medicaid Buy-In for Children program are also required to enroll in STAR Kids.

Children and youth who receive services through the following 1915(c) waiver programs will receive their basic Medicaid health services (acute care and some LTSS) through STAR Kids and will continue to receive their waiver LTSS through their waiver program:

- HCS
- CLASS
- DBMD
- TxHmL
- YES

Children and youth who reside in a community-based ICF/IID or a NF will receive their acute care services and service coordination through a STAR Kids health plan.

Children and youth who are dual-eligible receive most of their acute care services through Medicare, but receive LTSS and service coordination through the STAR Kids MCOs.

Children and youth may be on the HIP program and enrolled in STAR Kids at the same time.

All STAR Kids members have access to service coordination through an MCO. The service coordinator is responsible for coordinating acute care and LTSS. The service coordinator develops an individual service plan with the member, the member's family members, and providers and can authorize certain

services. The program also ensures that each member has a PCP who knows their health care needs and can coordinate their care through a medical home. STAR Kids MCOs also offer additional services not available in traditional FFS, such as value-added or case-by-case services.

Medically Dependent Children Program

MDCP provides HCBS to children and young adults under 21 years of age as an alternative to residing in a NF. Services include respite, flexible family supports, employment assistance, supported employment, adaptive aids, and minor home modifications. Transition assistance services are available for individuals transitioning from a NF to the MDCP waiver program. In state fiscal year 2015, MDCP served an average of 5,256 individuals per month with an annual expenditure of \$88.6 million all funds.

Children and young adults with disabilities receiving benefits under the MDCP waiver began receiving benefits under STAR Kids on November 1, 2016.

Nursing Facilities

NFs provide services to meet medical, nursing, and psychological needs of persons meeting a level of medical necessity requiring 24-hour care. NFs are paid a daily rate based on the individual needs of Medicaid

eligible residents and must provide services and activities that enable persons residing in the facility to attain and maintain their highest feasible level of physical, mental, psychological, and social well-being. Texas has adopted optional eligibility standards that allow people with incomes of up to 300 percent of the SSI FBR to qualify for Medicaid-funded NF care, although most of their income must be used toward the cost of their care.⁶

In addition to room and board, required services include nursing, social services and activities, over-the-counter drugs (prescription drugs are covered through Medicaid or Medicare Part D), medical supplies and equipment, personal needs items, and rehabilitative therapies.

Since March 1, 2015, most Medicaid clients age 21 and over receiving NF services are enrolled in STAR+PLUS. STAR+PLUS benefits for NF residents include service coordination and value-added services. The STAR+PLUS MCOs are responsible for adjudicating claims, including prescription drug claims for NF services.⁷

⁶The SSI federal benefit rate is the maximum amount an individual can receive in Supplemental Security Income on a monthly basis. See www.ssa.gov/ssi/text-general-ussi.htm.

⁷Prescriptions for individuals who are dually eligible have their prescriptions covered under Medicare Part D.

In state fiscal year 2015, NFs served an average of 31,260 individuals per month through Medicaid at a cost of \$1.4 billion all funds. Also in state fiscal year 2015, an average of 3,487 individuals per month had their Medicare skilled NF co-insurance paid by Medicaid, with an annual expenditure of \$98.1 million all funds.

Medicaid Hospice Program

The hospice program provides palliative care in the home or in community settings, long-term care facilities (for example, NF or ICF/IID), or in hospital settings to terminally ill individuals for whom curative treatment is no longer desired and who have a physician's prognosis of six months or less to live. In accordance with federal law, children under 21 years of age receiving hospice services may continue to receive curative care from non-hospice acute care providers.

The goal of hospice is to provide palliative care for individuals and their families, not to treat or cure terminal illness. A team of doctors, nurses, home health aides, social workers, counselors, and trained volunteers works together to help the individual and their family cope with the terminal illness. Hospice services include physician services, nursing, counseling, PAS, therapies,

prescription drugs, and respite care. In state fiscal year 2015, the program served an average of 7,075 individuals per month with an annual expenditure of \$256.6 million all funds.

Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) is a comprehensive care approach providing an array of services for a capitated monthly fee below the cost of comparable institutional care. PACE participants must be age 55 or older, live in a PACE service area, qualify for NF level of care, and be able to live safely in the community at the time of enrollment. PACE participants receive all medical and social services they need through their PACE provider.

PACE offers all health-related services for a participant, including inpatient and outpatient medical care, specialty services (e.g., dentistry, podiatry, physical therapy and occupational therapy), social services, in-home care, meals, transportation, day activity services, and housing assistance. PACE is available in Amarillo/Canyon, El Paso, and Lubbock. Individuals in these service areas who are also eligible for STAR+PLUS may choose to receive services either through STAR+PLUS or PACE, but not both.

For state fiscal year 2015, the average number of participants per month receiving PACE services was 1,110 with an annual expenditure of \$37.5 million all funds.

Dual Demonstration

The Dual Eligible Integrated Care Demonstration Project, also referred to as the Dual Demonstration, is a fully integrated managed care model for individuals age 21 or older who are dually eligible for Medicare and Medicaid and required to receive Medicaid services through the STAR+PLUS program. More information on the Dual Demonstration may be found in **Chapter 11, Fee-for-Service and Managed Care.**

Medicare Advantage Dual Eligible Special Needs Plan

A Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) is a managed care delivery model specifically designed to coordinate care between Medicare and Medicaid covered services for individuals that are dually eligible for both programs. For more information on D-SNPs, please see **Chapter 11, Fee-for-Service and Managed Care.**

Services for People with an Intellectual Disability or Related Condition

Medicaid-funded LTSS for individuals with an intellectual disability or related condition include home and community-based waiver services and services in an ICF/IID. Home and community-based waivers provide individualized services and supports to people who live in their family's home, their own homes, or other community settings such as small group homes where a few individuals reside, depending on the waiver program. Residential and habilitation services are provided in ICFs/IID that vary in size, serving as few as six people up to several hundred. SSLCs are one type of ICF/IID.

Community Services and Supports: Waivers

Medicaid HCBS waiver programs provide services that enable people with intellectual disabilities and related conditions who qualify for an ICF/IID to be served at home or in a community-based setting to maintain and improve their independence and prevent institutionalization. These waiver programs are HCS, CLASS, TxHmL, and DBMD. Non-dual eligible adults enrolled in these waiver programs are also enrolled in the STAR+PLUS Medicaid managed care

program to receive their basic health services. In each of the waivers, home-based habilitation services were replaced by CFC, but are still provided by the waiver provider.

Home and Community-based Services

The HCS waiver provides individualized services to individuals of all ages who qualify for an ICF/IID level of care. Individuals live in their family's home, their own homes, or other settings in the community. Services include adaptive aids, minor home modifications, dental treatment, nursing, supported home living (now CFC habilitation but still provided by the waiver provider), respite, day habilitation, residential services, employment assistance, supported employment, and professional therapies. Professional therapies include physical therapy, occupational therapy, speech and language pathology, audiology, social work, behavioral support, dietary services, and cognitive rehabilitation therapy. Financial management services and support consultation are available to individuals who use the CDS option. Residential service options include host home/companion care, supervised living, and residential support services.

In state fiscal year 2015, HCS served an average of 22,443 individuals per month with an annual expenditure of \$947.2 million all funds.

Community Living Assistance and Support Services

The CLASS waiver provides HCBS to clients who have a diagnosis of a “related condition” by a licensed physician qualifying them for placement in an ICF/IID. A related condition is a disability other than an intellectual disability or mental illness which originates before age 22 and is found to be closely related to an intellectual disability because the condition substantially limits life activity similar to that of individuals with an intellectual disability and requires treatment or services similar to those required for individuals with an intellectual disability. Related conditions include disabilities such as cerebral palsy, epilepsy, spina bifida, and head injuries.

Services include case management, prevocational services, residential habilitation (now CFC habilitation but still provided by the waiver provider), respite (in-home and out-of-home), employment assistance, supported employment, adaptive aids/medical supplies, dental treatment services, occupational therapy, physical therapy, prescriptions, skilled nursing, speech and language pathology, behavioral support, minor home modifications, specialized therapies, support family services, continued family services, and transition assistance services. Financial management services and support consultation are available to individuals who use the CDS option.

In state fiscal year 2015, CLASS served an average of 4,910 individuals per month with an annual expenditure of \$225.4 million all funds.

Texas Home Living

The TxHmL waiver provides selected services and supports costing up to \$17,000 per year for individuals who qualify for ICF/IID level of care and live in their family homes or their own homes. Services include adaptive aids, minor home modifications, behavioral support, dental treatment, nursing, community support (now CFC habilitation but still provided by the waiver provider), respite, day habilitation, employment assistance, supported employment, and specialized therapies. Specialized therapies include physical therapy, occupational therapy, speech and language pathology, audiology, and dietary services. Financial management services and support consultation are available to individuals who use the CDS option.

In state fiscal year 2015, TxHmL served an average of 5,651 individuals per month with an annual expenditure of \$61.1 million all funds.

Deaf-Blind with Multiple Disabilities

DBMD provides HCBS as an alternative to residing in an ICF/IID to people of all ages who are deaf-

blind, or have a condition that will result in deaf-blindness, and who have an additional disability. Services include case management; day habilitation; residential habilitation (now CFC habilitation but still provided by the waiver provider); respite; supported employment; prescription medications; financial management services; adaptive aids/medical supplies; assisted living; audiology services; behavioral support; chore service; dental treatment; dietary services; employment assistance; intervener; minor home modifications; nursing; orientation and mobility; physical, speech, hearing, and language therapy services; and transition assistance services. Support consultation is also available to individuals who use the CDS option.

In state fiscal year 2015, DBMD served an average of 203 individuals per month with an annual expenditure of \$9.4 million all funds.

Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Condition

The ICF/IID program provides ongoing evaluation and individual program planning, as well as 24-hour supervision, coordination, and integration of health or rehabilitative services to help individuals with

an intellectual disability or related condition function to their greatest ability (related conditions are described in the CLASS waiver section of this chapter).

ICFs/IID are considered institutional settings. Adults receiving services through the ICF/IID program are also enrolled in the STAR+PLUS Medicaid managed care program to receive their basic health services. Children under age 21 receiving services through the ICF/IID program receive their basic health services through STAR Kids.

ICF/IID residential settings range in size from six beds to several hundred. In state fiscal year 2015, an average of 5,177 Medicaid-eligible individuals per month received services from non-state operated ICFs/IID with an annual expenditure of \$268.4 million all funds. All ICFs/IID must be certified by DADS, and the majority must also be licensed by DADS. All ICFs/IID also must meet the State Standards for Participation in the Texas Administrative Code, Title 40, Chapter 9, Subchapter E.

SSLCs are state-operated by DADS and are an example of ICFs/IID that are certified, but not licensed.

State Supported Living Centers

SSLCs serve people with an intellectual disability who have significant medical or behavioral

health needs in a residential campus-based community. SSLCs provide 24-hour residential services, comprehensive behavioral treatment, and health care, such as medical, psychiatry, nursing, and dental services. Other services include skills training; occupational, physical and speech therapies; adaptive aids; day habilitation, vocational programs, and employment services; participation in community activities; and services to maintain connections between residents and their families and natural support systems. Services and supports are provided at 12 SSLCs operated by DADS and the ICF/IID component of the Rio Grande State Center operated by DSHS.⁸ Each center is certified as an ICF/IID, with approximately 60 percent of the operating funding from the federal government and 40 percent from state general revenue and third-party revenue resources. Individuals receiving services through an SSLC are excluded from enrollment in Medicaid managed care.

Nearly two-thirds of the overall SSLC population has a dual diagnosis in which an individual has been diagnosed with an intellectual disability and a mental health disorder. During state fiscal year 2015, an average of 3,241 individuals lived in SSLCs with an

annual expenditure of \$684.1 million all funds.

Additional Resources and Programs

Promoting Independence Initiative and Money Follows the Person

LTSS include both institutional settings, such as NFs and ICFs/ IID, and community-based services. Historically, NF appropriations could not be used to fund community-based services when individuals expressed their desire to receive services in a more home-like setting. However, in response to the 1999 *Olmstead vs. L.C.* U.S. Supreme Court decision, the state launched the Promoting Independence Initiative, which provided the opportunity to change this policy.

The 2002-03 General Appropriations Act, S.B. 1, 77th Legislature, Regular Session, 2001 (Article II, HHSC, Rider 37), established a Money Follows the Person (MFP) policy whereby the funding for individuals moving from NFs to community-based services could be transferred from the NF budget to the community-based services budget. MFP allows individuals to be able to choose how and where they receive their LTSS. Other support services have subsequently been developed to help in the identification of

⁸ These functions will transfer to HHSC on September 1, 2017.

individuals who want to leave an institutional setting and to assist them in their relocation back to the community. Rider 37 was codified by H.B. 1867, 79th Legislature, Regular Session, 2005, and a separate budgetary line item for MFP was established.

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HHSC and DADS successfully competed for a federal Deficit Reduction Act of 2005 MFP demonstration (MFPD) award to build upon and enhance the Promoting Independence Initiatives. The MFPD began in 2008 and will continue through 2019.

Under MFPD, the state works with individuals residing in NFs, community ICFs/IID with nine beds or more, and SSLCs who want to relocate to the community. The state receives enhanced funding for 365 days for each individual who enrolls in MFPD. In order to be an MFPD participant, the individual must have been in an institutional setting for at least 90 days (exclusive of Medicare billable days) and be willing to sign an informed consent to enroll in the demonstration.

As of June 2016, MFPD has helped over 10,000 individuals transition from institutional to community-based services. Another 34,598 individuals transitioned under the Texas Promoting Independence Initiative.

The MFPD enhanced funding and MFP grant create opportunities to fund a variety of projects, including direct service provision as well as information technology, staff resources, and other infrastructure-related functions. Some of these projects include:

- Community supports (e.g., cognitive adaptation services, substance abuse services) for individuals transitioning from NFs with co-occurring behavioral health needs in Bexar County and its contiguous counties, and Travis County;
- Incentives for providers of community ICFs/IID with nine or more beds who want to close their facilities voluntarily and provide residential choice for their current residents;
- Hands-on assistance from relocation contractors to assist in the transition back to the community as well as short-term post-relocation contacts for individuals who have moved back into the community to ensure a more successful relocation;
- Enhancement of data collection, reporting and quality assurance systems, and provider monitoring;
- Financial assistance to local Long-Term Care Ombudsmen to assist NF residents who want to learn more about community-based alternatives;

- A customized employment project for providers who want to assist individuals receiving services in an ICF/IID or an ICF/IID waiver program to achieve integrated employment at local businesses;
- Administrative assistance for Relocation Contractor Services and Direct Service Workforce Development;
- Transition specialists housed at each SSLC to improve the quality of the relocation process;
- Funding of 14 Aging and Disability Resource Centers (ADRCs) to hire housing specialists who will concentrate their efforts on the identification and expansion of affordable, accessible, and integrated housing;
- Funding of 14 ADRCs to provide options counseling to non-Medicaid NF residents interested in learning about community LTSS;
- Establishment of a Quality Reporting Office to provide additional in-house capabilities to monitor, discover, describe, and create intervention strategies to promote quality across demonstration activities and Medicaid 1915(c) waivers; and
- Establishment of a crisis intervention team staffed by Austin-Travis County Integral Care for individuals who reside in Travis County who have left an SSLC within the previous five years and

who are experiencing either a behavioral or mental health crisis or have a history of intermittent behavioral challenges. Eligible individuals must also require the establishment of a proactive action plan to maintain stability.

Aging and Disability Resource Centers

ADRCs provide a “no wrong door” approach to accessing services. Each ADRC is comprised of a network of local service agencies that coordinate information, referrals, and linkages to both private and public LTSS programs and benefits, including Medicaid. ADRCs assist individuals with decision-making about services tailored to meet their needs. ADRCs also provide assistance with system navigation and care transition support services through collaboration with hospitals and NFs. Key community partners include area agencies on aging, community services regions, and local intellectual and developmental disability authorities. There are 22 ADRCs operating throughout Texas.

Service Delivery Options

Individuals have multiple options through which certain LTSS (most commonly, attendant care) may be delivered. Each option requires a different level of responsibility of the individual.

Agency Option

The Agency Option is the traditional method of service delivery where services are delivered through a provider agency. The provider agency is the employer of attendants or other direct service workers, and is responsible for:

- Recruiting, hiring, managing, training, monitoring, and dismissing employees;
- Employee payroll, taxes, and costs associated with employment;
- Determining the rate of pay and benefits for employees;
- The liability of the employee, such as an on-the-job injury;
- Retaining contractors and vendors; and
- Providing back up services.

Provider agencies are licensed or certified by DADS and must comply with DADS licensure and program rules. The provider agency⁹ or service coordinator coordinates with the individual or authorized representative to monitor services and ensure the individual is satisfied with their services.

Consumer Directed Services Option

CDS is an LTSS option in which the individual receiving services has choice and control over the delivery

of services. In some cases, parents of minor children or an individual's guardian has the control and choice on behalf of the person receiving services. The CDS option allows the individual or the individual's legally authorized representative to be the employer of record of the direct care worker providing services. The individual or legally authorized representative has responsibility for hiring, training, supervising, and, if necessary, dismissing the employee. Individuals may appoint a designated representative to assist with some employer responsibilities, like submitting time sheets.

Those who use the CDS option are required to select a financial management services agency (FMSA) that provides orientation, writes paychecks for the providers, and pays federal and state employer taxes on behalf of the employer. In addition to an FMSA, individuals who choose the CDS option may request support consultation. Support consultation is an optional support service for individuals who want additional help to coach and train their employees and other employer-related skills.

CDS is one option for service delivery and does not preclude the use of the traditional agency-based service delivery system for those who prefer it. Individuals may choose the agency option for some services and the CDS option for

⁹ DBMD only.

others. Informed choice is important to the concept of consumer direction. An individual's case manager or service coordinator is responsible for ensuring the individual and their family understand the risks and benefits of the choice to direct their own services.

CDS is an option for certain services in the following programs:

- Waivers: HCS, CLASS, TxHmL, DBMD, MDCP.
- State plan services: PAS, CAS, PCS, CFC.
- Managed care programs: STAR+PLUS, STAR+PLUS HCBS, STAR Kids, STAR Health.

Service Responsibility Option

SRO is available only in Medicaid managed care. SRO is a hybrid of the agency option and CDS option in which an individual, the MCO, and a provider agency work together to provide the individual with increased control over the delivery of their services. In Medicaid managed care, services with the CDS option also have SRO.

In SRO, the MCO provides the individual or their authorized representative with a list of provider agencies participating in SRO. The agency then meets with the individual to understand their preferences and service needs. The agency and the individual select their direct care workers

and train the providers to meet the individual's preferences and needs. The providers are employed by the agency and the agency is accountable for all employer-related responsibilities like payroll and employer taxes. The individual selects and trains the providers and works with the agency to develop service back-up plans and to dismiss providers when necessary.

