

*The Texas  
Money Follows the Person Demonstration  
Operational Protocol*

Texas Health and Human Services Commission  
Texas Department of Aging and Disability Services

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## Section I, Part A – Project Introduction

### Introduction to the Texas MFP Demonstration

Texas was one of the first of four states to have a comprehensive working plan in response to the Supreme Court's *Olmstead* decision (June 1999). Then Governor George W. Bush issued an immediate response to the *Olmstead* decision with Executive Order (GWB-99, September 1999) which began Texas' Promoting Independence Initiative (Initiative). The Executive Order mandated a high-level report that analyzed Texas' long term services and supports system and required that policy and financing recommendations be made to the Governor and the Texas legislature in 2001, in order to be in compliance with the *Olmstead* decision.

The 77<sup>th</sup> Texas Legislature (2001) codified the report's recommendations in Texas law through Senate Bills (SB) 367 and 368; the report, itself, became Texas' original *Promoting Independence Plan* (Plan). This first Plan had approximately one hundred recommendations impacting all individuals who are aging and/or with a disability (physical, intellectual, developmental, behavioral) across Texas' health and human services system.

Every two years prior to Texas' legislative session (biennial), the human services system submits a revised Plan based on new recommendations from a stakeholders' oversight committee (the Promoting Independence Advisory Committee [Committee] – which meets quarterly). As of June 2016, there have been seven revisions to the original plan which now encompasses more than a hundred initiatives for change. The Plan has and continues to impact the state development of its long-term services and supports policy to provide individual choice and self-determination.

As part of the original Initiative and legislative action by 77<sup>th</sup> Texas Legislative Session (2001), two of the more major policy initiatives began, which have had lasting impact on state and national policy: (1) "Money Follows the Person" for individuals residing in nursing facilities (NF); and (2) the Promoting Independence priority populations for individuals with intellectual and developmental disabilities (IDD) residing in large (fourteen-plus bed) community Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and the state supported living centers (SSLCs).

These accomplishments were the result of strong advocacy from consumers and advocate organizations, informed providers, and strong governmental leadership. This coalition continues in its efforts to meet goals of the state's Promoting Independence Plan while the Promoting Independence Advisory Committee aggressively provides its advisory function.

## Money Follows the Person

Texas is one of the originators of the “Money Follows the Person” (MFP) financing policy and as of June 30, 2007 Texas had transitioned 13,337 individuals from nursing facilities to community-based services.<sup>1</sup> Texas’ MFP policy began on September 1, 2001 as a result of a rider to then-Texas Department of Human Services’ appropriations (DHS – this part of DHS is now part of the Texas Department of Aging and Disability Services). This rider allowed Medicaid-certified individuals who reside in a NF to access 1915 (c) waiver and other community services without being placed on an interest (waiting) list. Subsequent legislatures continued the rider and the 79<sup>th</sup> Texas Legislature (2005) codified the policy into law with House Bill 1867. Since the beginning of the policy, the state has understood the importance of a supportive infrastructure to assist individuals in their personal transition. These support programs and policies include:

- Transition to Life in the Community (TLC) funds: general revenue funds to assist an individual to pay for household and moving expenses that are not available under Medicaid.
- Transition Assistance Services (TAS): a \$2500 one-time capped allowable expense under the adult nursing facility 1915 (c) service array to assist an individual in paying housing down payments and the purchasing of household items in order to establish a community residence. Community Transition Teams (Teams): these are public-private regional community resource coordinating groups who work with individual and systematic barriers to community relocation; these Teams were established with the assistance of a 2002 Real Choice Grant.
- Relocation Contractors: this is a statewide network of contracted organizations who hire relocation specialists to help identify individuals in NFs who want to relocate back into their communities. Relocation specialists provide outreach, identification, facilitation, and housing navigation services to assist in the relocation, as well as post-transition follow-up activities.

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<sup>1</sup> In this document, MFP, sometimes called Promoting Independence, refers to the Texas response to Olmstead in which individuals living in nursing homes who receive Medicaid can request services in the community without being placed on a waiver interest list. The MFP Demonstration refers to the national program in which Texas receives administrative funds and enhanced match for certain services that assist individuals in relocating from institutions to the community.

- Housing Voucher Program: this program is administered through Texas' housing financing agency (Texas Department of Housing and Community Affairs) to provide Section 8 Project Access Vouchers for individuals leaving NFs.

*Amendment #5:*

*.With the addition of TAS to the Home and Community-based Services (HCS) waiver in November 2015, the service is available in the 1115 and all 1915(c) waivers.*

## Promoting Independence Priority Populations

The original Promoting Independence Plan (2001) mandates that individuals in state supported living centers or in medium (nine to thirteen) large (fourteen-plus) community ICFs/IID have expedited access to Texas' HCS 1915(c) waiver. Individuals residing in a SSLC may access HCS waiver services within six months of referral, while individuals residing in large community ICFs/IID may access community-based services within twelve months. Since these programs began, 1,031 individuals have moved from the state supported living centers and another 796 individuals have moved from large community ICFs/IIDs into HCS.

Individuals in large community ICFs/IID and state supported living centers must go through an annual "Community Living Options" (CLO) process to inform those residents of their rights and community options. This extensive process engages the individual and/or their legal guardian in a face-to-face meeting with facility staff to review their current status, and to help identify those individuals who want an alternative living arrangement to the institutional setting. The 80<sup>th</sup> Texas Legislature (2007) mandated that the CLO process be administered to state supported living center residents by the local intellectual and developmental disability authority (LIDDA) <sup>2</sup>. (see Glossary).

## Key Demonstration Objectives

MFP is not a new concept for Texas. Our extensive history with nursing facility MFP and relocation for individuals with IDD gives Texas both the knowledge and the infrastructure to successfully implement this *Operational Protocol* and to enhance the state's current efforts. Texas has six years of experience working with individuals in institutional settings, providing these individuals with the information and assistance they need in order to make an informed choice on where they want to receive their long

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<sup>2</sup> Name change required by

**HB 1481 82nd Texas Legislature, Regular session**

<http://www.capitol.state.tx.us/BillLookup/History.aspx?LegSess=82R&Bill=HB1481>

term services and supports. Texas has demonstrated its willingness to rebalance its system and has successfully pioneered many of the national efforts in community transition.

There have been many lessons learned during the past six years, which have provided the data on which to base this OP. The state has identified many of the barriers to a successful relocation. Texas will use the MFP Demonstration to respond to those identified barriers and to provide the necessary additional supports. The initiatives identified in the original OP included:

- Community behavioral health cognitive Adaptation training and substance abuse services
- Overnight support services<sup>3</sup>
- Post-transitional services; and
- Voluntary closure of nine-plus bed community ICFs/IID.<sup>4</sup>

As significantly, Texas understands the importance of a robust regulatory and quality management process. The state has implemented policies and procedures to ensure a safe environment so that individuals will receive quality community services. The state also understands, however, that an individual or their guardian may want to take certain risks in order for that individual to relocate back to the community. Texas strongly supports the principles of self-determination and that an individual with capacity or their guardian should have the final decision in the delivery of their services

The following are Texas' statements of fact that it will meet the four key demonstration objectives as outlined in statute. The statements of fact are categorized under three headings: *Ongoing Public Policy*; *Recent Legislative/Policy Action*; and *Demonstration Activity(ies)*.

***The state must address the four key demonstration objectives as outlined in statute in their project introduction. These objectives are to:***

- 1) Increase the use of home and community-based, rather than institutional, long-term care services;***

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<sup>3</sup> As of the March 2017 update of the OP, overnight support services are no longer a demonstration service. The take-up rate was low and the state decided to remove it from MFPD.

<sup>4</sup> While support for voluntary closure of ICFs/IID continues to be a goal of Texas rebalancing, the mechanism for shifting funds from institutional to community based settings depends on legislative approval.

## Increase in Use of Home and Community-Based Services

Texas has and will increase its use of home and community-based services by:

### Ongoing Public Policy

- Assisting relocation contractors to help identify individuals who want to relocate and facilitate that transition (see above).
- Proposing the continuation of the budgetary line item within DADS appropriation for MFP.
- Allocating 1915(c) waiver slots for individuals with intellectual and developmental disabilities who want to leave the SSLC system or large (fourteen-plus bed) community ICFs/IID.
- Dedicating line items in both the DADS and Health and Human Services Commission appropriations to help support community services and relocation activities (\$2.6 million).
- Contracting activities to help children relocate back to the community by supporting their biological parents or if that is not possible, establishing alternative families to assist the biological parents (Family-based Alternative program).
- Mandating through Senate Bill 368 (77<sup>th</sup> Legislature, 2001) the process of permanency planning for children in institutional settings to establish plans for relocation to the community and for subsequent six month reviews.
- Passing flexible nursing delegation rules.
- Maintaining the nation's only 1929(b) program, as part of its state plan entitlement services, which provides individuals with up to 300% of SSI with attendant services.

### Recent Legislative/Policy Action

- Expanding the MFP policy to allow children (0-21) with intellectual and developmental disabilities who are in NFs to access a HCS 1915(c) waiver.
- Increasing the individual cost cap for (c) waiver programs from 100 to 200 percent of the NF cost, and from 80 to 200 percent of the ICF/IID cost.
- Dedicating HCS 1915(c) waiver slots for children (0-21) who are aging out of Texas' Foster Care system.
- Dedicating NF 1915(c) waiver slots for children (0-21) who are aging out of Texas' EPSDT program.
- Implementing new legislation that will improve Texas' outreach and information process to individuals within its state supported living center system to inform them

of their community options (this is known as “Community Living Options,” an annual process, which will be conducted by the Texas’ Local Intellectual and Developmental Disabilities Authorities (LIDDA)).

- Expanding the long-term services and supports managed care system to include five services areas; individuals who meet the Supplemental Security Income (SSI) eligibility criteria will have access to 1915(c) nursing facility waiver services through a managed care system without having to be on an interest (waiting) list.
- Funding a specialized nursing rate in all of the state’s 1915(c) waivers and the 1115 waiver to assist individuals with ventilator needs to be able to relocate/remain in the community.

*Amendment #5: January 1, 2013 through January 2017*

- *Completing the legislatively directed statewide expansion of managed care long-term services and supports, replacing the Community-based Alternatives waiver program, to provide individuals residing in rural service areas, who meet the SSI eligibility criteria, access to the 1115 home and community-based waiver services without going on the interest list (September 1, 2014).*
- *Adding the legislatively mandated access to managed acute care services and related service coordination for individuals, age 21 or over, with intellectual or developmental disabilities who receive long term services and supports through one of the state’s 1915(c) IID waivers. (September 1, 2014).*
- *Increasing appropriations since 2010 to transition individuals from institutions to fee for service waiver and community attendant services, per legislation.*
- *Adding diversion opportunities for adults and children at imminent risk of institutionalization to community fee for service waiver programs, per legislation, since 2010.*
- *Added nursing facility services into managed care for individuals age 21 or older, per legislation. (March 1, 2015).*
- *Expanding the 1915(c) and 1115 home and community based waiver service arrays to include supported employment and employment assistance, delivered by an agency or through consumer direction (November 2014).*
- *Adding Cognitive Rehabilitation service to the select 1915(c) waivers and the 1115 service array (November 2014).*
- *Implemented Community First Choice in managed care and fee for service 1915 (c) waivers for individuals with intellectual and developmental disabilities, allowing the state to use the enhanced Medicaid match to provide community based services to individuals who are on interest lists for 1915 (c) waiver slots, effective June 1, 2015.*

- *Provided acute care and some long term services to children through a managed care model, effective November 1, 2016.*

## **Demonstration Activities**

- Introducing two new Demonstration services within the MFP Demonstration to provide additional community supports for individuals with behavioral health needs and for those who require overnight assistance.
- Including as part of the MFP Demonstration the activity of working with providers of nine-plus bed community ICFs/IID who want to close their facilities, take their Medicaid-certified beds off-line, and possibly become HCS waiver providers, which will offer those residents community options.
- Piloting, as part of the Demonstration, an Overnight Support Service, which will allow more individuals with complex needs and without informal supports, to relocate back into the community to receive long term services and supports.

*Amendment # 5: As of September 1, 2014, Overnight Support Service was discontinued.*

***2) Eliminate barriers or mechanisms, whether in the State law, the State Medicaid plan, the State budget, or otherwise, that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice;***

## **Elimination of Barriers and Flexible Use of Medicaid Funds**

The Texas Legislature has done the following to eliminate barriers that prevent or restrict the flexible use of Medicaid funds.

### **Ongoing Public Policy**

- Codified Texas' response to the *Olmstead* decision (Senate Bill 367, 77<sup>th</sup> Legislature, 2001) and acceptance of the Promoting Independence Plan, which provides among its many initiatives: (1) expedited access to HCS 1915(c) waiver slots for individuals with IDD (and provided additional funding for those slots), and (2) requires intensive community mental health services for individuals with three more admissions within a six month period into a state mental health facility in order to avoid further hospitalization.

- Codified (House Bill [HB] 1867, 79<sup>th</sup> Legislature, 2005) the MFP policy and established a dedicated line item in the DADS appropriations for MFP funding. The law states that all individuals who meet the eligibility criteria may relocate back into the community without having to be placed on a 1915(c) waiver interest (waiting) list.

### **Recent Legislative/Policy Action**

- Attached the following Riders to DADS appropriation (80<sup>th</sup> Legislature, 2007):
  - Rider 37 dedicates 120 HCS 1915(c) waiver slots for Fiscal Years 2008-2009 for children aging out of foster care and 180 slots for individuals leaving fourteen-plus bed community ICFs/IID;
  - Rider 41 will provide HCS 1915(c) waiver slots for children (0-21) who reside in NFs;
  - Rider 43 will provide IDD 1915(c) waiver slots for fifty children residing in eight-bed or less ICFs/IID; and
  - Rider 45 will increase individual (adult) cost caps for NF 1915(c) waiver services from 100 percent of the NF costs to 200 percent and for individuals with IDD who are accessing the HCS 1915(c) waiver from 80 percent of the ICF/IID cost to 200 percent.

#### *Amendment #5:*

- *Senate Bill 1, General Appropriations Act, 83rd Legislature, Regular Session, 2013, Article II, Special Provisions Relating to All Health and Human Services Agencies, Section 61 provided funds to increase the base wage rate agencies and consumer employers must pay attendants to \$7. 50 per hour in FY 2014, \$7.86 in FY 2015.*
- *Implemented on June 1, 2015, as directed by Senate Bill 7, 83rd Legislature, Regular Session, 2013, Community First Choice, a 1915(j) state plan option, in the managed care 1115 waiver and fee for service 1915(c) waivers for individuals with intellectual and developmental disabilities, allowing the state to use the enhanced Medicaid match to provide community based services to individuals who are on interest lists for 1915(c) waiver slots.*
- *House Bill 1, General Appropriations Act, 84th Texas Legislature, Regular Session, 2015, Article II added funding for Community IDD Services for Persons with Complex Medical and/or Behavioral Needs, including:*
  - *Crisis respite and behavioral intervention programs (\$18.3m GR / \$18.6m AF);*
  - *ICF/IID and HCS rate add-ons for individuals with high medical needs (\$5.9m GR / \$13.8m AF); and*



- *Intensive service coordination for state supported living center (SSLC) residents transitioning to the community (\$3.5m GR / \$8.2m AF)*

## **2016 Legislative/Policy Action**

- *House Bill 1, 84th Legislative session<sup>1</sup>:*
  - *expanded reserve capacity groups for the IID waivers to include children transitioning from general residential operations and individuals from state hospitals, resulting in a total of 1,261 slots for Promoting Independence related to the Home and Community Based Services (HCS) waiver (\$29.7m GR / \$81.8m AF), allocated as follows:*
    - *500 slots for movement from large/medium intermediate care facilities for individuals with an intellectual disability or related condition (ICF/IID);*
    - *216 slots for children aging out of foster care;*
    - *400 slots for prevention of institutionalization/crisis;*
    - *120 slots for movement of individuals with intellectual or developmental disabilities (IDD) from state hospitals;*
    - *25 slots for Department of Family and Protective Services (DFPS) children transitioning from general residential operations facilities.*
  - *Added 1,300 HCS slots to comply with federal preadmission screening and resident review (PASRR) requirements relating to individuals transitioning or being diverted from entering a nursing facility (\$29.1m GR / \$84m AF), as follows:*
    - *700 slots for persons with IDD moving from nursing facilities; and*
    - *600 slots for persons with IDD diverted from nursing facility admission.*
  - *As directed by a rider to the Appropriations Act, refinanced General Revenue funds to add capacity to one of the 1915(c) IID waivers to increase the opportunity for individuals on the interest list to receive a limited level of service while waiting on the full scale IID waiver slot to open.*
  - *House Bill 1, General Appropriations Act, 84th Texas Legislature, Regular Session, 2015, Article II, Special Provisions for all Health and Human Services Agencies, Section 43 increased the base wage for attendants to \$8.00 per hour in FY 2016.*

## Demonstration Activity

- Attached Rider 7 to the Special Provisions of the Health and Human Services Commissions (state Medicaid agency) appropriation which will allow enhanced matching dollars from the MFP Demonstration to be utilized to enhance community services and supports.

### **3) Increase the ability of the State Medicaid program to assure continued provision of home and community-based long-term care services to eligible individuals who choose to transition from an institution to a community setting; and**

## Continued Provision of Community-Based Services

The following actions increase the ability of the state Medicaid program to assure continued provision of community-based services.

## Ongoing Public Policy

- Submittal of the biennial Promoting Independence Plan (Plan) to the Governor and the Texas Legislature, which states the need for reduction and ultimate elimination of Texas' community interest lists in addition to scores of other recommendations to enhance the community-based long term services and supports system.
- Scheduled quarterly meetings of the Promoting Independence Advisory Committee (PIAC), which oversees the hundreds of initiatives within the Plan, makes additional recommendations for new initiatives, and provides overall oversight on the state's compliance to the *Olmstead* decision. Codification of the MFP policy into statute (see above discussion on HB 1867).
- Settlement of a lawsuit that requires the Health and Human Services Commission to request in its LAR a twenty percent reduction of the community interest (waiting) lists for the next two biennia (Fiscal Years 2010-2011 and 2012-2013).
- Codification of the MFP policy into statute (79<sup>th</sup> Legislature, 2005 – see above discussion on House Bill 1867).

## Recent Legislative/Policy Action

- Increased coverage within the long term services and supports managed care system which allows all individuals who are aging and/or with physical disabilities on SSI, and who meet the eligibility criteria, to receive 1915(c) waiver services.

- Inclusion of additional HCS 1915 (c) slots to address enhanced efforts to provide community options for individuals who want to leave the state supported living center system

#### *Amendment #5*

- *House Bill 1, 84th Legislative Session increased funding to provide for 3,040 waiver slots for individuals on waiver program interest lists (\$51.5m General Revenue (GR) / \$122.2m All Funds (AF), including:*
  - *104 slots for Medically Dependent Children Program ( MDCP)*
  - *752 slots for Community Living Assistance and Support Services (CLASS)*
  - *2,134 slots for Home and Community-based Services (HCS)*
  - *50 slots for Deaf Blind with Multiple Disabilities (DBMD)*

#### **Demonstration Activity**

- Inclusion of Rider 7 to the Special Provisions of the Health and Human Services Commission (state Medicaid agency) appropriation which will allow enhanced matching dollars from the MFP Demonstration to be utilized to enhance community services and supports.
- Inclusion of all individuals in Demonstration as part of the baseline information that is utilized in the development of the agency's Legislative Appropriation Request (LAR) which is used in building the state's two-year budget.
- Inclusion within this *Operational Protocol* that the state assures it will continue services to individuals who transition.
- Inclusion of an assurance within this *Operational Protocol* that the state will evaluate the success of the behavioral health and the overnight support services demonstration services to determine their inclusion in current state 1915(c) waivers for statewide services.

***4) Ensure that a strategy and procedures are in place to provide quality assurance for eligible individuals receiving Medicaid home and community-based long term care services and to provide for continuous quality improvement in such services.***

Texas has always had a strong commitment to quality for all its recipients of services. This commitment was enhanced through a three-year Real Choice Systems Change

Grant awarded by CMS in 2003 to improve quality in community-based programs. Two of the major accomplishments of the grant were the development of a systematic approach to gathering information on the experiences of individuals receiving services in the community and the first phase of the development of a Quality Assurance and Improvement (QAI) Data Mart.

## Quality Strategies and Continuous Quality Improvement (Ongoing Public Policy)

### **Annual Face-to-Face Surveys**

Each year, Texas conducts face-to-face consumer surveys to obtain information directly from the individuals receiving community-based services, and measure achievement of their goals and aspirations. Depending upon the characteristics of the individuals being surveyed, two different survey instruments are utilized.

Texas is a member of the National Core Indicators (NCI) project developed by the Human Services Research Institute. The NCI project is designed to assist member states (22 states) with developing performance and outcome measurement strategies for their programs. The project provides a nationally recognized survey instrument, the NCI Consumer Survey, which was designed specifically for people with intellectual and developmental disabilities. The survey contains multiple questions to calculate specific indicators that are grouped by four different domains: consumer outcomes, system performance, health, welfare and rights, and self-determination.

The second survey instrument Texas uses is the Participant Experience Survey (PES) developed by MEDSTAT Group, Inc. for CMS. The PES was designed to collect information directly from elderly and non-elderly adults with physical disabilities and divides questions into five domains: access to care, choice and control, respect/dignity, community integration/inclusion, and self-determination.

The results of these surveys are shared with internal and external stakeholders to identify experiences of the individuals receiving services, to develop intervention strategies and, to assist in program improvement activities.

*Amendment #5:*

*2016 Quality Strategies and Continuous Quality Improvement (Ongoing Public Policy)*

*DADS no longer conducts the Participant Experience Survey. For the IID population, the state:*

- o Conducts the National Core Indicators Survey;*
- o Collects and reports annually to CMS quality measures related to the 1915 (c) waiver assurances;*

- *Extended quality monitoring by state supported living center (SSLC) staff of community-based services for individuals transitioning out of an SSLC from 90 days post exit to one year.*

*Enhanced monitoring by LIDDA staff of services received by individuals who transitioned out of an SSLC. The state recently participated in a several state study using the National Core Indicators for the managed care population.*

## **Continuous Quality Management**

Texas also employs the process of continuous quality management (CQM) to determine whether its programs operate in accordance with CMS' approved design and meet statutory and regulatory assurances and requirements. CQM is one of the mechanisms to ensure individuals achieve desired outcomes, identify opportunities for program and service improvement, and ensure that public funds are spent efficiently and for the benefit of the people of Texas. The major activities are conducted by the following divisions:

- Regulatory Services (RS) Division. This division is responsible for the licensure and/or certification of nursing facilities, intermediate care facilities for individuals with intellectual disabilities, assisted living, adult day care facilities, and home health and hospice agencies. Surveyors monitor the performance of these providers by conducting routine surveys, inspections and complaint/incident investigations and require a corrective action plan if state violations and federal deficiencies are found. Follow-up surveys and inspections are conducted to ensure that the provider has effectively implemented any required corrective action plan. All surveys and inspections are unannounced and include an observation of the care of the individual.
- Provider Services (PS) Division. This division is responsible for conducting on-site contract monitoring visits to ensure providers are in compliance with program rules and to verify service delivery and payment. Provider complaint and payment histories are collected from a DADS database and reviewed prior to conducting the monitoring visits.
- Consumer Rights and Service (CRS) Unit. This unit maintains a complaint data base and receives complaints from applicants, individuals enrolled in Medicaid programs, or their families and representatives. Staff from the CRS unit will investigate the complaint and attempt resolution of it unless the complaint involves abuse, neglect, or exploitation of an individual receiving services. Complaints involving allegations of abuse, neglect, or exploitation are referred immediately to the Texas Department of Family and Protective Services (DFPS), the agency with

statutory responsibility for investigation of such allegations. Resolution of complaints not referred to DFPS are tracked and recorded in the CRS Complaint Data Base.

- Adult Protective Services (APS). APS is a division of Texas Department of Family and Protective Services within the Texas Health and Human Services Enterprise. APS is responsible for investigating allegations of abuse, neglect, and exploitation of adults who are elderly or those with disabilities, including cases in which a provider is alleged to have abused, neglected or exploited a participant. APS assigns one of four priority levels to complaints at the time of the complaint intake. APS complaint investigators must contact the alleged victim by phone within 24 hours of intake. The investigator may change the priority level as a result of the phone contact. APS must make the initial face-to-face contact with the alleged victim based on the priority level.

DADS is responsible for abuse, exploitation, and exploitation investigations of persons who are elderly and persons with disabilities or other residents living in facilities licensed by DADS.

*Amendment #5:*

#### *Continuous Quality Improvement*

*Senate Bill 711, 84<sup>th</sup> Legislative Session, expanded the scope and jurisdiction of Adult Protective Services (APS) Provider (formally APS Facility) program's jurisdiction to investigate abuse, neglect, and exploitation. These bills ensure continued State of Texas compliance with the Center for Medicaid and Medicare Services (CMS) requirements for the health and welfare of recipients of home and community-based services (HCBS). The bill (1) expanded the authority of APS to investigate, among other things, all home and community-based service providers whether providing services in a traditional or managed care service delivery model, (2) clarified and addressed the gaps and inconsistencies that resulted from evolving service delivery changes and changes in contracting arrangements, and (3) updated statutory language and requirements related to provider and agency responsibilities.*

*Individuals with complaints against an MCO can contact the STAR PLUS complaint email box or HHSC ombudsman.*

## **Demonstration Activities**

QAI Data Mart. Texas is advancing its work on its QAI Data Mart which will be a primary source of data for filing MFP Demonstration reports. The QAI Data Mart will compile data currently collected in multiple automated systems. Consultants have designed the data mart to produce standardized reports, as well as provide capability for ad hoc

reporting. The areas covered by the reports will include: participant demographics; services utilization; enrollments; levels of care; plans of care; consumer-directed options, critical incidents; abuse, neglect, and exploitation incidents; long-term services and support (LTSS) provider compliance and oversight; transfers; discharges; complaints, and recouplements. The system will have the capability to provide management reports at the participant level.

At least quarterly, Texas will compile reports regarding performance of the MFP Demonstration and provide them to program staff for review and appropriate action. Additionally, these reports will be presented to the MFP Demonstration Advisory Committee for their review and comment on the status of the MFP demonstration and program improvement activities.

- Quality of Life surveys: Texas will comply with the Demonstration's Quality of Life surveys as prescribed by CMS.

# 1. Case Studies

***Provide a detailed description, from a demonstration participant's perspective, of the overall program and the interventions for transition and rebalancing that the State proposes to use under the demonstration. The case study should walk the reader through every step of the proposed processes. These steps include, but are not limited to, the initial process of participant identification, processes that will occur prior to transition, those processes employed during the actual transition into community life and those processes that will be utilized when the individual has been fully transitioned into a home and community-based program.***

Before the Case Studies are presented, it should be noted that the issues/processes impacting the transition process for individuals who are aging and for those with physical disabilities are, for the most part, the same. Major relocation activities include: securing housing, establishing community supports, choosing the appropriate provider of functional supports, and helping the individual to (re)establish social networks. The different services/supports that an aging individual may require are: training on fall prevention; lack of many social or community supports because of the death of a spouse/friends; increased need of medical supports because of deteriorating health/disease progression; increased attention because of an initial fear of living alone after extended institutionalization; depression and other behavioral issues as a result of the aging process; supports for dementia and/or Alzheimer's disease; securing appropriate eyeglasses and/or hearing aids.

Texas will be utilizing existing 1915 (c) waivers as its community-based system and will employ current rules, policies, procedures, and assurances to CMS as program criteria. The transition from the MFP Demonstration back to the State Medicaid program should be relatively seamless for the individual unless he/she was receiving a demonstration service – however, the main service array should not vary.

Each individual enrolled in the MFP Demonstration will be re-assessed on an annual basis in order to determine ongoing eligibility. This renewal process is good for a year unless there is a significant change in the individual's condition. For the significant majority of MFP Demonstration participants this re-assessment will occur just prior to the end of the Demonstration period. For those individuals who left the Demonstration due to a hospitalization or other institutional placement, this re-assessment may occur somewhat off-cycle to the movement from the Demonstration to the regular state Medicaid program.



## Nursing Facility Case Study

### Client Characteristics

- *Name:* Milton Jones
- *Sex:* Male
- *Age:* 54
- *Diagnoses:* Broken Back with Paralysis of Lower Extremities
- *Date of Nursing Facility Admission:* January 20, 2005
- *Legal Status:* Legally Competent Adult
- *Current Residence:* STU Nursing Care, a 256 bed large nursing facility located in Amarillo, Texas

### Background

Milton is 54 years-old and resided in a nursing facility for nearly two years. Milton had been a long-haul truck driver for about ten years when he had an accident on an interstate highway during a winter blizzard in the Texas Panhandle. He sustained a broken back with paralysis in the lower extremities, and after a six week stay in a rehabilitation hospital, he was transferred to a nursing facility in Amarillo.

Before the accident, Milton rented a home in a small town outside of Marble Falls, Texas, a city approximately 600 miles from Amarillo. Milton had no immediate family and was also estranged from his ex-wife. Before the accident, he had monthly phone calls with his 22-year-old son who lived in Dallas.

After about eighteen months in the nursing facility, Milton felt he was too young to be in a nursing facility and desperately wanted return to Marble Falls or at least live closer to the community where his son could visit him more frequently.

### Learning about Community Options

When Milton first arrived at the nursing facility in Amarillo, he remembered hearing from a DADS eligibility worker about some community options that may be available. However, at that point, he had been in pain, and because he thought he was going to receive rehabilitation services in the nursing facility and then leave, he did not pay much attention. So after a year and a half, he started asking the nursing facility staff about leaving. This seemed difficult because he appeared to need 24-hour care and he could not walk or transfer himself very well.

One of his friends in the nursing facility who was getting ready to move suggested that Milton speak with the Ombudsman from the Area Agency on Aging (AAA) and the

relocation specialist, both of whom frequently visited the nursing facility. He had seen the Ombudsman talking with other residents and asked to speak with him. The Ombudsman gave Milton a brochure called "*Money Follows the Person to Community Living*" and contact information for the local relocation specialist, who is contracted by the state to specifically assist nursing facility residents, who want to relocate, and the Department of Aging and Disability Services (DADS) case manager.

In Texas, consumers are informed about community options when they apply for Medicaid. Nursing facility social workers, AAA Ombudsman, and relocation specialists are direct sources of information about services in the community.

### **Assessment for Transition Services**

Relocation specialists routinely check the Minimum Data Set (MDS) Q1A information provided to them by DADS to see who has expressed an interest in moving to the community. In this case, the referral came from the AAA Ombudsman's Office. Within a week of this referral, the relocation specialist went to the nursing facility to meet with Milton to verify his request, discuss his relocation needs, and conduct a relocation assessment. The relocation specialist also provided Milton with a brief description of the types of 1915(c) waiver services available and told him that a DADS case manager would provide more detailed information when the two met in the near future; the relocation specialist helped to facilitate that meeting.

The relocation specialist then began talking with Milton about the types of transition support he might want during and after his transition to the community. The relocation specialist said that they could re-visit the transition assessment as frequently as needed after relocation. The relocation specialist told Milton that this ongoing process was intended to support him through the transition; however, Milton would be making the decisions. He could use as much or as little relocation support as he wanted.

The relocation assessment identifies the following information:

- Personal data
- Medical conditions and professional care needs such as the need for physical therapy
- Previous home care arrangements (if any)
- Housing and neighborhood preferences
- Financial situation which would be important in securing housing
- Family supports that can be provided
- Transportation needs
- Public and private supports needed

- Assistive technology needs

During the relocation assessment, Milton requested to be able to live in a place where his son could visit and stay with him for several days. Milton also requested to be close to a grocery store, a bookstore because he enjoys reading, and would need transportation to medical appointments. The relocation specialist assisted Milton with contacting the local DADS office so he could request community-based services and begin the enrollment process.

A couple of days later, the DADS case worker contacted Milton to schedule a visit at the nursing facility to begin the application process for community-based services. The case manager discussed program guidelines, medical and financial eligibility criteria, and services for the various programs that were available to Milton. The case manager also informed Milton that he had several options for directing his services. He could select the consumer directed services (CDS) option where he is the employer of his attendant and could set the wages for his attendant within the rate set by the state. If he selected CDS, he would need to work with a financial management agency. Alternatively, Milton could select an option called the Service Responsibility Option (SRO) where he could select, train, and supervise his attendant but the direct service (home health) agency remained the employer of record. The final option discussed with Milton was one in which he could rely on the home health agency to find his attendant. The case manager discussed the advantages and disadvantages of each option. While Milton liked the idea of hiring his own attendant, he decided to start with the agency option and then check into CDS later.

Milton chose the Community-based Alternatives (CBA) program as it offered everything he needed including nursing services, personal attendant services, minor home modification, adaptive aids, transportation to medical appointments, and professional therapies like physical therapy and occupation therapy (see Glossary).

The case manager then provided Milton with a list of providers and asked him to choose a home health agency to complete the rest of the assessment. She told Milton that the next step was to meet with the home health agency and that she would fax the referral to the home health agency he selected so that they could complete the *Level of Care Assessment* for community services.

Milton met with his chosen home health agency to complete his *Level of Care Assessment* for community-based services and to develop his service plan. Three activities then had to occur: (1) the home health agency had to accept Milton's referral; (2) the DADS case manager had to verify that he had met all the eligibility criteria including medical necessity, financial eligibility, medical effective date, and (3) the services had to be identified in the service plan. Once these activities were accomplished, the DADS case manager notified Milton, the relocation specialist and the

social worker at the nursing facility to finalize discharge plans and arrange transportation to Marble Falls.

### **Service Coordination**

Prior to the move, Milton met with his DADS case manager, relocation specialist and others to develop a plan to ensure the success of his transition. Together they revisited Milton's goals and objectives for living in the community as well as the respective responsibilities of Milton, his community support and the staff supporting his transition.

Because of Milton's extensive functional and support needs, the DADS case manager also let Milton know that there are a number of community-based organizations that might help him resolve problems that might arise during the transition and throughout his enrollment in the CBA program. This additional community support comes through the regional Community Transition Teams (Team) that DADS originally established as part of a 2002 CMS Real Choice grant.

There is one Team in each of the DADS regions and they are comprised of public-private partners with representatives from: DADS, consumers, AAAs, Adult Protective Services, advocacy groups, housing organizations, long term services and supports providers, nursing facility staff, AAA Ombudsman, LIDDA, Mental Health Authorities, and other not-for-profit and for-profit organizations. The Team meets monthly to address specific barriers that prevent a nursing facility resident from relocating into the community, to ensure continued success, and promote effective transitions from nursing facilities back to the community. The Team also addresses systematic barriers within their communities.

One of the major barriers to Milton's relocation was his lack of community housing. In Texas, there are three sources of housing assistance that can help with making monthly rent payments: HOME rental vouchers; Tenant Based Rental Assistance (TBRA); and the Texas' Housing Voucher Program (HVP), which provides *Project Access* vouchers to persons leaving nursing facility settings. Each of these sources of housing assistance is from the U.S. Department of Housing and Urban Development to the state housing finance agency and local public housing authorities. Because of limited housing resources, relocation contractors help individuals fill out the paperwork for placement on waiting lists for every type of housing assistance program.

Because of the limited resources for housing assistance, it took several months to find housing to meet Milton's preference for enough space so his son could visit and that was also in the para-transit service area. Also, he did not realize that it would take so long to find a place to live that could accommodate his physical disabilities and that he could afford. Many of the housing options were not wheelchair accessible and did not have the kind of shower he needed. Everything was on hold until Milton could find a

place to live. During this time, his relocation specialist visited him every few weeks to give Milton an update on the housing situation.

While the relocation specialist was working to secure housing for Milton, the MFP Demonstration Project Director was meeting with the local public housing authority (PHA) to explain the Demonstration and need for dedicated housing vouchers for nursing facility residents who wanted to relocate. The Project Director provided training and educational materials on Medicaid and the availability of long term services and supports. He also discussed the opportunities provided through the Demonstration and how the Demonstration could benefit clients of the PHA. The state agency and the PHA signed a Memorandum of Understanding (MOU) detailing how the state agencies and the PHA would work together and the commitment of the PHA to dedicate ten vouchers specifically for Demonstration participants.

After three months, the relocation contractor was able to obtain one of these ten new tenant-based rental assistance vouchers for Milton.

Texas also offers two types of community transition supports to individuals who reside in nursing facilities and want to receive their long-term services and supports in a community setting. These services can be used for setting up a household in the community. Transitional Assistance Services (TAS) is provided under the Medicaid 1915(c) waiver and will provide one-time start-up funds of up to \$2500 to help an individual establish a community residence. Start-up funds available through TAS are not allowed for individuals relocating to Adult Foster Care or Assisted Living facilities. The start-up funds can be used for expenses directly related to moving, including but not limited to paying for moving expenses; housing deposits; utility deposits; cooking utensils; other moving-related expenses and household start-up costs.

Also, DADS administers a general revenue program named Transition to Life in the Community (TLC). The TLC program can provide funds for expenses that are not covered by Medicaid through TAS or other long-term services programs. TLC funding is considered a wrap-around activity to TAS.

Milton, the DADS case manager, the home health agency, and the relocation specialist, determined a discharge date from the nursing facility once the residence was established. During the intervening time, the DADS case manager helped Milton identify any household items, such as furniture, dishes, towels and bedding, and/or security deposits that he required to be bought through TAS/TLC. Finally, even though his new apartment was accessible, Milton needed to have a special shower chair before he could move; the home health agency provided the chair.

## **Post-Transition**

On the day of discharge and relocation, Milton's relocation specialist met him when he arrived at the apartment. Milton noticed that the kitchen was stocked with groceries and

he had a few sets of clothing in his bedroom. The DADS case manager and home health agency made sure that Milton's personal assistance worker reported to work at the same time Milton showed up at his new apartment.

Milton initially had difficulty with his nurse making visits on a regular basis. Concerns like this made him wonder if he could survive alone in his apartment. He discussed this with his DADS case manager, and the home health agency was able to meet his nursing needs on a regular basis. Before leaving, the relocation contractor gave Milton his telephone number. The DADS case manager also gave Milton her telephone number and the number of the home health agency in case Milton had any problems or questions that needed attention before her next contact; he was also told who to call in case of an emergency.

As indicated in his service plan, the direct services staff attends to Milton a few times a week as required, and the case manager periodically checks on Milton to ensure that he is adjusting to his new living arrangement and that the services authorized in his plan of care are being delivered.

However, one day, his direct service worker failed to show up as scheduled. When Milton tried to get himself in his wheelchair to go to the phone, he began to feel very dizzy and had to lie back down. For a few minutes he panicked and then remembered his Emergency Response System (ERS) device he received through the CBA program as part of his back up system. Milton followed the directions given to him by his service provider, and punched the button on the ERS device which was programmed to go to: (1) the home health agency emergency number and to (2) a neighbor downstairs who had volunteered to be unpaid support for Milton in an emergency. As part of the emergency backup plan, the neighbor had a key to his apartment. Within the next five minutes, he heard the neighbor unlock his apartment door and announce herself. Then the phone rang and the neighbor handed it over to Milton. It was the home health agency. Milton said that his worker had not shown up and that he needed the agency to send a back-up immediately. Within the next hour another attendant from the agency arrived.

The home health agency filed the incident on their complaint log and indicated the actions taken to remedy the situation and steps taken to prevent a reoccurrence. The complaint log was reviewed by DADS in their next on-site inspection.

Over the next three month period, the relocation specialist will visit Milton four times in the first month, two times during the second month and once during the third month. In between these visits, the relocation specialist will talk to Milton over the telephone on an as needed basis. Finally, the DADS case manager will visit Milton at least every six months unless circumstances warrant more frequent contacts.

## MFP ICFs/IID Case Study

### Client Characteristics

- *Name:* John Brown
- *Sex:* Male
- *Age:* 36
- *Diagnoses:* Moderate Intellectual Disability, Seizure disorder (controlled w/ medications), Schizophrenia (unspecified)
- *Level of Need:* LON 8
- *Date of Last Staffing (IDT):* August 16, 2006
- *Date of Last Community Living Options:* August 16, 2006
- *Legal Status:* Legally Competent Adult (Mother is actively involved in decision-making process.)
- *Current Residence:* ABC Place, a 90 bed large Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) facility located in Austin

### Background

John resided at ABC Place since graduating high school in 1990. At John's request, his mother is actively involved in his life, but is not his Legally Authorized Representative (LAR) or guardian. His mother was unable to control John's behavioral outbursts by herself, and sought a long-term care option that would provide John the structure, active treatment and behavioral support that she believed he needed. John participated in workshop activities where he earned money helping to assemble barbeque pits for a large local manufacturer. The workshop was located on the campus of his residence. His behavioral episodes of physical and verbal aggression were minimized over the years with the structure of the institutional setting. He received medication to control his seizure disorder, as well as to treat his schizophrenia.

### Learning About Community Options

At the time someone moves into a community ICF/IID or a state supported living center and at least each year thereafter, the resident is presented with information about community living alternatives. This is done through the Community Living Options (CLO) process that will be discussed in greater detail later in this *Operational Protocol*. The CLO process identifies the following factors:

- The person's personal preferences for living arrangements.

- The LAR/family preferences for living arrangements.
- Identification of medical, behavioral/psychiatric issues.
- Quality of life issues.
- The recommendation of the LIDDA if an alternative living arrangement has been requested (see Glossary for definition of LIDDA).

John and his mother indicated through the annual CLO process that John wanted to move into the community with one of his friends at his annual staffing. His Qualified Intellectual Disability Professional (QIDP), who was an employee of the community ICF/IID, contacted the local LIDDA in late August 2006 to refer him for community placement. John wanted to live in a house with his friend and maybe one other person. John's mother was concerned about his safety and well-being and therefore they agreed that John would need staff with him 24 hours. John and his mom wanted to be involved in hiring the staff in his home. Also, he was interested in having a yard because he likes plants and wanted to grow a garden. In addition, John indicated that he wanted to have a job where he could earn more money. He indicated he is interested in wood working and taking care of animals.

Once it was determined that John was interested in moving out of his current home, John asked his QIDP to invite a staff from the LIDDA to his planning meeting. At the meeting, the LIDDA service coordinator provided John and his mother with an *Explanation of Services and Supports* (Appendix F). Based on the preferences of John and his mother, his name was registered on the Home and Community-based Services (HCS) waiver interest (waiting) list. Under the Texas Promoting Independence Plan, individuals living in large community ICFs/IID have expedited access to the HCS 1915(c) waiver within a twelve month period.

### **Choosing a Provider**

On February 1, 2007 DADS notified the Austin/ Travis County LIDDA that a HCS slot was available for John. Concurrently, DADS faxed ABC Place a courtesy notification that John would be offered an HCS slot soon. On February 3, 2007 Austin/Travis County LIDDA mailed a letter to John, in care of his mother, at his local address and his mother's home in Austin, Texas. John's mother responded by phone to the LIDDA that she and John were ready to pursue living options in the HCS program. Because the case manager at the LIDDA had already been involved in the planning process for John, she was aware of his desires for his life and scheduled an appointment with John and his Mother.

On the day the meeting was held, many of John's and his mother's questions were answered regarding how to work with providers to develop his needed supports and services. The contact names and telephone numbers of local area HCS providers were



furnished to John's mother and they both co-signed a *Verification of Freedom of Choice* form that establishes their choice of the HCS Medicaid 1915(c) waiver program rather than the ICF/IID program. It was at this meeting that John and his mother were informed about the MFP Demonstration and presented with the *Informed Consent* document which they signed.

John's mother emphasized that this decision was contingent on locating a provider that would develop the services and supports that were contained in John's plan. John and his mother also wanted to make sure they would be involved in choosing the staff that supported him. Because John had developed some long-term relationships with staff that had worked with him at ABC Place, he was interested in having these staff members come and work for him in his new home.

John and his mother reviewed available options and over the next couple of weeks they visited with three different providers of HCS services in the Austin area. John's mother had no problem with contacting each provider by calling the local numbers provided, and setting appointments to meet the provider's representative in person. In two instances, John and his mother were able to actually visit the home that was being considered for John and his friend.

One of the issues that developed over this period was the need for coordination between John's team and his friend's team so that they could live together. John's friend Tim was receiving his HCS slot two weeks after John got his slot. In two of the homes that were considered, John and Tim needed to choose a third roommate in order to afford the rent. In the third instance, there was no home to visit but the provider was helpful in describing how services might be provided in an apartment setting or in a foster/companion setting. John's mother indicated to the LIDDA service coordinator that she preferred for John to live outside her home, and the providers all assured her this was possible with the proper structure and support to meet his needs.

### **Transition Process**

After meeting with HCS provider XYZ Inc., John and his mother determined that he wanted to receive HCS services from this provider. John's mother notified the LIDDA service coordinator who then scheduled a time to meet with John, his mother and the provider to put a plan in place for John's move. The person centered plan was updated and a proposed Individual Plan of Care (IPC) was developed and reviewed by John and his Mother. In the meeting John and his mother signed a *Documentation of Provider Choice* form and then, with XYZ Inc.'s case manager, once again reviewed his needs and desires for successful community living. This information was recorded on the IPC which is the instrument that identifies all formal Medicaid 1915(c) waiver and informal services and supports that an individual wants and needs to live in the community. The IPC was signed by all parties to indicate agreement.

John and his mother were informed that there were three different types of living arrangements under the HCS 1915(c) waiver: (1) one's own home or family home, (2) a foster/companion care setting, or (3) a residence with no more than four individuals who receive similar services. John chose to go into a three-person Residential Support Services (RSS) residence with his friend Tim and another person. John was also referred to the Department of Assistive and Rehabilitative Services (DARS) for supported employment. At the request of John and his mother, the HCS service coordinator facilitated the development of services that addressed John's needs and desires once the enrollment was approved by the state office. The HCS service coordinator then helped implement the services in John's plan, and continued to be a part of John's team by participating and monitoring the plan to ensure all of the agreed upon services were being provided.

### **Post-Transition**

Following admission into the HCS program, XYZ's case manager became responsible for ongoing coordination of John's services and needs. John's IPC included the 24-hour residential supervision and support inherent in a residential supportive services 3-bed residential living arrangement. The big difference for John was that he was able to interview and participate in the hiring of all the staff that worked with him, including the nursing services that are used to supervise his medication administration, the psychological services to address behavioral needs, and the supported employment services to assist him on the job at the local cabinet shop.

In addition to John receiving twenty-four hour residential supervision, his XYZ case manager ongoing contact with him to see how he is getting along at the residence and to respond any of his issues with his relocation.

After two months, John's attendant began arriving late and one day did not show up as scheduled. The group home staff notified his program provider because they are contractually required to maintain a system of service planning and service delivery that is continuously responsive to changes in the individual's condition, abilities, needs, and personal goals as identified by the individual or the individual's LAR. Additionally, the program provider must ensure the continuous availability of trained and qualified employees or contractual service providers to deliver the required services as determined by the individual's needs. Once notified of the situation, John's back-up service provider arrived quickly.

This situation was reported to the DADS complaint hotline number by his mother. DADS intake desk reviewed the information, made a priority assessment on its risk to health and welfare, and used the information during its onsite inspection.

## Managed Care/Behavioral Health Case Study

### Client Characteristics

- *Name:* Gloria Cox
- *Sex:* Female
- *Age:* 46
- *Diagnoses:* Chronic Deep Vein Thrombosis, Type II Diabetes Mellitus, Schizoaffective Disorder
- *Date of Last Nursing Facility Admission:* August 3, 2007
- *Date of Last Living Options:* August 16, 2006
- *Legal Status:* Legally Competent Adult
- *Current Residence:* HIJ Nursing Facility, a 168 bed nursing facility located in San Antonio, Texas

### Background

Gloria Cox is a 46-year-old female with a diagnosis of Schizoaffective Disorder, Bipolar type, who was on psychotropic medication since she was 20 years old. Prior to admission to a nursing facility, Ms. Cox lived with her boyfriend Milan, who had Schizophrenia for approximately 20 years. Ms. Cox relied on Milan to help her with daily activities since she began to have difficulty ambulating due to chronic deep vein thrombosis in both of her legs, and Type II diabetes mellitus. Milan also assisted her by doing laundry, grocery shopping, housekeeping and cooking.

Ms. Cox required insulin injections twice a day and took other medications, but needed assistance with her daily insulin injections as well as filling her pillbox each week. Ms. Cox required some assistance transferring to and from bed, or bath, to her walker and assistance with appropriate toileting. She was able to bathe, feed and groom herself with prompting, although she often dressed inappropriately before entering the nursing facility (e.g., wore several shirts or dresses at once, wore a parka in hot weather, wore stained or unwashed clothing). Ms. Cox also needed assistance dressing herself and in particular putting on shoes.

Ms. Cox was placed in the nursing facility by her mental health caseworker and Adult Protective Services after Milan was admitted to the psychiatric hospital approximately eight months ago. She had bouts of depressed mood that was intensified with her inability to ambulate well. Ms. Cox had no family members or friends who remained involved in her life, other than Milan, who came to visit her at the nursing facility once a

week. Milan attended church regularly and attempted to get Ms. Cox to go with him, but she refused to go saying that she was uncomfortable around crowds. Ms. Cox also had a history of self-medicating with alcohol and street drugs before entering the nursing facility.

DADS uses Minimum Data Set 2.0 (MDS) data to help determine who might want to transition from a nursing facility back into the community. Item Q1A of Ms. Cox's initial MDS screen indicated that she wanted to leave the nursing facility to live in the community and also indicated that she had prior behavioral health issues.

### **Learning About Community Options**

The MDS data is transmitted to the local relocation contractor which triggers a visit by the relocation specialist. The relocation specialist verified that Ms. Cox wanted to move back into the community, and that she had a prior history of mental health and substance abuse issues. Ms. Cox indicated that her goal was to live with Milan again some day, but feared that he could be hospitalized again, thus causing her to return to the nursing facility. Ms. Cox also indicated that she wanted Milan involved in her life, and wanted him to take part in helping her with her decisions about the move.

After the visit, the relocation specialist obtained her informed consent and referred Ms. Cox to the local DADS Star+PLUS Support Unit (SPSU) to begin her relocation to community services (see Glossary). The SPSU was contacted rather than a DADS case manager because San Antonio is in a managed care catchment area where long term services and supports are provided through the Star+PLUS Medicaid 1915(c) waiver.

Ms. Cox was informed that Star+PLUS is a Texas Medicaid managed care program designed to provide health care, acute and long-term services and support through a managed care system. The 1915(c) waiver program provides a continuum of care with a range of options and flexibility to meet individual needs. The program increases the number and types of providers available to Medicaid clients.

Participants of Star+PLUS select a managed care organization (MCO) from those available in their county, and receive Medicaid services through the managed care health plan. Through these managed care health plans, the Star+PLUS program combines traditional health care (such as doctor visits) and long-term services and support, such as providing help in the individual's home with daily activities, home modifications, respite care (short-term supervision) and personal assistance.

Service coordination is a main feature of Star+PLUS. Medicaid clients, their family and providers work together to help clients coordinate health, long-term and other community support services.

## **Choosing a Service Provider**

The SPSU provided Ms. Cox with information so that she could select a Star+PLUS MCO. Concurrently, the relocation specialist assisted Ms. Cox in transitioning her Supplemental Security Income (SSI) benefits to the community setting. She chose a MCO who assigned a service coordinator who assisted her in developing a service plan.

The service coordinator also convened a staffing by the transition team. The transition team included representatives from: Ms. Cox, the local mental health authority, the relocation contractor, the Organization for Screening, Assessment and Referral (OSAR – the substance abuse services provider), the public housing agency and local advocates. The transition team helped to initiate all the supporting activities to make Ms. Cox's relocation to the community a reality.

The service coordinator visited Ms. Cox in order to have assessed her needs, and discuss the types of home and community-based services that were available. Shortly after the assessment, the service coordinator and Ms. Cox agreed on her individual plan of care. The plan included peer support, home and community-based 1915(c) waiver services through the Star+PLUS 1915(c) waiver program, Cognitive Adaptation Training (CAT) and screening/assessment for substance abuse services through the OSAR.

The CAT services were selected because of the unique behavioral health needs of Ms. Cox. CAT services are rehabilitation services that address the cognitive deficits of the individual, and assist the person to establish their environment and provide tools to support skill acquisition including improvement in medication adherence, personal care and activities of daily living, social skills, and integration into the community.

The service coordinator also discussed the three types of consumer directed service options available to Ms. Cox (see discussion under the Nursing Facility Case Study). Ms. Cox did not feel she was ready to select consumer directed services but wanted to reconsider the option at a later date

While Ms. Cox wanted to move back with Milan, who was now living in the community again, she realized that to increase the success of the transition that she would need support in maintaining her sobriety and independence. After discussing possible living arrangements with the relocation specialist, she chose to live in a licensed adult foster care home until she is ready to live in an apartment of her own with Milan. Ms. Cox visited the foster home where the foster care provider explained where she was to sleep, the types of activities available and the meal options such as joining the family in the dining room or eating her meal in her room. Ms. Cox indicated that she was pleased with the living arrangement, the foster family and the family pets.

## Post Transition

As part of her individual plan, Ms. Cox received personal care assistance, adaptive aids, physical health care and counseling through Star+PLUS. Ms. Cox was assisted in locating a local pharmacy that delivers medication. Her service coordinator helped her arrange for dental services through the local Health District, assisted Ms. Cox in completing an application to a local transportation provider in order to receive transportation to and from her medical appointments, and assisted her in learning how to use the public transportation system to attend a support group for individuals recovering from addiction. She also received CAT from the CAT provider to assist her in organizing her environment and learning to perform daily activities, such as how to do her own laundry, dressing appropriately for the season, and managing her medications.

The CAT provider worked closely with Ms. Cox's personal care provider to ensure that cognitive adaptation is understood and supported by her personal care attendants. The relocation specialist helped Ms. Cox understand how to work with the members of her support team and to advocate for herself. The service coordinator ensured that Ms. Cox's continued to receive the health, long-term services and supports, and behavioral health services she required.

After training and assistance from the CAT provider, Ms. Cox was ready to move from the group home setting to her own apartment. The relocation specialist monitored Ms. Cox's progress over the training period and when she was ready to move, identified suitable, accessible and subsidized housing for Ms. Cox's consideration. Ms. Cox decided at this time to live with Milan, so they were shown three available apartments and they selected a furnished apartment which was closer to a grocery store and her physician's office. The relocation specialist assisted Ms. Cox in relocating, and visits her and Milan periodically to ensure that they are getting along well.

Ms. Cox continued to receive her acute and long term services and supports through the Star+PLUS program, and once she was settled and functioning on a day to day basis in her new home, Ms. Cox began receiving psychosocial rehabilitative services through the local mental health authority to help maintain and further her independence.

Ms. Cox's Star+PLUS service coordinator periodically monitors her situation to ensure that she is receiving the health and long term care services described in her plan of care and that these services are working for her. When changes are required, or once every 12 months (whichever is less) the Star+PLUS service coordinator revises the plan of care, with the active involvement of Ms. Cox, her providers and Milan, to reflect Ms. Cox's evolving needs and preferences. The local mental health provider reviews and updates Ms. Cox's psychosocial rehabilitation plan every 90 days, coordinating their activities and services with the individual plan developed by the Star+PLUS service coordinator. Finally, the relocation specialist visits Ms. Cox periodically both in person

and by telephone. Ms. Cox is provided with phone numbers for each of these organizations/individuals and told what to do in an emergency.

### **Loss of Medical Necessity**

Ms. Cox significantly improved during the Demonstration period as the result of better coordinated care through the managed care organization and being the recipient of CAT services. Ms. Cox became a compliant individual and took her medications in a timely manner. Both her behavioral and medical health improved to such a degree that upon her annual reassessment, as she prepared to transition from the Demonstration to regular STAR+PLUS services, she was denied medical necessity (MN). The decision to deny MN was appealed to a Fair Hearing judge who upheld the decision.

The STAR+PLUS service coordinator worked with Ms. Cox and Milan, and evaluated her for attendant services. Ms. Cox met the functional eligibility criteria for that service, and the service coordinator worked with her and the attendant care provider agency to develop a service plan. It was determined that Ms. Cox would receive fifteen hours per week of attendant services. The consumer directed services (CDS) option was offered but declined. Ms. Cox continues to receive her acute care services through STAR+PLUS, while the local mental health provider continues to review and updates her psychosocial rehabilitation plan every ninety days coordinating activities with the managed care service coordinator.

Ms. Cox is thriving in the community and increasingly is becoming more engaged in social interactions. She is considering re-entering the workforce and has requested information about Texas' Medicaid Buy-In program, and has contacted the Texas Department of Assistive and Rehabilitative Services about vocational training.

## ICFs/IID Voluntary Closure Case Study

### Client Characteristics

- *Facility Name:* ABC Place
- *Facility Owner:* Texas Concepts
- *Facility Type:* 90 bed Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID)
- *Location:* Austin, TX
- *Year Built:* 1957
- *Client Name:* Jim Johnson
- *Sex:* Male
- *Age:* 52
- *Diagnoses:* Profound intellectual disability, cerebral palsy, and diabetes
- *Legal Status:* Mother is legal guardian

### Background

ABC Place was built in 1957 and was converted to a large (fourteen-plus bed) community ICF/IID in 1976. It is owned and operated by Texas Concepts who also owns several six bed ICFs/IID in the Austin area and operates Home and Community-based Services (HCS) 1915(c) waiver service programs. ABC Place serves all persons diagnosed with an intellectual or developmental disability, but specializes in medically fragile/medically complex individuals. The facility had a current census of 67 and over the past several years has found it increasingly difficult to meet their goal of a census with of at least ninety percent capacity. This decreasing census, combined with the increasing cost of maintenance for a fifty year old building, has resulted in ABC Place operating with a deficit for three consecutive years.

Jim moved to ABC Place in 1982. He was mobile in a manual wheelchair with assistance from a helper. Due to severe contractures, Jim required total physical assistance with dressing, grooming, meals, hygiene, and other activities of daily living. Jim's mother, Eunice, his legal guardian, was and continues to be active in his life.

ABC Place's parent company, Texas Concepts, approached DADS in October 2007 to discuss the feasibility of a voluntary closure of ABC Place due to severe financial hardships associated with continued operation. Texas Concepts indicated that rather than just close their doors and relocate their current residents, they wanted to follow the



voluntary closure protocol associated with the Money Follows the Person Demonstration (MFP Demonstration).

Representatives from Texas Concepts and the Administrator of ABC Place met with DADS State Office representatives on November 21, 2007, to discuss the closure process.

In Texas, the cost of operating a HCS residential facility is more expensive than operating a large community ICF/IID. This higher cost has been an obstacle to the overall reduction of beds in the large community ICF/IID program through voluntary closure. To minimize this obstacle, Texas will use its enhanced Federal Medical Assistance Annual Percentage (FMAP) to help off-set the costs associated with the closure of a large ICF/IID.

Texas Concepts indicated to DADS that the largest barriers to voluntarily closing this facility were: 1) meeting the requirement of overall cost-neutrality to the state; and 2) maintaining operations (utilities, mortgage, staff salaries, etc.) during the closure period as the census and revenue declined.

DADS advised Texas Concepts to begin contacting all ABC Place residents/ guardians/ legally authorized representative (LAR) to inform them of the possibility of a facility closure, and to complete an updated *Community Living Options* (CLO) instruments on all current residents (as described elsewhere in the Operational Protocol, the CLO is a formal mechanism where the individuals and/or family member or legal guardian and the facility have a meeting to discuss the individual's current status and review all community options).

## **Learning about Community Options**

Management of ABC Place invited all residents and their family members/LARs to a meeting on November 14, 2007 to discuss the possibility of closing ABC Place and what the impact would be for the residents. Upon receiving this notification, Eunice Johnson, Jim's mother, was extremely distressed and resistant to the thought of uprooting Jim from his home of 26 years and feared there would be negative physical and emotional consequences for Jim in a new environment.

At the November 14, 2007 meeting, the administrator described the proposed process for closure and how it would impact the residents. She presented the following information:

- Residential living options available to the residents.
- Community Living Options (CLO) process to be conducted prior to the closure which included the:
  - Updating of the CLO documentation.

- Identification of the proposed timelines for the closure and relocation of residents.
- Overview and scheduling of visits to the various living arrangement options and various providers
- Documenting informed choice related to living arrangement and choice of service provider.
- Description of the relocation assistance to be furnished by the provider.
- Provider assurances that the facility would remain in compliance with regulations during the closure process and ensure appropriate and adequate staffing during the closure.
- Provider intention to continue as a provider of ICF/IID services and whether the provider's plan included the conversion of ICF/IID services to Home and Community-based Services (HCS).
- Provider assurance to furnish written and verbal notice to each individual and the individual's legally authorized representative (LAR) or family at least thirty calendar days prior to the facility closure. The notice included a description of assistance that was available from the provider and the LIDDA during the relocation process, along with contact information. In addition, the provider assured all residents that they would cooperate with the applicable LIDDA to assist individuals in making an informed choice.

At the conclusion of the meeting, the residents and/or their family members/LARs had the ability to meet with their Qualified Intellectual Disability Professional (QIDP) to discuss any additional issues or concerns. Shortly after the meeting, Jim's mother/guardian was contacted by Jim's QIDP and an updated CLO instrument was completed which provided information of possible residential options. Ms. Johnson indicated at that time that she was most comfortable with Jim residing in a large community ICF/IID and was very angry about the closure.

### **Final DADS – Texas Concepts Negotiation**

On January 20, 2008, representatives from Texas Concepts and ABC Place met again with DADS Central Office staff to discuss voluntary closure of the facility. DADS requested that Texas Concepts present preliminary information regarding where their residents would relocate and a budget for closure.

The following information was presented at this meeting:

- ABC Place's census was 67 and 48 of those individuals indicated that if ABC Place should close, they wanted to pursue HCS residential placement.

- Forty-eight of these individuals chose the Residential Support Services (RSS) or Supervised Living (SL) model available in HCS due to medical complexity and need for intense supervision.
- Twelve individuals indicated that they were aware of their options and chose to live in a different large community ICF/IID facility.
- Seven individuals expressed interest in a small (six-bed) ICF/IID group home placement.
- ABC Place provided DADS with potential Individual Plans of Care (IPCs) for those individuals interested in HCS residential placement so that cost neutrality considerations of the closure could be determined.

DADS and Texas Concepts were able to successfully negotiate an agreement on the terms for voluntary closure of ABC Place in order to safely and properly discharge all residents, transition the residents, and cease operations. The state would use part of its enhanced funding to support residents in their relocation to community services. In addition, facility closure would occur on May 1, 2008 with all services, including appropriate staffing, to be provided by the facility until all residents had relocated.

On February 1, 2008, ABC Place formally notified all residents/ guardians/ LARs that ABC Place would be closing effective May 1, 2008. The local LIDDAs for all affected residents were also notified. The LIDDAs began contacting residents/ guardians/ LARs to complete *Verification of Freedom of Choice* forms and ensure education of all living options.

### **Choosing a Provider**

During the months of February, March and April 2008, provider agencies were chosen by the residents, and living arrangements were secured. This was a very difficult time for Jim and his mother and their anger about the closure continued to grow.

One of the QIDP's scheduled a follow-up meeting with Jim and his mother in order to gain a better understanding of their concerns, and provide further information on the various living options available for Jim. The QIDP: (1) provided a list of residential housing options available under the HCS waiver program; (2) provided a listing of ICFs/IID options; (3) explained the services available under each of these living arrangements; and (4) offered to help to set up appointments to visit any of these facilities. Jim and his mother finally began to feel that someone was listening to them.

After this meeting, Jim's mother wanted to know more about the Residential Support Services (RSS) option under HCS. RSS allows the individual to live in a three-bed or less group home with twenty-four hour on-site staff. The QIDP met with Jim and his mother again, and discussed the RSS model with them; they agreed to visit a number of places. Ms. Johnson indicated that she was pleased with the services provided by the

staff at ABC Place and requested that Jim be able to do an overnight visit at one of Texas Concepts' RSS homes. Jim's QIDP arranged for this visit to occur.

Following this visit, Jim and his mother decided that his needs could be met in an HCS environment, and requested RSS placement with Texas Concepts. A case manager for Texas Concepts met with the family and Jim's IDT from ABC Place to create his Individual Program Plan. Over the course of the next two months, Jim was encouraged and assisted to make numerous visits to HCS group homes to become more acclimated to the setting prior to his move. On April 16, 2008, Jim was officially discharged from ABC Place and admitted to his new home in the community.

The QIDP further reassured Jim's mother by telling her that if Jim desired to return to the ICF/IID program, the request would be made to Jim's case manager. The case manager would notify the Local Intellectual and Developmental Disability Authority (LIDDA) of the request so that Jim's level of care/level of need assessment would be updated, and submit that request. On acceptance to an ICF/IID, the service coordinator would provide assistance and direction for Jim's transition from waiver program services back to an ICF/IID.

Please refer to the *Transition Process* portion of the MFP ICFs/IID case Study as the process is exactly the same.

### **Transition Process**

As per agreement with DADS, the majority of resident discharges occurred during a one month period (April 2008) to lessen the fiscal impact associated with a declining census. Direct service staff from ABC place was offered employment with Texas Concepts ICF/IID group homes and HCS programs. Thirty nine individuals who chose HCS services selected HCS programs affiliated with Texas Concepts. These residents and their families indicated that familiarity and long-standing relationships with staff members were important factors in choosing Texas Concepts' programs.

During the transition process, ABC Place kept the residents/LAR/Guardians informed of the closure process and advised them that their staff were available to answer questions and offer assistance. Please refer to the transition process portion of the *MFP ICF/IID Case Study*, as previously described because the process is exactly the same.

### **Post-Transition**

Please see the *MFP ICF/IID Case Study* for a description of the post-transition process. The only difference between that case study and the voluntary closure case study is that many of the employees of ABC Place were chosen by the individuals transitioned to provide their services in the new living arrangement. The reason for this is because

many of the direct services staff from ABC Place chose to work for Texas Concepts HCS program.

## 2. Benchmarks

**Provide a list of proposed annual benchmarks that establish empirical measures to assess the State’s progress in transitioning individuals to the community and rebalancing its long-term care system. The first two benchmarks were specifically required under the MFP Demonstration.**

### Required Benchmark One – Persons Transitioned

**The projected number of eligible individuals in each target group of eligible individuals to be assisted in transitioning from an inpatient facility to a qualified residence during each fiscal year of the demonstration.**

*Amendment # 5: See WFPB for FY2017, Populations Transitions Chart, for actual and anticipated transitions 2012 through 2016.*

*In 2013 and 2014, Texas expected to transition 1200 per year.*

*In 2015-2016, Texas expected to transition 1350 individuals each year.*

*In 2017, Texas expects to transition 781 individuals.*

*Amendment # 5: update supersedes previous projections. Transitions from ICFs are dependent upon legislative approval. We anticipate a reduced number of transitions from ICFs because the legislature is not currently approving transfer of funds from institutional to community settings.*

**From FY 2011 forward, Texas will assist 1362 individuals, per year to relocate from the following types of qualified institutions:**

- Nursing facilities
- Community ICFs/IIDs that voluntarily choose to close
- *Medium and Large Community ICFs/IID*
- *State Supported Living Centers (SSLCs)*

### MFP Target Groups FY 08 – FY 11

MFP Demonstration Enrollment	Target Group	FY08	FY09	FY10	FY11	FY12	FY13	FY14	FY15	FY16	
											TOTAL
Number of individuals relocating from medium & large community ICFs	IDD	200	325	375	375						1275

and SSLCs, including children under the age of 22											
<b>Number of individuals relocating from ICFs/IID because of closure</b>	<b>IDD</b>	42	94	94	237						<b>467</b>
<b>Number of individuals relocating from nursing facilities</b>	Elderly	157	157	157	388						<b>859</b>
	Physical Disability	118	118	118	292						<b>646</b>
	<b>Sub- Total</b>	<b>275</b>	<b>275</b>	<b>275</b>	<b>680</b>						<b>1505</b>
<b>Number of individuals relocating from nursing facilities with behavioral health needs</b>	Elderly	29	29	29	29						<b>116</b>
	Physical Disability	21	21	21	21						<b>84</b>
	<b>Sub- Total</b>	<b>50</b>	<b>50</b>	<b>50</b>	<b>50</b>						<b>200</b>
<b>Number of individuals relocating from a nursing facility and receive Overnight Companion Services</b>	Elderly	11	11	11	11						<b>44</b>
	Physical Disability	9	9	9	9						<b>36</b>
	<b>Sub- Total</b>	<b>20</b>	<b>20</b>	<b>20</b>	<b>20</b>						<b>80</b>
<b>Total MFP Demonstration Enrollment</b>		<b>587</b>	<b>764</b>	<b>814</b>	<b>1362</b>						<b>3527</b>

*Amendment No. 3 revisions for this benchmark have increased the number of cv relocations for each target group, include all community ICFs/IID that close regardless of size, and add children under the age of 22, a Texas Promoting Independence Priority Population, as an eligible person for the Money Follows the Person Demonstration. The changes to enrollment estimates in years 2008-2010 are to correct mathematical errors (i.e. in year 2008 the total was reported as 572 individuals but should have been 587).*

*Texas has been very successful with the ICF/IID voluntary closure target group but at*

*the time of Amendment #3 of the OP, there are no new applicants. Accordingly, the revised estimate is based on 237 individuals relocated through the voluntary closure target group in 2011 and another 100 in 2012. After 2012, Texas will revise these estimates annually during the supplemental funding request.*

The original application estimated that there would be a total of 2616 individuals participating in the MFP demonstration. The original Operational Protocol estimated that 3135 individuals would participate in the MFP demonstration. This is because the 80<sup>th</sup> Texas Legislature (2007) directed DADS to enhance its efforts in communicating community options with residents (intellectual and developmental disabilities) of the state supported living center system. This renewed effort is known as the “Community Living Option Information Process” and was legislated through Senate Bill 27 (80<sup>th</sup> Legislature, Regular Session, 2007). Texas believes that this renewed effort will increase the number of individuals with IDD who will want to participate in the MFP Demonstration.

Finally, after the CMS review of the Operational Protocol regarding question number 8, number of ICF/IID beds taken off-line, the estimate was reduced to 2999 because DADS’ original voluntary closure benchmark did not take into consideration that approximately thirty percent of people leaving a ICF/IID will choose to move to another ICF/IID rather than community services.

Initial MFP Proposal. The original application estimated that 2,616 individuals would transition over the five year demonstration period. Of this total, it was estimated that 1,400 individuals would transition from nursing facilities and 1,216 would transition from ICFs/IID.

Operational Protocol Submission. For reasons identified in the preceding question, the Operational Protocol was increased to 3,135 individuals (a 519 increase). The estimated nursing facility transitions remained the same (1,400) while the ICFs/IID transitions increased to 1,735 (which include the dual diagnosis of 70 individuals).

Revised Submission. As Texas was reviewing CMS’ responses to the Texas Operational Protocol, the State found a few other areas that it wanted to clarify/revise. First, the number of individuals transitioning as a result of voluntary closure of an ICF/IID was reduced by thirty percent (see response to the previous question). The next change pertains to the number of individuals transitioning from nursing facilities. The total remains the same at 1,400. However, review of historical program information reveals that 42.9 percent of nursing facility relocations are by individuals under the age of 65. Accordingly, the “physical disability” nursing facility population was increased from 537 to 600 individuals while the number of 65+ decreased from 1007 to 800.

For clarification purposes, the “Mental Illness” target population remains the same at 200 individuals and is included within the nursing facility transition target population.



The “Dual Diagnosis” population of seventy individuals should have never been listed as a separate category because it is part of the category of individuals with intellectual and developmental disabilities. These seventy have been combined with the ICF/IID population that will move into the Home and Community-based Services (HCS) waiver.

Texas will be using the additional dollars allocated in the initial CMS grant award. The revised budget to reflect the revisions in the number of people estimated to be in the MFP Demonstration can be found at Appendix I.

## **Required Benchmark Two – Qualified Expenditures for HCBS**

### ***Qualified expenditures for HCBS during each year of the demonstration program.***

The following benchmarks document Texas’ projected expenditures for fiscal years 2008-11 for community-based long-term services and supports programs. These are Medicaid expenditures and do not include Title III, IV, XX or state general revenue programs. These projected expenditures are shown in the table below. Program descriptions for state entitlement services are provided in the glossary and descriptions for 1915(c) waiver services are provided in the *Benefits and Services* section of this *Operational Protocol*.

Texas’ legislature meets on a biennial basis beginning the second Tuesday in January of odd-numbered years. The Legislature appropriates a two-year budget with the fiscal year beginning on September 1st.

The state agencies can not predict what the Legislature will appropriate beyond the current biennium (FYs 2008-2009). Therefore, that is why the figures for FY 2010 and FY 2011 are the same as for FY 2009. The FY 2009 figures will be the base numbers for the FY2010-11 biennium. The new budget-writing cycle will begin in the spring of the even-years prior to the start of a new Legislative session. Staff will present information during the preparation of the new Legislative Appropriations Request (LAR).

The appropriations, built on forecast and case load models, are expected to be expended on Texas’ home and community-based programs and, therefore, should be considered “qualified expenditures” for the purposes of the MFP Demonstration. The Texas Legislature only appropriates dollars that it believes will be qualified expenditures based on the state agencies Legislative Appropriation Request (LAR). Texas will prepare to build its Fiscal Years 2010-2011 biennial LARs in the spring 2008 for the consideration of the 81<sup>st</sup> Texas Legislature (January 2009 – May 2009). Again, the state agencies will utilize historical data, demographic growth, caseload projections and forecasting models to build the LARs. The dollars in chart provided are our best estimations on proposed qualified expenditures.

<b>Texas HCBS Appropriations (X000)</b>	<b>FY2007 Baseline</b>	<b>FY2008</b>	<b>FY2009</b>	<b>FY2010</b>	<b>FY2011</b>	<b>FY2016</b>	<b>FY2017</b>
Managed Care Entitlement HCBS (Star Plus)	\$ 190,932	\$304,003	\$317,136	\$317,136	\$317,136		
Primary Home Care (PHC)	\$ 450,356	\$409,608	\$418,350	\$418,350	\$418,350	\$16,567	\$17,018
Community Attendant Services (CAS)	\$ 312,930	\$344,412	\$350,324	\$350,324	\$350,324	\$638,889	\$659,148
Day Activity & Health Services (DAHS)	\$ 99,886	\$95,484	\$96,871	\$96,871	\$96,871	\$7,881	\$8,083
Community-Based Alternatives Waiver (CBA)	\$ 415,252	\$417,836	\$429,497	\$429,497	\$429,497		
Home and Community-Based Services Waiver (HCS)	\$ 455,182	\$533,150	\$603,821	\$603,821	\$603,821	\$1,081,380	\$1,211,979
Community Living Assistance and Support Services Waiver (CLASS)	\$ 103,805	\$132,291	\$142,600	\$142,600	\$142,600	\$246,822	\$265,013
Deaf-Blind Multiple Disabilities Waiver (DBMD)	\$ 6,339	\$7,703	\$8,088	\$8,088	\$8,088	\$13,584	\$14,771
Medically Dependent Children Program Waiver (MDCP)	\$ 21,464	\$41,744	\$46,554	\$46,554	\$46,554	\$44,114	\$45,484
Consolidated Waiver Program (CWP)	\$ 3,798	\$4,214	\$4,214	\$4,214	\$4,214		

Texas Home Living Waiver (TxHml)	\$ 7,488	\$8,201	\$8,201	\$8,201	\$8,201	\$63,457	\$67,542
Money Follows the Person (MFP) Promoting Independence (PI) Initiative	\$ 72,268	\$75,341	\$82,097	\$82,097	\$82,097	\$52,772	\$52,627
Managed Care (Star Plus) Waiver	\$ 114,141	\$190,146	\$197,880	\$197,880	\$197,880		
Program of All-Inclusive Care for the Elderly (PACE)	\$ 25,749	\$29,779	\$29,806	\$29,806	\$29,806	\$38,728	\$38,728
Total	\$ 2,279,588	\$2,593,913	\$2,735,440	\$2,735,440	\$2,735,440		

At a minimum, the DADS and the Health and Human Services Commission will be requesting a 20% increase in (c) waiver appropriations for SFY 2010-2011 and 2012-2013 per a lawsuit settlement. However, the ultimate amount of the final appropriations is the sole decision of the Texas Legislature.

The figures presented in all of the Benchmarks for capitated programs indicate the long term services and supports expenditures; they do not include the acute portion. The long term services and supports portion of the capitated rate is based on historical and encounter data for long term services and supports. Furthermore, all information regarding the (c) waivers is for community-based long term services and supports.

*Amendment # 5: Added appropriations for FY2016-2017 biennium.*

### **Benchmark Three – Individuals Served through Behavioral Health**

Texas is proposing two new demonstration services for individuals who have co-occurring behavioral health issues (a mental illness or substance abuse) and want to relocate from a nursing facility (NF) to a community residence of their choice. The demonstration services will provide additional community supports during the pre-transition and post-transition phase of an individual's overall relocation. The two new supportive services will be *Cognitive Adaptation Training (CAT)* and *Adult Substance*

*Abuse Treatment Services (ASATS)*; each service will be explained in more detail in the *Demonstration Services* section of this *Operational Protocol*. These services will be provided in the nursing facility when appropriate, and in the community upon transition.

These demonstration services are being proposed as a pilot project within the larger context of the overall Demonstration. The pilot will be limited up to fifty individuals per year who are current NF residents in the San Antonio service delivery area. If this pilot is successful, then Texas will consider an amendment to the 1915(c) waivers to make these demonstration services available statewide.

An additional benefit of this pilot will be the extensive training of community direct care and professional workers in CAT skills. This training will be generalized to populations at-large, thereby assisting individuals not in the official Demonstration pilot. The benchmark number of 145 is less than the maximum we hope to serve because, given the complexity of the population and care delivery systems which must be coordinated and the delay in grant implementation due to receiving CMS OP approval, there may be less individuals served in the initial years. However, the MFP demonstration budget is based on serving 200 individuals, which is our goal.

<b>FY</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>
Target	20	35	40	50	100	200	225	250	250	75
Actual	13	55	119	159	240	291	226	208	192	

*Amendment # 5: Added targets and actual numbers enrolled for CY 2012 through CY 2017.*

**Benchmark Four – Annual Change in the Number of Licensed ICFs/IID Facilities and Certified Beds Taken Off-Line.**

Texas will work with providers of nine-plus bed community ICFs/IID who voluntarily want to close their facilities. Texas will work with these providers to take those certified beds off-line and provide HCS 1915(c) waiver community service options. Those residents will be given several options on where they want to move.

Based on previous DADS experience, over seventy-five percent of individuals in nine-plus bed community ICFs/MF choose a small group home as their preferred HCS waiver living arrangement. This living arrangement is more expensive than residing in a nine+ bed ICF/IID. This cost differential has always been an obstacle for some providers who want to downsize or close their facilities and become HCS providers;

Texas currently requires that any conversion not exceed the cost of community-based services. For purposes of this Demonstration, Texas will utilize the Demonstration's enhanced matching funds to assist with the transition infrastructure costs (non-room and board) from institutional to community-based services. Additionally, the term "cost-neutral" does not have the same connotation as used by CMS for its 372 reports.

*Amendment #5: The target number of ICF/IID beds taken offline and the decrease in certified beds identified in the semi-annual reports for 2012 and beyond were added to the narrative:*

<b>Licensed Medium and Large Community ICFs/IID's</b>	<b>FY 2012</b>	<b>FY 2013</b>	<b>FY 2014</b>	<b>FY 2015</b>	<b>FY2016</b>
# Beds taken offline	50	150	50	50	50
Accumulated % Decrease In Certified Beds	45%	50%	55%	60%	65%

<b>Licensed Medium and Large Community ICFs/IID's</b>	<b>FY 2008</b>	<b>FY 2009</b>	<b>FY 2010</b>	<b>FY 2011</b>
# Beds at End of Fiscal Year (FY 07 end of year = 2368)	2308	1691	1451	1365
Actual	2368	2278	1661	1421
Accumulated % Decrease In Certified Beds	2.53%	28.58%	38.72%	42.36%
Actual	0%	3.8%	29.86%	39.99%

### **Benchmark Five – Public Housing Authorities and Housing Related Issues**

The Texas Department of Housing and Community Affairs (TDHCA) is the state housing finance agency and a public housing authority. TDHCA allocates funding of federal housing funds/programs to local Public Housing Authorities (PHA) in non-participating jurisdictions throughout the state. PHAs in larger communities receive funding directly from the U.S. Department of Housing and Urban Development (HUD); there are 475

PHAs in Texas. There is no central state oversight authority and PHAs develop their own programs and priorities through their local Consolidated Housing Plans.

Until recently, Texas' health and human service agencies and PHAs have had very little interaction on housing issues. Governor Rick Perry's Executive Order RP-13 established TDHCA as a member of the Promoting Independence Advisory Committee (PIAC), which oversees Texas' response to the Olmstead decision. In 2002, TDHCA began administering approximately thirty-five "Project Access" housing vouchers for individuals who transition from institutions to a community living arrangement. It was at this time that DADS and TDHCA began the process of collaborating on a number of housing issues.

One result of this collaboration materialized last year when the PIAC approached TDHCA to request an increase in funding for housing assistance during the development of their Consolidated Housing Plan. TDHCA responded favorably by increasing annual funding for Tenant-Based Rental Assistance (TBRA) vouchers from \$800,000 to \$2,000,000.

These recent activities of the PIAC and TDHCA have brought attention to the continued need for health and human service agencies and advocates to work closely with the state and local PHAs. The efforts necessary to increase the stock of affordable and assessable housing and rental assistance must come through mutual cooperation, identification of housing need and education by all parties involved. Because of the increased attention of preparing this *Operation Protocol*, TDHCA is preparing a request to its Board to increase the number of Project Access vouchers from thirty-five to fifty.

The MFP Demonstration Project Director will act as the housing liaison for the Health and Human Services Enterprise housing related issues; the Enterprise is comprised of the Health and Human Services Commission and its four operating agencies: DADS, the Department of State Health Services, the Department of Assistive and Rehabilitative Services, and the Department of Family and Protective Services. Furthermore, Texas will build upon its recent preliminary successes to establish more comprehensive working relationships with its state housing finance agency and its PHAs. Texas will begin this process with the following activities:

### ***Development of a Housing Inventory/Registry***

DADS will work with the TDHCA, the Texas Council on Developmental Disabilities, United Cerebral Palsy of Texas, and the Texas Low-Income Housing and Information Services to develop a housing inventory that will be linked on each agency's website. Individuals interested in looking for affordable housing will be able to search these websites. These activities will begin in 2007 and will be an ongoing effort to provide the following information from state and local PHAs and public and private owners of rental stock. The inventory/registry will include:

- Number of affordable housing units in their inventory and accessible units.
- Number of housing vouchers currently available and the number dedicated to individuals with disabilities.

### ***Training Activities***

DADS, in conjunction with its partners, will:

- Collect and distribute basic information on housing and housing plans. Information collected and shared will include: the most recent Consolidated Housing Plan and Annual Action Plan to identify priorities for HOME, Low Income Housing Tax Credit, Community Development Block Grant and other programs used to develop affordable housing.
- Develop a Computer Based Training (CBT) curriculum for PHAs regarding the HHS Enterprise home and community-based services. This project will begin in state fiscal year 2008.
- Create a Housing Advocacy E-mail Distribution list to distribute housing related information. As an example, federal Notice of Funds Availability (NOFA) and draft housing/action plans will be distributed in a more expedient manner.
- Provide linkages to the DADS Promoting Independence website for individuals who want more information about Texas' Public Housing Authorities (housing plans, rental application requirements, housing availability, etc.).

The following measurable activities will act as sub-measures for the overall housing benchmark.

### ***Number of New Vouchers***

Texas is very reluctant to establish specific outcomes regarding activities for which it has no control, such as housing stock/vouchers. However, while Texas' intention is to surpass the following measure, a very modest outcome measure for the MFP Demonstration is established below and , which is based on activities currently being achieved in preparation for full implementation. Texas will review this benchmark each year to revise the number upward based on our expected success.

*Amendment #5: In the past, this benchmark reported on housing vouchers and units set aside by Public Housing Agencies for occupancy by MFPD participants.*

*As of June 2016, this benchmark will also include units occupied by MFPD participants under the Section 811 Project Rental Assistance (PRA) housing program. The 811 PRA program provides subsidized rental housing units for*

individuals with disabilities. Pursuant to an agreement between the Health and Human Services Commission and the state housing agency - Texas Department of Housing and Community Affairs (TDHCA) - some of these units are dedicated to "target populations". The target population includes individuals participating in the MFP Demonstration. The target for CY2016 and remaining years is 10 vouchers/units per year.

<b>Benchmark</b>	<b>FY 08</b>	<b>FY 09</b>	<b>FY 10</b>	<b>FY 11</b>	<b>FY 12</b>	<b>FY 13</b>	<b>FY 14</b>	<b>FY 15</b>	<b>FY 16</b>
<b>Number of new units/vouchers dedicated to the MFP Demonstration</b>	15	20	25	30	10	10	10	10	10
<b>Actual</b>	70	101	150	133	20	90	72	0	13

**Target Out-of-Compliance PHAs**

*Amendment #5: This benchmark ended 2011.*

DADS will target PHAs that are out of compliance with HUD performance standards to help them understand HHS Enterprise long-term services and supports programs, and obtain support for providing housing opportunities for individuals wanting to move from institutional care settings. The number of contacts and status of discussions will be reported annually.

<b>Targeting Out of Compliance PHAs</b>	<b>FY 2008</b>	<b>FY 2009</b>	<b>FY 2010</b>	<b>FY 2011</b>
Number of Out-of-Compliance PHAs Visited Per year	5	5	5	5
Actual	0	1	3	0



### **Visit the Ten Largest PHAs in Year 1**

*Amendment #5: This benchmark ended 2011.*

DADS will visit the ten largest public housing authorities in Texas to provide them with education and information on the current Promoting Independence Initiative and the MFP Demonstration.

	<b>FY 2008</b>
<b>Visit 10 Largest PHAs</b>	
Number of Large PHAs Visited Per Year	10

### **Visit Twenty-Five PHAs Per Year**

*Amendment #5: This benchmark ended 2011.*

After the ten largest PHAs are visited in Year 1, DADS will go to at least twenty-five additional housing authorities per year to provide them with education and information on the current MFP Initiative and the new MFP Demonstration.

<b>Visit 25 PHAs Each Year</b>	<b>FY 2008</b>	<b>FY 2009</b>	<b>FY 2010</b>	<b>FY 2011</b>
Total Number of Additional PHA Visits Per Year	0	25	25	25
Actual	00	35	33	27

### **Review and Comment on PHA Consolidated Housing Plans**

*Amendment #5: This benchmark ended 2011.*

The Promoting Independence Advisory Committee will review the TDHCA draft Consolidated Housing Plans/Annual Action Plan (CHP/AAP) and provide comments on increasing need for housing opportunities for senior citizens and individuals with disabilities. Each year, the PIAC will also review at least three other CHP/AAPs to help prepare advocates for their own review and comments at public hearings of housing authorities.

<b>Consolidated Housing Plans</b>	<b>FY 2008</b>	<b>FY 2009</b>	<b>FY 2010</b>	<b>FY 2011</b>
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Number of PHA Consolidated Plans Reviewed/Commented Per Year	4	4	4	4
Actual	5	9	10	6

### 3. CMS 100 Percent CMS Administrative Project Funding

The Centers for Medicare and Medicaid Services has provided Texas with 100 percent Administrative funds for the following projects:

#### 1. Relocation Contractor Training

The scope of services for Relocation Contractors includes requirements for coordination with other community organizations, better defines the identification and assessment process, continued focus on post-relocation follow-up activities, working with community partners and being involved with Demonstration activities. Relocation contractors will be required to target Medicaid eligible nursing facility residents with complex needs by definition of the Demonstration.

In the past, training provided to Relocation Contractors was limited to one or two key relocation contractor administrative staff. Texas is proposing extensive three day training for both relocation contractor administrative staff and their relocation specialists. The curriculum will include but not be limited to: guardianship; working more extensively with Local Intellectual and Developmental Disability Authorities and Mental Health Authorities; transportation; housing navigation; MDS 3.0 Section Q referrals, working with families or other community supports.

In addition to specific training for Relocation Contractors, funds will be used to provide other types of training that benefit individuals/organizations in the relocation process. One such training is for Community Transition Teams (CTTs) on issues and activities associated with relocating from a nursing facility. DADS regional staff is responsible to organizing CTT meetings in each of the eleven service regions (statewide coverage) and attendance is open to any organization involved in relocating an individual from a nursing facility. Organizations represented in CTT meetings include relocation contractors, nursing facility social workers, both fee-for-service and managed care service coordinators, local ombudsmen, adult protective services staff, Area Agencies on Aging and local housing authority representation.

#### *Amendment 5:*

*Traditionally, this budget category was used for training for relocation contractors. In 2012, CMS approved the removal of "Relocation Specialists" as the funds needed to be used for various other training activities. Funds from this budget category will be used to provide training to Relocation Specialists, Local Contact Agencies, Community Transition Teams, LIDDAs, Local Mental Health Authorities, Managed Care Service Coordinators, and nursing facility staff. Regional conferences will be held for all parties associated with the Money Follows the Person relocation process as well as meetings for stakeholders and training*

related to implementation referral agent and service coordinator roles in HUD Section 811 PRA.

## **2. Outreach and Technical Assistance**

Public Housing Authorities. These funds will be used to technical assistance to Public Housing Authorities (PHAs) in an effort to expand the stock of affordable, accessible, and integrated housing (units and vouchers), develop and print Demonstration brochures for each of the target populations, and increase our education and assistance to relocation contractors.

In an effort to expand the housing stock for prospective Demonstration participants, funds were requested to attend the annual conference of the Texas National Association of Housing and Redevelopment Officials (TxNAHRO) as a vendor. TxNAHRO membership is made up of key executives and staff from PHAs.

*Amendment # 5: Outreach funds will also be used to provide information on self-direction at informational meetings across the state and to create informational brochures designed to encourage nursing facility staff to assist in transitioning residents.*

## **3. Housing Specialists**

This pilot project will create four positions that will be contracted through Aging and Disability Resource Centers (ADRCs) in four different DADS service regions (two urban and two extra-urban/rural area of Texas). If successful, a new funding request will be submitted to CMS to expand the program statewide. Housing Specialists will focus their efforts on opportunities to increase the availability of affordable, accessible, and integrated housing options for individuals transitioning from an institutional setting to the community. Housing Specialists will attend PHA meetings, review and provide public comment on housing plans, assist Relocation Contractors in securing housing for Demonstration participants, and attend local meetings with organizations such as: PHAs; city/county housing planning departments; Community Transition Team; working with local developers/housing providers and support Aging and Disability Resource Centers (ADRCs).

*Amendment # 5: The Housing Navigator program assists local communities increase the overall inventory of accessible, affordable and integrated housing. CMS originally approved this project for \$1,150,000 per year (24 ADRCs x \$50,000 each) through 2015 plus an additional \$25,000 for training (\$1,175,000 total) to expand the HN program statewide. Only eight new ADRCs were added instead of the originally projected 10, for a total of 22 ADRCs statewide.*

#### **4. Local Contract Agency**

As a result of the new MDS 3.0, Section Q, funds were approved to implement a pilot project to establish ADRCs as statewide Local Contract Agencies (LCAs) for nursing facility residents who will be spending down their resources and would become eligible for the Demonstration. Nursing facility residents identified for referral by the new MDS 3.0 Section Q would be referred to one of the LCA who will provide them basic information about community options and opportunities for relocation back into the community. All Texas nursing facilities will be provided direction for which ADRC to contact.

The state has contracted this function with ADRCs to act as a statewide “virtual system navigator” and assist consumers by: (1) providing options counseling; (2) exploring community options; and (3) facilitating access to services, programs and resources that will assist in the individual’s relocation from nursing facility back into the community.

The counselors are responsible for providing preliminary identification of data needed to establish formalized tracking systems and communication networks. In addition, they would also provide information for the eventual development of a procedure manual and training information. This function is separate from our current relocation activity and will assist individuals who do not meet the criteria to be served by the relocation contractor.

#### **5. Workforce Development and Quality Management**

Business/Research Analyst. This position will develop a relocation database for use by relocation contactors. The database will be designed to transmit secure MDS Q data to relocation contractors and facilitate reporting and analysis of monthly reporting. This position will also manage, maintain, and enhance Demonstration reporting, prepare monthly, quarterly, and semi-annual reports to CMS and provide data to DADS sister agency, the Department of State Health Services (DSHS), regarding the Demonstration Behavioral Health Pilot. This position will free up approximately 25-35 percent of the Demonstration Project Director’s work load which will be redirected to higher level policy and program management and PHA outreach activities.

*Amendment #5 Update: Beginning in CY 2016, this position was renamed Database Developer/Business Analyst.*

#### **6. Relocation Contractor Program Quality Management Specialist**

With the expansion of relocation contract catchment areas and an increase in the number of anticipated nursing facility relocations, this position will be responsible for the

day to day activities associated with management, oversight, and technical assistance to relocation contractors. This position will develop relocation contractor policy and procedure, training manuals, data systems, contract monitoring and program analysis for quality management and improvement of the program.

## **7. Behavior Health Pilot**

DSHS will contract for functions which collectively total 3.4 FTEs. The functions will facilitate sustainability of effective aspects of the MFP Behavioral Health Pilot (BH Pilot), provide policy recommendations and programmatic improvement, administer the BH Pilot in expanded service areas, and promote / disseminate effective practices relating to community transition for adult nursing facility residents with behavioral health (mental health and / or substance abuse) conditions. Functions will include:

- analyzing qualitative and quantitative data on processes and outcomes in the MFP BH Pilot to guide process improvement and inform policy recommendations;
- identifying, documenting and codifying nursing facility relocation and community living challenges for people with behavioral health conditions;
- identifying, documenting and codifying effective community relocation and community support practices for this population in Texas and other states;
- identifying and developing the mechanisms to disseminate effective relocation and community support practices throughout the State (examples might include: written guidance, practice manuals, technical assistance sessions, etc.);
- developing written policy options for financing, procuring and administering demonstration behavioral health services in the Texas Medicaid system
- developing written policy options for integrating behavioral health; demonstration services into the Medicaid-funded long term care system and for effectively coordinating behavioral health services with long term care and acute care systems;
- identifying eligible individuals and conducting recruitment for the BH Pilot in order to increase total number of enrollees; and
- implementing and administering the BH Pilot in a different service area.

The FTE equivalents include functions for Quality Assurance and Programmatic Improvement (.75 FTE), Quantitative Data Collection (.25 FTE), a Behavioral Health Specialist (1.0 FTE), and Administration and Policy Specialists (1.4 FTEs)

*Amendment # 5: This project merged with the behavioral health pilot described in item #13.*

## **8. Workforce Development Program Specialist**

This position provides ongoing and future development efforts regarding the LTSS workforce. The Health and Human Services Commission along with DADS undertook a year-long study assisted with a stakeholder advisory committee on issues pertaining to community-based direct service workers (DSW). There are many recommendations that require the ongoing support of a dedicated staff person. The Demonstration has been a vital part of this process and has funded a “realistic job preview video” from its rebalancing fund.

The position will be dedicated to the expansion and greater efficacy of the Consumer Directed Services for all of Texas’ 1915(c) Medicaid waivers and oversight and implementation of DADS and the Texas Health and Human Services Commission (HHSC) workforce initiatives, including but not limited to recruitment, retention and quality of the LTSS workforce.

*Amendment # 5: Texas continues to support efforts to recruit and retain a qualified direct service workforce. We shifted from hiring a specialist to funding projects that may more directly impact individuals and agencies seeking qualified direct service workers. In CY 2017, several projects will create training modules and materials related to topics identified by DSWs as training needs including working with individuals with mental health issues, substance abuse, or dementia. In addition, administrative funds will be used to provide regional trainings on trauma informed care, person-centered thinking and consumer directed services. In addition to training, funds will be used to sponsor a forum on DSW issues and to fund collaborations on the local level between local workforce development boards and managed care organizations and other local partners.*

## **9. LIDDA Program Specialist.**

This position is to facilitate communication with LIDDAs, providers and state supported living centers concerning individuals who are relocating into community programs from nine or more bed community based ICFs/IID facilities or from state supported living centers. The position has responsibility for:

- Tracking of the status of movement of individuals from facilities being voluntarily closed because of funding from Money follows the Person or being closed involuntarily because of regulatory actions.
- Tracking of the status of individuals referred for community placement from state supported living centers.

- Facilitating problem solving for individuals.
- Providing routine status information to DADS management staff.
- Providing quality assurance for enrollment and CMS reporting issues related to the Demonstration.
- 
- Development of policy and procedure related to the voluntary close of community ICFs/IID.

*Amendment # 5: This project ended and the functions were folded into the Enhanced Community Coordination Project, described below.*

### **10. State Supported Living Center Community Living Specialists**

In order to comply with some of the provisions referenced in the Department of Justice (DoJ) Settlement Agreement (inserted below as T.1.a, T.1.b.1 and T.1.b.2) and supported by the United States Supreme Court's Olmstead decision (June, 1999), the SSLCs must provide residents, legally appointed representatives (LARs)/actively involved family members, and facility staff with educational opportunities to become knowledgeable of community supports and services that can be used to assist with the relocation of residents from the SSLC to a community setting with services through Home and Community Services (HCS) 1915(c) Medicaid waiver. Three DoJ agreements are:

**T.1.a.** Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's Legally Authorized Representative(LAR), that the transfer is consistent with the individual's Personal Support Plan, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.

**T.1.b.1)** The Personal Support Team will identify in each individual's Personal Support Plan the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The Personal Support Team will identify the major



obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.

**T.1.b.2)** The SSLC shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.

- To help accomplish these activities twenty four he Community Living Specialist's will be hired to conduct the following activities:
- working under the general supervision of the Assistant Commissioner of State Supported Living Centers;
- performing complex consultative work and resource identification in the geographic areas assigned to the twelve state supported living centers and Rio Grande State Center in coordination with the Demonstration;
- scheduling and conducting on-site training to SSLC staff, residents, LARs, and family members regarding community relocation processes, relocation planning, Community Living Option Information Process (CLOIP) discussions, etc.
- consulting with the facility Qualified IID Professionals (QIDPs) regarding the personal support team's identification of needed supports and services for individuals referred for alternate placement, identification of barriers to alternate placement, and initialization of programming to overcome the identified barriers.
- participating and serving as a resource to the personal support team members in planning meetings related to community placement referrals, CLOIP issues, relocation planning meetings, etc.
- working with the facility Admissions/Placement Department with the coordination of facility-sponsored, community awareness educational opportunities including: Provider Fairs, community tours, in-service training, etc.

In addition, the Community Living Specialist will:

- assist with monitoring and assessment of individuals in a SSLC as they relocate into a community setting;
- conduct on-site monitoring of the HCS and ICF/IID programs;

- compile a Resource Guide detailing community supports/services currently available in the geographic areas supported by the SSLCs and the Rio Grande State Center;
- assist with the placement of residents in successful community placements;
- monitor the activities of personal support teams' identification of needed supports and services for individuals referred for alternate placement, including the identification of barriers to alternate placement, and initialization of programming to overcome the identified barriers;
- participate in personal support team meetings related to community referrals, CLOIP issues, discharge planning meetings, placement return meetings, etc.; and
- work closely with the facility Directors of Admissions and Placement and QIDP Coordinators, along with State Office representatives.

Specific proposal details:

- Twenty-four facility community living specialists who will be housed within each SSLC and Rio Grande State Center.
- One state office community living specialist coordinator.
- The twenty-four community living specialists would be equivalent to a QIDP II and the state office community living specialist coordinator would be equivalent to a QIDP III.
- Reimbursement for mileage (as they will be unable to utilize facility transportation) and lodging for training/meetings at state office will also need to be considered into the final salary. Overnight travel will not be a usual occurrence as the position will be working in geographic areas defined by a state supported living center.

Risks vs. Benefits: Resources currently available at the SSLCs to perform the responsibilities outlined above are extremely limited. These positions would provide the facilities with additional outside resources that can be utilized to stress independence and choice for the resident and improve the community relocation processes at each of the facilities.

*Amendment #5: Community Living Specialists are now called Transition Specialists. As of CY16, the number of Transition Specialists was reduced to 13.*

*Amendment #5: Continuity of Services Specialist added*

### **Continuity of Services Specialist**

*The Continuity of Services Specialist was added to provide additional oversight and assurance that individuals transitioning from SSLCs continue to receive adequate services during and following their transition to the community. Work involves on-site (SSLC) assessment of facility organization and processes related to community transitions including the coordination of available resources to ensure compliance with the Promoting Independence Initiative and the DOJ Settlement Agreement. Provides recommendations to the facility regarding transition processes and monitors agreed upon changes to process. Reviews Settlement Agreement Monitoring Reports for assigned facilities and coordinates response with the State Office Continuity of Services Coordinator. Reviews transition plans, post move monitoring reports and interdisciplinary team meeting summaries for individuals with delayed transitions. Identifies and provides transition related training for facility staff.*

### **11. In-House Evaluation/Program Quality and Effectiveness**

One systems analyst is currently working on the Demonstration and the relocation contractor program to design a prototype for data collection and reporting for this crucial function supporting the Demonstration. The systems analyst also develops routine reports that are capable of descriptive reporting about current activities.

This new funding request would provide the necessary resources to track trends and conduct an annual evaluation of the Demonstration by developing additional in-house capabilities to monitor, discover, describe and create intervention strategies to promote quality across Demonstration activities. This would be accomplished by adding a Research, Quality and Reporting Office (RQR Office) for the Demonstration. The RQR Office will be responsible for: collecting data about participants and the enabling processes and services of programs; performing in-house evaluation of programs; creating performance measure reports; performing research and analysis to assist with quality programs directed at enhancing program effectiveness and maintaining foundational support systems; reducing returns to institutions; and creating and managing reports for the Demonstration for State, Federal and external stakeholders. The proposal will not only benefit the Demonstration but all of the DADS community-

based programs. In addition, these activities will help DADS meet additional CMS requirements regarding quality reporting. The roles for the RQR Office include:

**Senior Quality Analyst** – This person will perform analysis on a variety of initiatives to create an in-house evaluation of the program each year. One anticipated initiative includes a comparison between Demonstration participants and others receiving similar services through an institution or other community programs across quality of life, time spent out of the hospital, decline in function, time before death, significant events involving life and safety and dollars spent. Anticipated challenges include access to all costs for Demonstration participants such as food stamps, affordable housing allowances, etc. A second identified initiative is the evaluation of acute care for individuals who return to facilities to help identify new services needed to keep them in the community and isolate potential risk factors around demographics such as ethnicity, gender, age, mental illness, substance abuse, setting (rural/urban), etc. This analyst will take findings from the Statistician and Performance Measure Analyst described below.

**Research Statistician** – This person will be a statistician familiar with research design for program evaluation including data analysis techniques, and common software used for statistical analysis, such as the Statistical Package for the Social Sciences or Statistical Analysis System. This person will have experience working with large datasets and can prepare numeric, graphic and written presentations to communicate results of the program evaluation. The Demonstration currently has some reporting capability but lacks the resources to design research questions and conduct surveys and perform statistical analysis to identify trends for alerts to providers that might reduce returns to institutions. Texas has staff working on what is happening in the Demonstration population but does not have the resources to determine why. Discovering the underlying trends and answering the why questions will provide the capability to identify the most meaningful areas to target for operational and policy changes to improve the chances of individuals remaining in the community.

**Performance Analyst** – This person will organize and track performance metrics. Texas has done a significant amount of work on performance measures and performance management for the 1915 (c) waivers. This work and the new data sources being created specifically for the Demonstration provide the basis for performance reporting. Because Texas serves hundreds of thousands of individuals through a variety of waiver choices (currently thirteen waivers), each with potentially different performance metrics in the waiver, creating Demonstration performance metrics across these programs is challenging over time. In addition, the Texas Demonstration seeks to track new measures generated by the enhanced in-house program evaluation requested here.

## **Expected Outcomes**

Texas seeks in-house, in-depth analysis and evaluation of the Demonstration on an annual basis. Growth in the Demonstration provides opportunities for individuals but creates stress on support systems. Identifying those stress points early could define the state's ability to create and sustain a program that both improves quality of life for individuals and saves the state and CMS money over the long run. Striving for effectiveness and efficiency at the same time is the benchmark Texas seeks to achieve. These resources will enable the data driven analysis and evaluation that can inform good decision making.

*Amendment #5: Together these positions provide critical support for the MFPD project by generating reports used for regularly scheduled reporting to the Centers for Medicare and Medicaid Services (CMS) as well as organizing and tracking CMS-required performance metrics and reporting for the 1915 (c) waivers. The MFPD performance measures mirror the 1915 (c) performance measures. The state shifted the focus from the in-house evaluation to addressing specific issues identified as barriers to transitions during the demonstration.*

### **12. Office of the Long-Term Ombudsman Demonstration Activities**

Individuals seeking to move from a NF to the community face a number of decisions and are involved with several professionals to accomplish a successful relocation. The agencies and staff involved are usually not onsite every day, however designated ombudsmen are onsite which makes them an immediate source for initiating a response. If problems occur in an individual's plan to relocate, such as unreturned phone calls, conflicting information, interference by facility staff and family, and other complaints, ombudsmen are immediately available for the individual to report a complaint and experience remedies on their behalf.

Though long-term care ombudsmen have historically supported the Money Follows the Person policy as created in September 2001, they have not been formally utilized in the process. With the Minimum Data Set (MDS) 3.0, Section Q implementation, ombudsmen face new demands to respond to inquiries about the relocation process and living options from individuals, providers, and other professionals. Additional funding for the long-term ombudsmen program will help to off-set the additional cost as Section Q implementation will generate new inquiries from individuals with all levels of need and income. An ombudsman is needed to provide an in-person response for some individuals that will reduce stress on the individual, improve accountability by NF staff, and provide all parties with an additional resource during relocation.

This project has two components. First, the Office of the State Long-term Care Ombudsman will hire a part-time contracted employee to train, monitor, and support the implementation of long-term care ombudsman services for Section Q implementation. This position will provide comprehensive statewide training to local ombudsmen over three days. Funding will be used to reimburse ombudsmen for transportation, lodging, and meals, as well as the cost of the training facilities and required materials.

Second, reimbursement will be made to local long-term care ombudsman programs for services provided by a certified ombudsman relating to implementation to the MDS 3.0 Section Q requirements. Texas contracts with 28 local long-term care ombudsman programs, housed in area agencies on aging (AAAs). Local ombudsmen are trained and directed by the State Long-Term Care Ombudsman at DADS. Aging and Disability Resource Centers (ADRCs) and AAAs view the ombudsman as a resource for responding in-person to requests for help for individuals living in nursing facilities. Ombudsmen are needed to:

- provide counseling and education about the Demonstration process and explain rights to individuals, family members, and providers; and
- work to resolve complaints about the Demonstration process.

### **Example 1: Counseling and Education**

An ombudsman makes a routine visit to individuals living in a NF. While in the dining room, an individual tells the ombudsman he wishes to move to his former home in the community. The ombudsman meets with the individual in a private location, seeks more information about his wishes, and inquires about his ability to pay for home-based services. Based on this information, the ombudsman provides educational materials about the local contact agency for relocation services and offers to assist the individual with calling the agency. With permission from the individual, the ombudsman informs facility staff about the request and asks for their assistance to help the individual return to a community setting.

### **Example 2: Casework**

A relocation specialist, operating in a local contact agency, contacts an ombudsman to report problems working with a NF administrator. The specialist describes a facility administrator interfering with efforts to relocate an individual to her own apartment, alleging the administrator contacted Adult Protective Services (APS) who assessed the individual and opposes the move. The ombudsman visits the individual in the NF, as well as other residents, to ensure the individual is not identified as a complainant. The

ombudsman investigates by interviewing individuals involved, starting with the resident to obtain her permission to work on her behalf. Relevant records are reviewed and consultations made with the physician, relocation specialist, administrator and APS worker. The ombudsman verifies the relocation specialist's complaint and organizes a meeting with the individual and all parties involved. In the meeting, resident rights are discussed. The Demonstration process is described and available community supports are discussed. All parties recognize this as a resident rights issue and the administrator agrees to not further interfere with the process. For the next several weeks, the ombudsman monitors the situation through phone calls and in-person discussions with the individual. With sufficient evidence that this barrier was removed, the ombudsman closes the case and encourages the individual to contact the ombudsman if any problems arise.

Ombudsmen maintain positive working relationships with NF staff that are keys to successful relocations. With these relationships, ombudsmen are uniquely qualified to negotiate among facility staff, relocation staff, family members and individuals when barriers are encountered. Because ombudsmen make a minimum of quarterly visits to all nursing facilities, and in many cases make monthly or more frequent visits, individuals have access to an advocate who will carry messages on the individual's behalf to all necessary parties and make every effort to resolve complaints to the satisfaction of the individual.

"Virtual system navigators" are located in specified ADRCs and also serve non-Medicaid individuals who want to move out of a NF. Though the non-Medicaid group of individuals is significantly smaller than Medicaid eligible individuals, their needs may require in-person contact to provide counseling and education about the Demonstration process, answer questions, and resolve problems associated with the relocation. Ombudsmen are in a position to receive referrals from virtual system navigators and respond with a visit to the individual in the facility. The 100 percent administrative funding will also be available to assist this NF population.

As specified in Section 712(d) of the Older Americans Act, ombudsmen must not disclose any identifying information about a resident of a NF without the individual's consent. Furthermore, residents are protected by law from retaliation for voicing complaints, so the ombudsman ensures all identifying records are not disclosed outside of the Texas Long-term Care Ombudsman Program, unless the resident consents to such disclosure or by court order.

### **Expected Outcomes:**

The Texas Long-term Care Ombudsman Program has the capacity to provide support

to all individuals in the Demonstration who are relocating from a NF to the community. Under this proposal, ombudsmen will:

- support approximately 560 individuals by providing counseling and education about the Demonstration process and other living options to individuals, family, and facility staff;
- help educate NF staff about the “person-centered planning” aspects of Section Q to help the NF move from a protectionist attitude to one supporting an individual’s desires about living in the community, and;
- work to resolve approximately 1,120 complaints associated with Section Q implementation.

*Amendment #5:*

*As of CY 2016, AAAs became responsible for funding the activities of local Ombudsmen in helping individuals transition from nursing facilities to the community. Because of the reduced workload, the funding for the position responsible for overseeing this initiative will end in CY 2017.*

### **13. Department of State Health Services (DSHS) Behavioral Health Pilot**

Relocating individuals who have been institutionalized for an extended period and avoiding reinstitutionalization is very challenging. These challenges are compounded when the individual also has severe mental illness or a substance use disorder. Successful relocation requires a good working knowledge of how to use the resources available through the Demonstration process and partners; skill in delivering evidence-based mental health services critical to increasing independence and, engaged, supportive stakeholders.

The Behavioral Health Pilot is an established benchmark in the Texas Operational Protocol with specific enrollment targets. This project will assist in meeting and exceeding the benchmark. (Texas has increased this benchmark in the 2012 budget is submitted to CMS). DSHS will use a multifaceted approach to assist in relocating individuals with severe and persistent mental illness and / or substance use disorders from nursing facilities and other long term institutions to community living.

- Increase the knowledge base of Local Mental Health Authorities (LMHAs) and other DSHS providers regarding resources available through Texas’ Demonstration to assist them in reintegrating individuals into their communities and how to coordinate effectively with these resources. The state’s 38 LMHAs are the significant traditional community-based service delivery system for



individuals with severe mental illness.

- Increase the skill level of LMHAs and other providers in delivering effective, evidence-based psychosocial rehabilitation services focused on increasing independent living and health management skills. Psychosocial rehabilitation is offered to individuals with the most intensive needs who are most at risk of becoming institutionalized or re-institutionalized. This approach will include training in evidence-based practices and a certification program in psychosocial rehabilitative evidence-based practices. The focus will be on individuals leaving institutions and those at significant risk of institutionalization.
- Augment current outreach / education efforts by distributing a professionally produced video to stakeholders explaining and demonstrating how individuals with behavioral health disorders can benefit from the Demonstration Behavioral Health Pilot.

#### *Behavioral Health Pilot Training*

The training will focus on the relocation process, long term services and supports available through DADS and the Texas Health and Human Services Commission (HHSC), and how to effectively coordinate with and use these resources. Training will include LMHA direct service and administrative staff and potentially other DSHS providers. Five regional one-day trainings will be provided to a total of 200 individuals.

#### *Behavioral Health Pilot Psychosocial Rehabilitation training and certification*

Topics will include evidence-based rehabilitative practices such as Illness Management and Recovery (IMR) and Cognitive Adaptation Training (CAT), which has shown positive outcomes within the Behavioral Health Pilot population. The emphasis of CAT is on teaching individuals basic daily living skills and providing compensatory strategies to bypass cognitive deficits. IMR focuses on health self-management, recovery and more advanced coping skills. There will be ten regional trainings lasting 2 days each, provided by nationally recognized experts in these practices.

Training will include topics such as: the meaning and purpose of psychosocial rehabilitation, how to build skills to provide services effectively and creatively, recovery and person-centered services, the process of engagement and education on how to work with individuals who also have substance abuse issues. The national experts will also provide consultation to DSHS and the local providers for up to 6 months after the trainings to ensure effective implementation of the practices.

The experts will follow a “train-the-trainer” model. Each LMHA or provider organization will send four to six staff to the trainings, with at least two of these staff becoming “master” trainers at the local level. Master trainers will also provide clinical consultation to local direct service staff and others as needed to ensure quality, provide emotional support for staff, and increase motivation / morale.

Training will prepare local direct service providers for initial certification in evidence-based psychosocial rehabilitative practices. DSHS will contract with a state university or other entity to develop and maintain the certification process. The process may include online training, interactive testing, video review, shadowing, etc. To maintain certification providers, will be required to obtain annual continuing education.

#### *Behavioral Health Pilot Outreach, Marketing, Education: Video Production*

DSHS will contract for production of a Demonstration Behavioral Health Pilot video. Content could include a description of how to enroll in Demonstration, an overview of the mental health and substance abuse services that are offered in the Behavioral Health Pilot and examples of individuals who gained and maintained independence with the help of these services. This video will be targeted towards potential individuals, family members, NF staff, policy makers, and other community partners. The purpose of the video is to increase interest and enrollment in the Behavioral Health Pilot, to educate potential individuals (as well as family and legal representatives) about what services are offered under the Demonstration and Pilot, to provide a description of “what to expect” about the relocation process from a NF into the community, and finally, to highlight several examples of how the Behavioral Health Pilot works for actual individual participants. The video will be available via the Internet (DADS and DSHS websites) and will be distributed in DVD form to other state agencies and community partners.

#### ***14. Customized Employment Project***

The Customized Employment Project (Employment Project) will provide short-term administrative funds to one Intermediate Care Facility for Persons with IID (ICF/ID) and two Medicaid 1915(c) waiver providers – Home and Community-Based Services (HCS) and Community Living Assistance and Support Services (CLASS) to provide individuals with intellectual and other developmental disabilities (IDD) more opportunity to move out of congregate settings and into employment at local places of businesses.

The Employment Project will be structured as a collaborative effort with DADS, Medicaid providers, individuals with intellectual and developmental disabilities who are receiving services from DADS and the Department of Assistive and Rehabilitative

Services (DARS) as key stakeholders. (DARS is the Texas state agency responsible for vocal rehabilitation and employment training for individuals with disabilities.)

Three of DADS Medicaid providers serving forty or more individuals with intellectual and development disabilities will be selected to participate in this Employment Project. Each of the providers will operate different Medicaid programs (ICF/IID, CLASS and HCS). Smaller providers could apply as a group, or apply for a reduced amount of funds. The funds may be used by providers to improve their ability to set up policy and practices to provide quality customized employment services and meet the employment goals of the individuals it serves. Proposed examples of funds could be used are:

- hire or designate staff to provide general information about the Project to the community at-large;
- obtain training and technical assistance to implement the customized employment model;
- obtain training on social Security Administration work incentives and the basic components of a benefits plan;
- support staff person(s) for benefits and work incentives planning, supports, and services, a Community Rehabilitation Program (CRP; which are DARS contractors), and Employment Network (EN) for the Ticket to Work program.

Individuals served by the Medicaid providers, and their family members and advocates will receive training on employment and community support services. Benefits of the proposed project include that the individual:

- will earn more money by working than by relying solely on Social Security benefits;
- can maintain their Medicaid eligibility while working;
- can establish relationships at work;
- experiment with working with little or no risk to their system of supports or their personal safety; and
- will live a higher quality life by becoming more integrated into their community.

DADS will hire a full-time contractor position for a period of five years to support the Employment Project, implement of DADS Supported Employment Training and Technical Assistance Plan (internal initiative that identifies a variety of activities) and conduct other activities designed to increase the employment rate among the individuals receiving DADS services.

DADS will also contract with an organization to provide the training and technical assistance described in this proposal to Medicaid providers, CRPs, and DADS and DARS staff. DADS, with input from DARS, will select the contractor through a formal bidding process; select the Medicaid providers to participate in the Project through an informal process (one that does not use a Request for Proposals); and contract with an entity to perform an evaluation of the Employment Project, including a cost-per-consumer analysis.

DARS will either designate staff to work directly with Medicaid providers to assist in obtaining CRP certification and a CRP contract with DARS, and to help the Medicaid providers to understand DARS employment services for individuals with IDD. DARS will also:

- provide information and training about this project to Vocational Rehabilitation Counselors located in the three Project areas;
- identify CRPs to provide employment services to individuals in each of the targeted Medicaid programs; and
- explain the Ticket to Work program when appropriate.

By the end of the first year of participation, the Medicaid provider will create and begin implementing a plan to relocate individuals served from congregate day settings to competitive employment and initiate employment services for at least fifteen percent of the individuals currently receiving segregated day services. By the end of the second year of participation, the Medicaid provider will support at least fifty percent of the individuals currently receiving segregated day services in competitive employment.

The Employment Project will create a change in current business practices by creating processes to integrate individuals into a community work environment. For those individuals in the Employment Project currently residing in an institutional setting, working in a community setting will provide them with an opportunity to experience life outside the institution and help create a desire to relocate from the institution. The Employment Project will also result in increased quality of life for Demonstration participants and a Texas.

By the end of the first year, the Medicaid providers will aim to (1) create and begin implementation of a plan to transition individuals from congregate day settings to competitive employment and (2) initiate employment services for 15 percent of the individuals currently receiving segregated day services. By the end of the second year of the Employment Project, the each Medicaid provider will attempt to achieve a goal that fifty percent of the individuals will be competitively employed two.

*Amendment #5 : This project ended in December 2016.*

### **15. Texas Department of Housing and Community Affairs (TDHCA) Staff Positions**

Administrative funding will be used to hire two full-time equivalent positions (FTE), a Housing Program Specialist and a Housing Program Coordinator that will assist the Texas Department of Housing and Community Affairs (TDHCA) to increase affordable housing options for individuals with disabilities that currently reside in institutions and choose to relocate into the community. This will be accomplished by the positions focusing their efforts on administration of the Project Access program (Section 8 housing vouchers) and outreach, marketing, and technical assistance regarding TDHCA housing programs to expand the affordable, accessible, and integrated housing stock for Demonstration participants.

The activities being proposed are mutually exclusive from the recent CMS-HUD 811 grant awarded to Texas and the position descriptions may change to incorporate the activities of the HUD Section 811 Project Rental Assistance program if this funding is awarded to TDHCA.

While Texas did receive 100 percent funding for Housing Navigators to generate interest and housing activity at the local level, these positions have a larger responsibility; the operations of the Texas' Public Housing Authority / State Housing Finance Agency (TDHCA). One of the FTE position will work primarily with the day to day activities associated with processing Project Access housing vouchers, recommending changes to the state housing plan, providing technical assistance agencies that help process the vouchers, and outreach activities. The other FTE position will provide housing program marketing and outreach to expand the number organizations that are interested in applying for various housing funds to benefit prospective Demonstration participants.

The FTEs will also focus on helping meet the MFP Demonstration housing benchmarks by providing opportunities for individuals with disabilities who wish to relocate out of

institutions by increasing awareness of available housing programs and providing assistance to accessing housing funding.

*Amendment #5: Texas Department of Housing and Community Affairs successfully applied for a CMS Real Choice Systems Grant (Grant) for U.S. Department of Housing and Urban Development (HUD) Section 811 funds. HUD Section 811 Project Rental Assistance (PRA) funds were awarded and will provide affordable, accessible and integrated housing for low income persons with disabilities. MFPD funding is used to partially fund the equivalent of two staff positions. One position is responsible for providing outreach, marketing, training and technical assistance to staff who work with MFP participants leaving institutions regarding the HUD Section 811 PRA program. The second FTE is allocated across several Money Follows the Person focused activities, including overseeing administration of two programs that provide Section 8 vouchers to individuals with disabilities exiting nursing facilities (Project Access and the HOME Program for Persons with Disabilities) and providing data analysis support for the Section 811 PRA program.*

#### **16. Promoting Independence Program Specialist**

The Demonstration has grown tremendously since first conceived in July 2006. This contracted staff specialist would assist in the management of the Demonstration; the MDS 3.0 grant; the HUD-CMS 811 housing grant, and; and all of the additional activities associated with the Promoting Independence Initiative (Initiative) and the Promoting Independence Advisory Committee (Committee).

The Initiative is Texas' response to the Olmstead decision (June 1999) which states that individuals with disabilities have the right under Title II, Americans with Disability Act, to live in the most integrated setting of their choice. The Initiative has been very successful in relocating individuals out of institutions and back into community settings. Since September 2001, over 27,000 individuals have relocated from NFs and 3,500 from ICs/IID. The Initiative coordinates all Olmstead activities across Texas' five health and human service agencies and TDHCA. This position will assist with activities associated with the Demonstration, the Initiative, and the Promoting Independence Advisory Committee. Some of the duties and responsibilities for this position will include:

- assisting with daily management of the Demonstration grant activities; preparation of the Operational Protocol;
- liaison with the Centers for Medicare and Medicaid Services (CMS) in all grant-related activities;

- preparation and submittal of all CMs and state required reports;
- convenion and monitoring internal and external workgroups;
- staff support to the Demonstration Grant Advisory Committee;
- support for all Promoting Independence Initiative activities;
- analysis of state/federal legislation and public policy;
- preparation of internal communications; and
- present information to internal/external stakeholders.

*Amendment # 5: This project has been assigned to an Assistant Project Director who tracks and monitors the MFPD budget, communicates with Project Leads on multiple administrative projects and serves as the subject matter expert in areas related to MFPD such as housing,*

*Amendment # 5: Additional projects funded with MFPD administrative funds include:*

### **17. Enhanced Community Coordination**

The goal of this project is to provide enhanced, better-coordinated services for individuals with intellectual and developmental disabilities (IDD) that are being relocated from institutional settings, including state supported living centers (SSLCs) and nursing facilities (NFs).

### **18. Medical, Behavioral and Psychiatric Teams**

This project strengthens the services and supports for individuals who have both IDD and complex medical/behavioral health needs as they relocate to community-based settings. This effort will significantly enhance: (1) medical, behavioral and psychiatric supports, and (2) community coordination. The Local IDD Authorities (LIDDA) will play a crucial role in this effort.

*Amendment # 5:*

*Consistent with the approved Sustainability Plan submitted by Texas, the following activity was added as a 100% Administrative Grant project.*

### **Employment Services Coordinators**

*As Texas begins to adopt the Employment First principles and practices, there will be a need for coordination of employment services for individuals with disabilities at the state level. This employment initiative will assist with the promotion and utilization of community-based services, as opposed to institutional-based services, and assist with the transition into community life activities for participants departing institutional settings.*



## Section I, Part B – Demonstration Implementation Policies and Procedures

### 1. Participant Recruitment and Enrollment.

***Describe the target population(s) that will be transitioned, and the recruitment strategies and processes that will be implemented under the demonstration. Specifically, please include a narrative description that addresses the issues below. In addition, the OP must include samples of all recruitment and enrollment materials that will be disseminated to enrollees.***

Texas administers a hugely successful MFP policy for individuals living in nursing facilities and expedited access for individuals with intellectual developmental disabilities living in large community ICFs/IID and state supported living centers. Since 2001, over 13,337 individuals have left nursing facilities while 1315 individuals have moved from large community ICFs/IID and state supported living centers to the HCS 1915(c) waiver program. While there are many formal mechanisms that have been established during the six year period, the programs are now enculturated with Texas' consumers, advocates, providers, and government officials. This knowledge base is the result of previous outreach and education, individual experiences and word of mouth. The state will build upon its current outreach systems and general community awareness.

### Target Population

***Nursing Facilities.*** The target population is individuals who have been residing in an institutional setting for at least *ninety days, excluding any days of rehabilitative services funded through Medicare*, are enrolled in Medicaid, and are currently living in a nursing facility. The MFP Demonstration specifically will target individuals with:

- Complex functional support needs who have not been able to transition out of nursing facilities.
- Co-occurring behavioral health conditions – mental illness or substance abuse problems – that live in nursing facilities in the San Antonio area.
- Individuals with a cognitive impairment or physical disability with a medical need for specific tasks required to be performed during normal sleeping hours (Overnight Companion Services in Region 4 and all fee for service areas in Region 11).

The second and third target populations will receive new MFP Demonstration services (which will be discussed *Part 2, Section 5 of this Operational Protocol*).

*Amendment # 5: Individuals with a cognitive impairment or physical disability with a medical need for specific tasks required to be performed during normal sleeping hours are no longer a specific target group.*

**ICFs/IID and State Supported Living Centers.** The target population consists of individuals who have been residing in an institutional setting for *at least ninety consecutive days, excluding any days of rehabilitative services funded through Medicare*, are enrolled in Medicaid, and are living in:

- *Medium (9-13 beds) and large (fourteen beds or more) Community ICFs/IID and State Supported Living Centers.*
- *Community ICFs/IID if the owner voluntarily chooses to close the facility.*
- *Children under the age of 22 residing in community ICFs/IID who will relocate to families*

*Amendment # 5: Additional reserve capacity populations include:*

- *Individuals in nursing facilities with positive PASARR screening for a developmental disability or mental health issue.*
- *Individuals in Hospitals.*

Recruitment Strategies

**Nursing Facilities.** Texas currently contracts with relocation contractors who employ relocation specialists that assist in the outreach and identification of individuals interested in relocation and then prepare them for community transition. Relocation Contractor services are available throughout Texas. If an individual chooses to transition, the relocation specialist coordinates the transition with the facility and the individual's case manager or service coordinator. In addition, representatives from the following organizations also provide information and help to recruit individuals into the MFP program:

- DADS case managers or Managed Care service coordinators (if the individual resides in a location where managed care services are available).
- Local Area Agencies on Aging.
- Local Long-Term Care Ombudsmen.
- Nursing Facility Social Workers.
- Nursing Facility Family Councils
- Local Long-Term Services and Supports Providers

- Community Transition Teams

*Amendment #5: With the statewide expansion of managed care in September 2014, DADS case managers have been replaced by MCO service coordinators. After securing CMS approval of the state's transition plan to move responsibility for service delivery in the rural service areas to a managed care model, the state terminated the Community Based Alternatives waiver program.*

*On March 1, 2015 nursing facilities become part of managed care for adults, resulting in the MCO service coordinator playing a significant role in supporting an individual's transition from a nursing facility to community support.*

**ICFs/IID and State Supported Living Centers.** Recruitment occurs by ensuring that residents are informed about alternative living arrangements. This occurs through the Community Living Options (CLO) process which occurs on an annual basis, or more often if requested, through the individual's interdisciplinary team (IDT). IDT membership includes the individual, the legally authorized representative (LAR) and at the request of the individual, family members, and other persons who are actively involved in the individual's life. The CLO process goal is to identify the following:

- The individual's personal preferences for living arrangements.
- The LAR/family preferences for living arrangements.
- Identification of medical, behavioral/psychiatric issues.
- Quality of life issues.
- The LIDDA recommendation, if an alternative living arrangement is requested. (NOTE: Due to recent legislation, LIDDAs will be working with individuals residing in state supported living centers to conduct the CLO process.)

Additional recruitment also occurs from a variety of different organizations listed in the *Outreach/Marketing/Education* section of the *Operational Protocol*. One of these organizations is Texas' federally mandated protection and advocacy agency, Advocacy, Inc. This organization has a program, Texas Community Integration Collaborative (TCIC), which assists individuals with disabilities of all ages to move from state supported living centers, ICFs/IIDs and nursing facilities. The TCIC offers:

- Training and technical assistance on individual choices and living options.
- Planning for an individual's future and identification and development of resources to support living in the community.
- Training and technical assistance to family members, facility staff, community service and support providers and others.

*Amendment # 5: Using MFPD administrative funds, Texas created Transition Specialists at each SSLC to provide education about community alternatives, to support individuals during the transition process, and to monitor post-transition the individual's progress and services in the community setting. In addition, the Continuity of Services Specialist was added to provide additional oversight and assurance that individuals transitioning from SSLCs continue to receive adequate services during and following their transition to the community.*

a. Participant Selection Mechanism

***Include the criteria and processes utilized to identify individuals for transitioning. Describe the process that will be implemented to identify eligible individuals for transition from an inpatient facility to a qualified residence during each fiscal year of the demonstration. Please include a discussion of: the information/data that will be utilized (i.e., use of MDS or other institutional data); how access to facilities and residents will be accomplished; and the information that will be provided to individuals to explain the transition process and their options as well as the state process for dissemination of such information.***

## **Identifying Individuals for Transition**

### **Identifying Individuals for Transition**

**Children.** Texas has a strong permanency planning process for children in institutional settings. The 77<sup>th</sup> Texas Legislature (2001) passed Senate Bill 368 which mandates a proactive permanency planning process which requires a plan to be established upon institutional admission with subsequent six month reviews. The LIDDA works with the family or the LAR to review community options and identify activities to return the child back into the community.

**Nursing Facilities.** As Texas has operated a MFP program for several years, most referrals of transition to a community setting are from word of mouth and from the organizations listed in the *Nursing Facility Recruitment Strategies* of this section (see above). Additionally, DADS maintains contracts with relocation contractors who in turn visit all nursing facilities in the state, help identify individuals who want to relocate, and facilitate the relocation process for return to the community.

Texas also uses information contained in the MDS dataset to the fullest extent possible in identifying eligible nursing facility residents, including those with complex supportive needs and those with behavioral health conditions. MDS Q1A information also is available on an aggregate level on the DADS Promoting Independence website for stakeholders to review. This data is the basis for identification of prospective participants, outreach to nursing facility residents and conducting a “transition”

assessment. Identification of individuals with co-occurring behavioral health conditions also will be accomplished by matching DADS' nursing facility MDS data to the Department of State Health Services (DSHS) Mental Health and Substance Abuse (MHSA) service records for the last five years. Information from the Preadmission Screening and Resident Review (PASRR) process and DSHS data system also will be used to assist in the identification of persons with behavioral health needs.

The information from these data sources is refreshed monthly and provided to relocation contractors.

*Amendment # 5: When the state incorporated nursing facilities into managed care (STAR PLUS), service coordinators from the MCOs along with the Relocation Specialists also began assuming responsibility for identifying individuals who want to move to the community and coordinating the transitions. The entities holding the relocation contracts continue to be the MDS 3.0 local contact agency for Medicaid recipients.*

**ICFs/IID and State Supported Living Centers.** As a result of the CLO process, an individual may be referred to the community through a designated LIDDA. In accordance with the Performance Contract, the LIDDA is required to provide an *Explanation of Services and Supports* (Appendix F).

The CLO helps ensure that the individual makes an informed choice regarding movement to an alternative living arrangement or registration on the most appropriate interest (waiting) list for 1915(c) waiver services.

Individuals who reside in ICFs/IID that voluntarily close will automatically be provided residential options through the CLO process.

It should be noted that under the Texas Promoting Independence Plan, individuals who live in *medium and large* community ICFs/IID or *State Supported Living Centers* have expedited access to the HCS 1915(c) waiver program, within twelve and 6 months of requesting community placement, respectively.

## **Access to Facilities and Residents**

***Nursing Facilities.*** Relocation contractors spend a considerable amount of effort to build working relationships with nursing facilities throughout the state. As part of the original Texas MFP Initiative, nursing facility administrators and directors of nursing were advised of DADS relationship with relocation contractors. Periodically, DADS sends out *Provider Letters* (Appendix B) to nursing facility administrators to remind them of the MFP Initiative and that relocation contractors are authorized to work with nursing facility residents.

Relocation specialists typically carry a copy of the most recent *Provider Letter* in case they encounter resistance in accessing a nursing facility. In the rare cases of a nursing

facility refusing access to a relocation specialist, one of DADS Regional Directors will contact the nursing facility to remind them of the MFP policy and request that the relocation specialist be granted access to any resident who desires to talk to the relocation specialist. Relocation specialists are required to contact DADS toll-free complaint hotline to initiate a formal investigation of nursing facility non-compliance. (Nursing facilities are required to provide client access under the provision of DADS rule, 40 TAC § 19.413.)

*Amendment # 5: With the inclusion of nursing facilities under managed care, the managed care service coordinators are responsible for coordinating the transition and make referrals to the relocation specialists as needed. Relocation specialists are members of the transition team.*

*In addition, the entities holding the relocation contracts serve as the Local Contact for Medicaid recipients who responded affirmatively to MDS section Q and relocation specialists are, therefore, are required to provide them information about community living.*

**ICFs/IID and State Supported Living Centers.** Access to residents in community ICFs/IID has not been an issue as the residents have the right to have guests and meet privately with individuals. Access to state supported living centers is also not an issue because they are owned and operated by the State of Texas. As mentioned previously, various advocacy organizations meet with residents in ICFs/IID and state supported living centers to discuss community living options.

As has been stated, the Promoting Independence Plan and the Texas legislature require the Community Living Option (CLO) process for all residents of large community ICFs/IID and state supported living centers. Under this policy, at least annually or more frequently if requested, the ICFs/IID or state school must discuss alternative living arrangements with the resident or the resident's Legal Authorized Representative (LAR). These discussions also are attended by all members of the Interdisciplinary Team (IDT). Each quarter, the Promoting Independence Advisory Committee receives aggregate reports on all CLO referrals. Information on the Community Living Options program will be discussed in greater detail in the next section of the *Operational Protocol*.

## **Information about the Transition Process and Options**

**Nursing Facilities.** As previously mentioned, information about the transition process and various services options can come from a number of sources. The three primary sources of information are identified below.

Relocation Contractor. The relocation contractor will provide relocation assistance and intensive service coordination activities to assist NF residents to transition to community settings of their choice.

Relocation assistance will consist of but will not be limited to:

- Providing information about Medicaid 1915(c) waiver and non-waiver, non-Medicaid services and supports.
- Providing for Transition to Life in the Community (TLC), and for all program placements other than Adult Foster Care and Assisted Living, Transition Assistance Services (TAS). Developing person/family-directed transition plans and arrangements.
- Advocating for individuals making the transition and their family.
- Coordinating needed services/resources to transition into the community, with such entities as the, local housing authority, the Mental Health Authority (MHA), the Texas Department of Assistive and Rehabilitative Services (DARS) regarding its relocation activities, and for:
  - Housing.
  - Mental health services.
  - Transportation (particularly in rural areas).
  - Medical/dental services, including prescriptions.
  - Durable medical equipment.
- Securing access to needed community services, such as:
  - Utilities/telephone.
  - Banking/bill payment/direct deposit.
  - Household items/furniture.
  - Special transit and local transportation providers.
- Follow-up assessment after transition for at least six months after the transition:
  - Once a week for the first month.
  - Twice a week for the second month.
  - At least once during the third month.
  - As frequently as the MFP participant requests.

*Amendment # 5: In addition to the entities listed above (local housing authority, the Mental Health Authority (MHA), the Texas Department of Assistive and Rehabilitative*

*Services (DARS)), the relocation contractor also coordinates with managed care organization service coordinators in the nursing facility and, if selected, the MCO service coordinator for the home and community based services.*

*With managed care expansion and the inclusion of nursing facilities, some of the relocation specialists' responsibilities have been assumed by the MCO service coordinator. MCO SCs are responsible for the following:*

*Providing information about Medicaid 1915(c) waiver and non-waiver, non-Medicaid services and supports;*

*Conducting transition and service needs assessments;*

*Developing service plans; and*

*Coordinating medical services, such as DME, dental, prescriptions.*

*TAS is available through STAR+PLUS 1115 and the 1915 (c) waivers. Relocation contractors obtain a separate contract to provide TAS as Medicaid providers.*

In addition to generic policies developed for the overall MFP effort, the Behavioral Health Pilot will include the following activities:

- The local Community Mental Health Center and OSAR will be included on the transition team and will train their staff.
- The transition team and the Department State Health Services (DSHS) will periodically present information on the pilot to local mental health advocacy groups and substance abuse provider organizations.
- The DSHS Client Rights' 1-800 Hotline staff will be provided with training on the pilot so that they may refer individuals to the pilot.

DADS case managers and Managed Care Organization service coordinators will work with nursing facility residents to determine their service needs and choices. Among the topics to be discussed are:

- How to qualify for services under the MFP policy.
- What happens if the person leaves the facility before the DADS' enrollment is complete.
- Discussion of the various 1915(c) waiver programs offered by DADS and HHSC.
- Discussion of the community options available under the MFP program.
- Other services available to assist in the successful transition to a community setting:
  - Relocation services.



- Transition to Live in the Community (TLC) services.
- Transition Assistance Services (TAS).
- Housing voucher programs.
- Discussion of the MFP *Informed Consent Form*.
- Relevant telephone numbers.

*Amendment # 5: As of September 1, 2014, MCO service coordinators assumed from DADS case managers the function of explaining MFPD to individuals and obtaining informed consent from those who agreed to be in the demonstration.*

With advent of the roll-out of STAR+PLUS in February 2007, the state recognized the need to clarify the various roles and responsibilities of the relocation contractors and the managed care service coordinators. DADS in conjunction with the Medicaid/CHIP Division held a statewide training meeting with its relocation contractors, the managed care organizations, and DADS local regional staff to detail each entities specific activities.

Briefly, the relocation contractor helps to provide outreach, education, and identification for potential nursing residents (NF) who want to relocate. Once identified, the NF resident is directed to the local DADS office for assistance in choosing a managed care provider. Upon that selection, a managed care service coordinator is provided who then takes the lead in relocation. However, the relocation contractor continues to have an important role in arranging housing and providing other relocation supports (and post-transition supports). It is the responsibility of the MCO service coordinator to coordinate all relocation activities with the relocation contractor.

*Amendment # 5: As nursing facility services for adults were included in managed care, the MCO service coordinator at the nursing facility began playing a key role in MFPD outreach. The name of the SPU was changed to the Program Support Unit (PSU) for simplicity. The MCO service coordinator or the relocation specialist support the nursing facility resident to complete an enrollment form to select an MCO for community services and send to the enrollment broker.*

<b>Function</b>	<b>Lead Responsible Party</b>	<b><i>Amendment #5 Lead Responsible Party</i></b>
Contact consumer after initial call to DADS. DADS makes referral to relocation contractor.	Star Plus Service Unit (SPSU)	N/A

Tell individual to contact the enrollment broker to select MCO		<i>Program Support Unit (PSU)</i>
SPSU posting of Form 3676-SPW, STAR+PLUS Waiver Program Pre-Enrollment HMO Assessment Authorization, to Tex Med. SPSU also send Form 3676-SPW to the Relocation contractor at the same time the form is sent to the HMO.	SPSU	<i>PSU</i>
Complete assessment including Form 3652-A, Client Assessment, Review and Evaluation (CARE); develop ISP; post ISP to TexMed.	MCO	<i>MCO</i>
Coordinate with Medicaid Eligibility	PSU	<i>PSU</i>
Relocation contractor makes initial contact with consumer and completes TLC application and forwards to DADS Provider Services, State Office. MCO works with the relocation contractor.	Relocation Contractor with support from MCO	<i>Either the MCO or the relocation contractor makes the initial contact.  The MCO makes a referral to the relocation contractor for relocation services which may include TLC.</i>
Develop relocation plan	MCO with support from the Relocation Contractor	<i>MCO</i>
<p>Arrange transition components of relocation plan:</p> <p>a. Transition to Life in the Community (TLC) and set up of household items - <i>Relocation Contractor</i></p> <p>b. Transition Assistance Services (TAS) and set up of household items - <i>HMO</i></p> <p>c. Individual Service Plan (ISP) – <i>HMO</i></p> <p>d. Set move out date – HMO in Coordination with SPSU and Relocation</p>	<p>MCO is responsible for overall coordination of the relocation plan.</p> <p>Relocation Contractor will support and provide specific components of the plan.</p>	<p><i>MCO responsible for TAS assessment and adding TAS to the IPC, ISP and the move out date.</i></p> <p><i>MCO will refer to relocation contractor for assistance, including TLC, assistance with housing and other non-medical supports.</i></p>

<p>Contractor</p> <p>e. Housing – <i>Relocation Contractor</i></p> <p>f. Present at time of discharge at home site – <i>Relocation Contractor</i></p> <p>g. Coordination with Nursing Facility - <i>HMO</i></p> <p>h. Coordination with Home and Community Support Agency (HCSSA) - <i>HMO</i></p> <p>i. Coordination of Mental Health services appropriate with the MHA</p> <p style="padding-left: 40px;">Medicaid – HMO</p> <p style="padding-left: 40px;">Medicare / non-Medicaid – Relocation Contractor</p> <p>j. Transportation – mainline, special transit and local transportation providers - <i>HMO</i></p> <p>k. Medical/dental services, including prescriptions - <i>HMO</i></p> <p>l. Durable medical equipment - <i>HMO</i></p> <p>m. Utilities/telephone – <i>HMO</i></p> <p>n. Banking/bill payment/direct deposit – <i>Relocation Contractor</i></p> <p>o. Household items/furniture – <i>TAS/TLC</i></p>		
<p>Follow up assessment/monitor process after transition is completed</p>	<p>MCO and Relocation Contractor</p>	<p><i>MCO and Relocation Contractor</i></p>
<p>Service Coordination</p>	<p>MCO</p>	<p><i>MCO</i></p>

***ICFs/IID and State Supported Living Centers.*** The LIDDAs, for individuals residing in state supported living centers, or the Interdisciplinary Team (IDT), for individuals residing in large community ICFs/IID, will meet with the individual or their Legally Authorized Representative (LAR) to provide information regarding community living options. These meetings will occur at least annually or upon the request of the resident

or LAR. The IDT/LIDDA must use the CLO instrument. The information discussed during the CLO meeting is summarized below (see Appendix C and F for all information discussed) and the meeting is conducted based on the self-determination philosophy and using an approach that is focused on the preferences of the resident/LAR.

When an alternative living arrangement is requested, the subsequent information will be used by the LIDDA to identify appropriate community resources and to develop the individual's service coordination plan.

- Individual Preference.
  - Where does the individual want to live?
  - What information has been provided on living options?
- LAR/Family Preference.
  - What information has been provided to the LAR/family member related to living options and permanency planning?
  - What is the LAR/family member's stated preference?
- Medical/Behavioral/Psychiatric Issues.
  - If present, how can these needs be met in alternative living arrangement?
  - What can the facility or LIDDA staff do to support/facilitate these needs in an alternative living arrangement?
  - What are the treatment needs?
- Quality of Life.
  - If a minor, has permanency planning been incorporated into the service plan and reviewed as required?
  - What efforts have been made to ensure LAR/family participation?
  - If a minor, have educational issues been addressed?
  - What are the most important factors for this person in choosing a place to live?
  - What would enable these factors to take place for the individual to live in an alternative living arrangement?
  - What can the facility or LIDDA staff do to support/facilitate these needs in an alternative living arrangement?
- LIDDA Recommendations/Input.
  - What alternative living arrangements are available to meet the individuals needs?

- Within what timeframe could placement in an alternative living arrangement occur?
- Was the LIDDA representative at the planning conference?
- If not, what was the source of the LIDDA input?

If an alternative living arrangement is requested, the LIDDA will discuss with the individual/LAR the various living arrangements and services available. During this discussion, the following topics are discussed (also see the DADS brochure, *Explanation of Services and Supports* located at Appendix F).

- Services and Supports Provided through DADS.
  - General Revenue funded services.
  - Determination of eligibility for services and supports.
  - Service coordination.
  - Community supports.
  - Respite.
  - Employment assistance.
  - Supported employment.
  - Nursing.
  - Behavioral support.
  - Specialized therapies.
  - Vocational training.
  - Day habilitation.
  - In-Home family support.
- Services under DADS Medicaid 1915(c) waiver Programs.
  - Types of 1915(c) waiver programs and services available.
  - Various living arrangements allowed under the 1915(c) waiver.
  - Eligibility criteria.
  - Enrollment process.
  - Consumer preferences and choice.
  - Selection of providers.
  - Consumer directed service options.

- Useful telephone numbers.

*Amendment # 5: If alternative housing is sought by the individual, the LIDDA will refer to the relocation specialists, who will conduct an assessment and become part of the service planning team.*

**Closure of Community ICFs/IID.** As part of the MFP Demonstration, Texas plans to target providers of community operated ICFs/IID who agree to voluntarily close. The actual procedures that will be followed for these facilities will be addressed in Section 1, Part B of this *Operational Protocol*. In addition to the above information provided to individuals residing in an ICF/IID, a facility that has chosen to voluntarily close will discuss the following issues with the individual/LAR:

- Types of living options for each individual.
- Description of the CLO process to be conducted prior to the closure which includes:
  - Update the current CLO documentation.
  - Identification of the proposed timelines for the closure and relocation of residents.
  - Preferred choice of living arrangements for individuals.
  - Description of the relocation assistance to be furnished by the provider.
- Actions the provider will take to ensure the facility remains in compliance with regulations during the closure process.
- Whether or not the provider intends to continue as a provider of ICF/IID services, and if provider's plan includes the conversion to Home and Community-based Services (HCS).
- Notification procedures, which will include the provider's written and verbal notice to each individual and the individual's legally authorized representative (LAR) or family at least thirty calendar days prior to the facility closure. The notice shall include a description of assistance that is available from: (1) the provider during the relocation process, (2) from the local LIDDA, (3) the fact that the provider will work in cooperation with the applicable LIDDA to assist individuals to make an informed choice, and (4) contact information.

Texas also provides additional support in the relocation of children. In these situations, DADS provides HHSC with a list of individuals who are under 22 years of age to ensure that these individuals and their families/LARs are offered assistance through the Family-based Alternatives Project.

The Family-based Alternatives project is operated by HHSC to assist children in institutions to return home to their birth families. When relocation to the family home is not possible, the project arranges for alternate families called "support families" who are

carefully matched with children and their birth families to jointly care for the child on a long-term basis with the birth family. The Family-based Alternatives contractor will work with permanency planners and relocation specialists to assist in the identification and transition of children from institutional settings to their homes or to support families.

### **Dissemination of Information**

Staff from HHSC, DADS and DSHS will market the MFP Demonstration by providing educational seminars and information about the MFP demonstration to the following organizations. (Please see the *Outreach/Marketing/Education* section of the *Operational Protocol* for a list of additional organizations that will assist in marketing the MFP Demonstration.)

- The Money Follows the Person Demonstration Advisory Committee.
- The Texas Promoting Independence Advisory Committee.
- The DADS Council.
- Legislature.
- All appropriate state business units concerning the MFP Demonstration.
- Representatives from Managed Care systems.
- Behavioral Health Providers in the pilot area.
- DADS case managers and MCO service coordinators.
- Guardianship staff.
- Meetings of various Long-Term Services and Supports provider associations.
- Statewide housing associations.
- Nursing Facilities, ICFs/IID and state supported living centers.
- The DADS, HHSC, and Texas Promoting Independence websites.

*Amendment #5: The Texas Promoting Independence Advisory Committee assumed the advisory role for the demonstration. There is substantial overlap in membership between the two committees and the MFP demonstration aligns with PIACs primary function to provide ongoing input on issues pertaining to community integration.*

## b. Qualified Institutional Settings

***The qualified institutional settings that individuals will be transitioning from, including geographical considerations and targeting, the names of the facilities for the first year, and an explanation of how the facilities being targeted meet the statutory requirements of an eligible institution.***

Individuals will be transitioning from Medicaid certified nursing facilities or intermediate care facilities for individuals with intellectual disabilities as defined in Section 6071(b) (3) of the DRA. With the exception of the two pilot projects, this MFP Demonstration project will be available statewide. HHSC, DADS and DSHS will collaborate in a pilot project in the San Antonio area for transition of individuals who have behavioral health conditions (mental illness or substance abuse issues) from nursing facilities. The second pilot will include individuals who transition from a nursing facility, require *Overnight Support Services*, and reside in three counties in the Rio Grande Valley area of South Texas. With the exception of state supported living centers, all other “institutional settings” are licensed under state rules.

A list of all nursing facilities, ICFs/IID, and state supported living centers is attached at Appendix D.

*Amendment #5: Per April 1, 2011 CMS/MFP guidance, Texas added hospitals as a qualifying institution. The Overnight Support Services pilot ended.*

## c. Minimum Residency Period

***The minimum residency period in an institutional setting and who is responsible for assuring that the requirement has been met.***

DADS will provide relocation contractors and DADS case managers with MDS data that identifies the date individuals were admitted into a NF. MFP Demonstration participants will meet the minimum residency requirement of *at least ninety days, excluding any rehabilitative services funded through Medicare*. Relocation contractors, DADS case managers and MCO service coordinators will physically review individual records to confirm the residency requirement. LIDDA service coordinators and state school staff will review the individual records to confirm the residency requirement for ICFs/IID and state *Supported Living Centers*.

*Amendment # 5: MCO service coordinators receive the MDS data rather than DADS case managers. The PSU verifies the minimum residency criteria has been met.*



d. Participant Eligibility for MFP Demonstration.

***The process (who and when) for assuring that the MFP participant has been eligible for Medicaid a month prior to transition from the institution to the community.***

HHSC has the responsibility for determining and certifying financial eligibility for Medicaid participants. HHSC Medicaid eligibility staff will advise DADS, DSHS, Relocation Contractors, ICFs/IID and state school staff of Medicaid eligibility on a monthly basis.

e. Re-Enrollment into the Demonstration

***The State's policy regarding re-enrollment into the demonstration. That is, if a participant completes 12 months of demonstration services and is readmitted to an institution including a hospital, is that participant a candidate for another 12 months of demonstration services? If so, describe the provisions that will be taken to identify and address any existing conditions that lead to re-institutionalization in order to assure a sustainable transition.***

For those individuals readmitted to an institution before reaching the twelve month demonstration period, their 365-day entitlement will resume upon re-entering the community setting.

Individuals may only re-enroll into the MFP Demonstration if they meet the institutional residency requirement (6 months) as required by CMS, are Medicaid eligible, and there has been change in their condition that would improve the likelihood of success in the community. In all cases, a thorough review of the original transition will be conducted to mitigate any problems for a second transition.

When there is a significant change in an individual's condition, there is a re-assessment of the individual and the development of a new Plan of Care (POC). There is every attempt to have the new POC meet the needs of the individual and prevent re-institutionalization.

If however, the individual must be institutionalized, the individual, upon condition stabilization and a desire to return to the community, will be reassessed for community-based services and a new POC developed. The individual's re-institutionalization will be taken under consideration during the reassessment, and when appropriate and within the current array of services, the case worker or the service coordinator will address the conditions that resulted in the original medical/functional deterioration. The relocation contractor will be notified and will provide additional contacts for individuals who have to go back into the institution and return back into the community. There are

going to be issues that were a one-time occurrence, without an expectation for a reoccurrence, and should not prevent the ability to return to the community.

Ultimately, the decision to return to the community remains with the individual and/or his/her legal guardian. Individuals who want to relocate and meet the eligibility criteria will be offered and encouraged to return to the community.

*Amendment #5: The state will draw down enhanced match for the **first** 365 days only. An MFPD qualified individual, who has completed 365 days of services and returned to an institution may leave institutional services to receive services in the community. The state would not draw down additional enhanced match beyond the first 365 days.*

*The residency requirement is 90 days instead of six months.*

#### f. Information to Make Informed Choices

***The State's procedures and processes to ensure that participants will have the requisite information to make choices about their care.***

Participants have requisite information to make choices about their care. The ability of an individual to receive adequate information and make informed choices about their living arrangements and the type of services they receive is paramount in all of HHSC and DADS programs. Each of the Medicaid 1915(c) waivers that will be used to transition individuals from nursing facilities, ICFs/IID, or state supported living centers back into the community requires that the state not only assure, but develop discovery mechanisms to substantiate that participants are afforded choice: 1) between 1915(c) waiver services and institutional care, and 2) among 1915(c) waiver services and long-term service and support providers.

During the process of outreach to nursing facility residents, the relocation specialist visits the resident to discuss the transition process. At this time, an assessment of the resident's relocation needs is documented and the relocation specialist contacts DADS for the assignment of a case manager. As identified in Section of B1a of this Operating Protocol, the DADS case manager (or Star+PLUS service coordinator if the resident resides in a managed care area) provides information about the transition process, long-term service and supports options available to the resident, consumer directed service options, and the types of residential settings available under the programs.

This same type of information identified in the preceding paragraph is provided to residents of ICFs/IID or state supported living centers through the Community Living Options process, which was identified previously in this *Operational Protocol*. During

this process, the applicant, guardian, LAR, and, if the LAR is not a family member, at least one family member, is provided with verbal and written explanation of the services and supports for which the applicant may be eligible. The discussion is documented on a form entitled *Explanation of Services and Supports* (copy located at Appendix F).

## **i. Training and Dissemination of Information**

**How training and/or information is provided to participants (and involved family or other unpaid caregivers, as appropriate) concerning the State's protections from abuse, neglect, and exploitation (ANE), including how participants (or other informal caregivers) can notify appropriate authorities or entities when the participants may have experienced abuse, neglect or exploitation.**

Information on reporting ANE is provided to the individual and LAR in writing. The service provider must ensure that the individual and their LAR are informed of how to report allegations of ANE. The service provider also provides the individual and their LAR with the toll free telephone numbers for the Texas Department of Family and Protective Services (DFPS) and DADS, who have the statutory responsibilities for ANE investigations.

Under the 1915(c) waivers for adults, DADS conducts a desk review of any alleged incident and DFPS investigates the allegation. In these cases, DFPS coordinates its activities with DADS.

In addition, an individual transitioning from a nursing facility or their LAR is provided with the following toll-free telephone numbers:

- DADS Consumer Rights and Services.
- Department of Family and Protective Services.
- Local Area Agency on Aging.
- Medicaid Hotline.
- State Long-Term Care Ombudsman Program.

Individuals transitioning from an ICF/IID or state school are provided with the following toll-free telephone contact for additional information or to ask additional questions:

- DADS Consumer Rights and Services.
- Advocacy, Inc. – <http://www.advocacyinc.org/index.cfm>
- EveryChild, Inc. – <http://everychildtexas.org/>
- Texas Center for Disabilities Studies – <http://uap.edb.utexas.edu/>

- Texas Council for Developmental Disabilities – <http://www.txddc.state.tx.us/>
- The Arc of Texas (and Texas Advocates) – <http://www.thearcoftexas.org/>
- Parent Association for the Retarded of Texas, Inc (PART) – <http://www.partoftx.org>
- United Cerebral Palsy of Texas – <http://www.ucptexas.org/>

**ii. Identify the entity or entities that are responsible for providing training and/or information and how frequently training and education are furnished.**

While a significant number of relocation activities are initiated through self identification by the individual/family member residing in a nursing facility, ICFs/IID or state school, the following organizations and/or individuals are involved as the primary entry point for all prospective MFP Demonstration participants:

- Nursing facility staff, especially the nursing facility social worker.
- ICFs/IID and state school staff.
- DADS case managers.
- MCO service coordinators.
- Local Intellectual and Developmental Disabilities Authorities.
- HHSC eligibility workers.
- Aging and Disability Resource Centers.
- Office of the Long-Term Care Ombudsman.
- Relocation contractors.

Representatives from these organizations provide accurate, timely information that explains how the programs work, what the benefits are, what supports are offered and how to apply. As with all programs, the information will be culturally and linguistically appropriate, and will be made available to the larger community (including family members) and other stakeholders.

As noted previously, individuals/LARs also receive information and education about reporting suspected cases of abuse, neglect or exploitation and the MFP Demonstration through routine contacts with relocation contractors, long-term care ombudsmen, nursing facility social workers, DADS case managers, home health agencies, MCO service coordinators, local LIDDAs and MHAs, and third-party not-for-profits. This information is available in English, Spanish and Vietnamese.

HHSC and DADS routinely hold training conferences for providers of long-term services and supports. The type and frequency of training is addressed in the Outreach/Marketing/Education section of the *Operational Protocol*.

Finally, the case worker and agency provider, or the managed care provider will provide a list of numbers the individual should call if they encounter problems; they will provide issue-specific information and set a priority of who they should call for what situation depending on the priority.

The individual will be provided, at minimum, specific information on the following: complaint procedures; rights and responsibilities; service delivery schedules; and names and telephone numbers of the person(s) delivering services.

## 2. Informed Consent and Guardianship

***Provide a narrative describing the procedures used to obtain informed consent from participants to enroll in the demonstration. Specifically include the State's criteria for who can provide informed consent and what the requirements are to "represent" an individual in this matter. In addition, the informed consent procedures must ensure all demonstration participants are aware of all aspects of the transition process, have full knowledge of the services and supports that will be provided both during the demonstration year and after the demonstration year, and are informed of their rights and responsibilities as a participant of the demonstration. Include copies of all informed consent forms and informational materials.***

### **a. Procedures for Providing Informed Consent**

#### ***i. Criteria and requirements to provide informed consent and represent an individual.***

Texas will require that all individuals participating in the MFP Demonstration or their Legally Authorized Representative (LAR) -- i.e., parent, guardian, or managing conservator of a minor individual, or a guardian of an adult -- be informed of all their rights and options for long-term services and supports and that participation is voluntary. This includes acceptance of services and the consent to participate in the evaluation component of the grant. The *Informed Consent* Form (Appendix E) will be signed only by the individual being transitioned or those who have legal authorization to act in the individual's behalf.

DADS case managers, home health agency service coordinators, MCO service coordinators, and LIDDA staff will secure the appropriate signatures on the *Informed Consent* form (Appendix E) which indicates that they have been informed and are voluntarily choosing to participate in the MFP Demonstration without coercion.

#### ***ii. Awareness of Transition Process/Knowledge of the services and supports***

Section 1, Part B1 of the *Operational Protocol* identifies the transition process and information provided to the individual/LAR for both nursing facility and ICFs/IID and state school transitions.

As noted previously, a significant number of individuals self-identify as candidates for transition. In many cases, the initial contact for a nursing facility transition is through the relocation specialist who provides information on the transition process and conducts an assessment of the individual's transition needs. The relocation specialist then contacts the nursing facility social worker about the possible transition, followed by a contact to a DADS case manager or Managed Care service coordinator who begins the assessment

process for medical eligibility (HHSC eligibility workers collect information to determine financial eligibility) and explains the transition process, the type of long-term services and support and consumer directed options available, and begins development of the plan of care.

For the individuals in an ICF/IID or state school who have not self-identified the desire to move into a community setting, the awareness of the transition process begins with the Community Living Options process. It is during this process that the individual's desires and choices for their preferred living arrangement are determined and information is gathered to effect a successful transition. The local LIDDA further discusses the transition process, assists in locating the preferred living arrangement, and develops a plan of care that takes into consideration the individual's need and choice for services and supports.

### ***iii. Information about Rights and Responsibilities***

Informed consent under this MFP Demonstration will include two components: 1) the acceptance of services and; 2) the consent to participate in the evaluation component of the project.

The consent for waiver services will follow current 1915(c) waiver practices (as dictated by CMS) and will be obtained during the care planning phase of the transition but prior to the delivery of home and community-based services. Risks of receiving certain services, the range of services that are available, and any restrictions on amount, duration and scope because of cost caps will be included in the informed consent process. Additional supports necessary to carry out the service plan will be fully explained to the prospective MFP Demonstration participant or representative, particularly with regard to self-directed services and supports.

The *Informed Consent* form will include the provision that participation in the MFP Demonstration is voluntary and protects project-related information that identifies individuals. The document will state that the information is confidential and may not be disclosed directly or indirectly, except for purposes directly related with the conduct of the project. The document will also indicate that the state will obtain written consent of the individual prior to disclosure of individual level information.

Finally, the *Informed Consent* form advises the individual that they can withdraw from the project at anytime, the MFP Demonstration period is for one year, the special demonstration services are available for one year, and that their existing Medicaid 1915(c) services will continue after the MFP Demonstration period as long as they continue to meet the eligibility requirements for the program.

## **b. Guardian Relationships**

***Provide the policy and corollary documentation to demonstrate that the MFP demonstration participants' guardians have a known relationship and do interact with the participants on an ongoing basis; and have recent knowledge of the participants' welfare if the guardians are making decisions on behalf these participants. The policy should specify the level of interaction that is required by the State. In addition, the State must set the requirements for, and document the number of visits, the guardian has had with the participant within the last six months. This information must be available to CMS upon request.***

### ***Guardian Relationship and Interaction with MFP Participants.***

Chapter XIII of the Texas Probate Code requires a guardianship to be determined and renewed annually by a probate judge, but does not include requirements about level of interaction. (There are 254 counties in Texas and each has their court for probate proceedings.) The annual report required by the Code, and filed with the court, requires the guardian to report the date of the last contact and the frequency of the contacts with the ward. However, the judge is given discretion to determine what is in the best interest of the ward and set minimum expectations for contacts. Many judges apply the national accreditation standard of one visit per month in this determination.

### ***MFP Participant Welfare***

For private professional guardians, the Texas Guardianship Certification Board has established a standard of one visit per month. The standards are linked to certification that is now required for these types of guardians (effective September 1, 2007).

For individuals who are wards of DADS guardianship program, DADS has adopted both the national and Texas standards, which have a minimum of one contact per month.

### ***MFP Guardianship Requirements and Interactions***

If a public guardian has been appointed for a prospective MFP Demonstration participant, the DADS case manager (or service coordinator, depending on the 1915 (c) waiver or in a managed care catchment area) will make personal contact with that guardian to explain the choices of the prospective MFP participant, key features of the MFP Demonstration program, and various long-term services and support options that are available to the individual.

However, neither HHSC nor DADS can dictate the relationship between a guardian and their ward as these issues are governed by the Texas Probate Code.

The DADS data management system does not track visits by private guardians.



### 3. Outreach/Marketing/Education

**Submit the State's outreach, marketing, education, and staff training strategy.**

**NOTE: All marketing materials are draft until the Operational Protocol is approved by CMS. Please provide:**

#### **a. Information to be communicated to enrollees, providers, and State staff**

Texas' Promoting Independence Initiative and Plan was created in 2001 and is well established within the long-term service and support systems throughout the state. Because of this success, participation in the MFP Demonstration for both nursing facility and ICFs/IID is expected to be consumer-driven.

Individuals in nursing facilities typically learn of the Promoting Independence Initiative and Plan by word of mouth or from relocation specialists, nursing facility social workers, Medicaid eligibility workers, or representatives of the local Office of the Long-Term Care Ombudsmen. Most participants relocate with the help of relocation specialists, DADS case managers, provider agency case managers or Managed Care service coordinators.

Individuals in ICFs/IID or state supported living centers typically learn of the Promoting Independence Initiative and Plan through the annual Community Living Option process (previously described in this *Operational Protocol*), through word of mouth, or from representatives of LIDDAs and local advocacy organizations.

Key players in the Promoting Independence Initiative and Plan are the relocation contractor, LIDDAs, and advocacy organizations which, provide outreach activities for individuals that reside in institutions and/or who have indicated an interest in relocating into community living arrangements.

The relocation contractor will provide relocation assistance and intensive service coordination activities to assist NF residents to transition to community settings of their choice.

Relocation assistance to nursing facility residents will consist of but will not be limited to:

- Providing information about Medicaid 1915(c) waiver, non-waiver, and other funded services and supports.
- Providing Transition to Life in the Community (TLC), and for all program placements other than Adult Foster Care and Assisted Living, Transition Assistance Services (TAS).
- Developing of person/family-directed transition plans and arrangements.
- Advocating for individuals making the transition and their families.

- Coordinating of needed services/resources to transition into the community, with such entities as the local housing authority, the Mental Health Authority (MHA), Department of Assistive and Rehabilitative Services (DARS) regarding relocation activities, and:
  - Housing.
  - Mental health services.
  - Transportation (particularly in rural areas).
  - Medical/dental services, including prescriptions.
  - Durable medical equipment.
- Securing access to needed community services, such as:
  - Utilities/telephone.
  - Banking/bill payment/direct deposit.
  - Household items/furniture.
  - Special transit and local transportation providers.
- Following-up on post-transition activities for at least six months:
  - Once a week for the first month.
  - Twice a week for the second month.
  - At least once during the third month.
  - More frequently as the MFP participants needs warrant.

A representative from the local LIDDA will provide relocation assistance and intensive service coordination activities to individuals living in ICFs/IID and state supported living centers to transition to community settings of their choice. When an alternative living arrangement is requested, the following information will be used by the LIDDA to identify appropriate community resources and to develop the individual's service coordination plan in coordination with the individual and/or the LAR.

- Individual Preferences:
  - Where does the individual want to live?
  - What information has been provided on living options?
- LAR/Family Preferences:
  - What information has been provided to the LAR/family member related to living options and permanency planning?
  - What is the LAR/family member's stated preference?

- Medical/Behavioral/Psychiatric Issues:
  - If present, how can these needs be met in alternative living arrangement?
  - What can the facility, LIDDA staff, or managed MCO service coordinator do to support/facilitate these needs in an alternative living arrangement?
  - What are the treatment needs?
- Quality of Life:
  - If a minor, has permanency planning been incorporated into the service plan and reviewed as required?
  - What efforts have been made to ensure LAR/family participation?
  - If a minor, have educational issues been addressed?
  - What are the most important factors for this person in choosing a place to live?
  - What would enable these factors to take place for the individual to live in an alternative living arrangement?
  - What can the facility or LIDDA staff do to support/facilitate these needs in an alternative living arrangement?
- LIDDA Recommendations/Input:
  - What alternative living arrangements are available to meet the individual's needs?
  - Within what timeframe could placement in an alternative living arrangement occur?
  - Was the LIDDA representative at the planning conference?
  - If not, what was the source of the LIDDA input?

In addition to generic policies developed for the overall MFP effort, the Behavioral Health Pilot will include the following activities:

- Inclusion of representatives of the Local Mental Health Authority and OSAR will be included on the transition team and will train their staff.
- Presentation of information regarding the pilot to the transition team, local mental health advocacy groups, and substance abuse provider organizations.
- Provision of training on the pilot to the DSHS Client Rights staff that operate the 1-800 hotline so that they can refer individuals to the pilot.

Additionally, DADS Regional and Local Services Division has the responsibility for supporting the regional Community Transition Teams (Team) that were originally

established as part of the 2002 Real Choice grant. There is one Team in each of the DADS regions, which is comprised of representatives from DADS, consumers, local area agencies on aging, Adult Protective Services, managed care organizations, advocacy groups, housing organizations, long-term services and support providers, nursing facility directors of nursing, nursing facility social workers, Ombudsman, LIDDAs, Mental Health Authorities, and other community-based organizations. The Team meets monthly to address specific barriers that prevent a nursing facility resident from relocating into the community, to ensure continued success and promote effective transitions from nursing facilities back to the community.

DADS Promoting Independence and MFP Demonstration staff conduct monthly teleconferences with all regional Team leads to discuss issues, receive program updates, and learn from the experiences of one another. The MFP Demonstration will be discussed both at the DADS monthly meeting of Team leads, as well as the Team meetings.

#### **b. Types of media to be used**

A computer based training (CBT) will be developed to orient DADS staff, nursing facility and ICFs/IID and state school providers on the MFP Demonstration. The DADS website has been revised to include information on the MFP Demonstration. Clients, family members and unpaid caregivers can access the site to get information on the MFP Demonstration. Press releases will be issued announcing the MFP Demonstration upon approval of the *Operational Protocol*.

#### **c. Specific geographical areas to be targeted**

The MFP behavioral health transition from nursing facilities to community living will be limited to San Antonio. The Overnight Support Services for individuals transitioning from nursing facilities will be limited to the counties of Hidalgo, Cameron, and Willacy which are in the Rio Grande Valley area of South Texas. All other MFP Demonstration activities will be statewide.

For the Overnight Support Services, program information will be sent to provider agencies in the three county area which explains the program. For the Behavioral Health pilot, information will be shared with the Mental Health Authority, relocation contractors, and the nursing facility social workers.

*Amendment # 5:*

*As of September 1, 2014, Overnight Support Service was discontinued.*

#### **d. Locations where such information will be disseminated**

- Information will be provided through the DADS website, including the Promoting Independence website.
- Stakeholders will be informed through the Promoting Independence Advisory Committee and the MFP Demonstration Advisory Committee.
- Policies and procedures will be incorporated into the appropriate case management and provider manuals that are posted on the HHSC/DADS/DSHS websites. Long-term services and supports providers will be advised upon posting of information.
- Information will be provided at the trainings conducted on the MFP Demonstration.
- Information will be provided through the following organizations:
  - Advocacy, Incorporated.
  - EveryChild, Inc.
  - Texas Center for Disabilities Studies.
  - Texas Council for Developmental Disabilities.
  - The Arc of Texas (and Texas Advocates).
  - Parent Association for the Retarded of Texas, Inc.
  - United Cerebral Palsy of Texas.
  - ADAPT.
  - Coalition of Texans with Disabilities.
  - Disability Policy Consortium.
  - Centers for Independent Living.
  - National Alliance on Mental Illness.

#### **e. Staff training schedules, schedules for state forums or seminars to educate the public**

- Relocation Contractors receive ongoing training about the MFP Demonstration through mandatory monthly meetings.
- Presentation on MFP and Housing at the NAHRO Annual Meeting in April 2007.
- MFP staff met with the Director of the Texas Guardianship Office in May 2007.
- Waiver Optimization Meeting with Stakeholders – Case Management – May 18, 2007.

- DADS Access and Intake Division - Stakeholder Meeting – May 29, 2007.
- HCS and TxHmL Applicant Meeting – June 4, 2007.
- Statewide Independent Living Council Meeting – June 8, 2007.
- DADS Council Meeting – June 15, 2007.
- Staff Ombudsman Training - June 13-15, 2007.
- Texas Assisted Living Provider Advocacy Group – June 28, 2007.
- HCSSA Quarterly Stakeholder Meeting – July 11, 2007.
- DADS/HCSSA/Stakeholder Meeting – July 13-17, 2007.
- Texas Traumatic Brain Injury Advisory Council Meeting - July 20, 2007
- HCS and TxHmL Provider’s Meeting – July 30-31, 2007.
- Texas Promoting Independence Advisory Meeting August 24, 2007.
- Area Agencies on Aging State Meeting – August 29, 2007
- Consumer Rights Officers Training (state supported living centers, State Hospitals and Community MHIID Centers) on September 5, 2007.
- Nine-Plus ICFs/IID Voluntary Closure Training – September 5, 2007
- Presentation at the Texas Workforce Commission State Conference, July 2007.
- Presentations to representatives from Managed Care systems by October 2, 2007.
- Presentation to the Private Providers Association of Texas – October 17, 2007.
- Presentation to the Children’s Policy Council.
- Specialized training on the MFP Demonstration to program managers, case managers and service coordinators from DADS, HHSC, MCOs, LIDDAs, and Relocation Contractors by November 1, 2007.
- DADS website will include updated information on the MFP Demonstration by November 1, 2007.
- MFP will meet with all DADS business units to educate them on the MFP Demonstration by November 1, 2007.
- Attend the annual meetings of various LTSS provider associations, provide seminar and MFP materials. Frequency: as they become available.
- Attend annual meetings of statewide housing associations to provide education on Medicaid programs and MFP programs. Frequency: as they become available.

The presentation schedule will be repeated throughout the Demonstration period. Many of the presentations are for organizations that have semi-annual or annual meetings and updates regarding the Demonstration will be presented. There is great interest in MFP and the Demonstration, and staff are already booking speaking engagements into 2008.

Also the Director of the Promoting Independence Initiative will always include the Demonstration in his presentations about the Initiative.

**f. Availability of bilingual materials/interpretation services and services**

All of DADS 1915(c) waiver programs are compliant with the bilingual materials/interpretation services for non- English speaking clients or individuals with communication limitations. DADS currently places an emphasis on communicating in Spanish and Vietnamese and will use the current resources available to communicate information pertaining to MFP.

**g. How individuals will be informed of cost sharing responsibilities**

As part of the normal 1915(c) waiver enrollment process, DADS staff will inform individuals verbally and in writing of any cost sharing responsibilities.

#### 4. Stakeholder Involvement

***Describe how the State will involve stakeholders in the Implementation Phase of this demonstration, and how these stakeholders will be involved throughout the life of the demonstration grant. Please include:***

***Chart Reflects Stakeholders Relationship and How they Influence the Project.***

##### **a. Stakeholder Organizational Chart.**

As part of the MFP Demonstration, Texas organized a MFP Demonstration Advisory Committee (MFPDAC). A description of the people and organizations which are members of the committee follows the organizational chart.

##### **b and c. Consumer and Institutional Providers Involvement**

Direct consumers, advocates, and providers will continue to play a critical role in the implementation and ongoing activities associated with this MFP Demonstration, just as they have in the creation and implementation of the current MFP and Promoting Independence initiatives. These groups played a critical role in the development of the MFP application and this *Operational Protocol*.

A Money Follows the Person Demonstration Advisory Committee (MFPDAC) has been established for this MFP Demonstration and represents aging and disability (physical, intellectual/developmental disability, sensory and mental disability communities) organizations, rural and urban providers, institutional and community providers, advocates and consumer members. Staff from the HHSC, DADS, DSHS, and TDHCA are ex-officio members of the MFPDAC.

There are a number of direct consumers on the MFPDAC – two individuals with physical disabilities, and one with intellectual and developmental disabilities; these individuals participate on the full MFPDAC and on the workgroups and will be part of the ongoing monitoring. The State has extended invitations to representatives of behavioral health consumers and will continue to provide outreach in order to get permanent representation. The State will continue to increase its overall number of direct consumer representation. Because of the geographical size of the State, scan call access is provided at all of its meetings.

The MFPDAC members' primary role has been to participate in the design of the *Operational Protocol*, and in the implementation of the MFP Demonstration. In addition, the MFPDAC will provide advice in the development of operational policy. The



MFPDAC has representatives from the following organizations. Additional descriptions can be found at the listed websites.

- **Texas Association of Home Care (TAHC).** <http://www.tahc.org/>
- **Coalition of Texans with Disabilities (CDT).** <http://www.cotwd.org/index.html>
- **The ARC of Texas.** <http://www.thearcoftexas.org/>
- **Advocates for Human Potential (AHP).** <http://www.ahpnet.com/>
- **Texas Health Care Association.** <http://www.txhca.org/>
- **University of Texas, Center for Disability Studies.** <http://uap.edb.utexas.edu/>
- **Consumers of Services.** Individuals who use long-term services and supports available through the Texas Health and Human Services Enterprise system.
- **Texas Silver-Haired Legislature.** <http://www.txshl.org/>
- **TX Assoc. of Area Agencies on Aging.** <http://www.nado.org/resources/t4abylaws.pdf>
- **Private Providers Association of Texas (PPAT).** <http://www.ppat100.com/>
- **DADS Council.** The Texas Aging and Disability Services Council provides management and policy recommendations to the executive commissioner of the Texas Health and Human Services Commission and the commissioner of DADS regarding the management and operation of DADS.  
[http://www.dads.state.tx.us/news\\_info/council/index.html](http://www.dads.state.tx.us/news_info/council/index.html)
- **ADAPT.** <http://www.adapt.org/>
- **United Cerebral Palsy (UCP) of Texas.** <http://www.ucptexas.org/>
- **National Alliance on Mental Illness (NAMI).** <http://www.nami.org/>
- **Texas Council of Community Centers, Inc.** <http://www.txcouncil.com/>

In addition, anyone who wishes to attend and participate in the MFPDAC meetings is welcome to attend and add comment to the discussions. Because of the geographic size of Texas, scan call capability is made available to all who want to attend the meetings.

The MFPDAC will monitor this MFP Demonstration through successful conclusion, and will report periodically to the Promoting Independence Advisory Committee (PIAC) which meets quarterly. The MFPDAC will review the project status on a quarterly basis and provide recommendations for program improvement and successful transition outcomes. The PIAC will provide direction for the current MFP and Promoting Independence initiatives.

To obtain the widest participation possible for the MFP Demonstration, the DADS organizational unit for Stakeholder Relations helps to ensure stakeholder input, participation and involvement and serve as a central point for scheduled, ongoing communication and input. This unit assists staff throughout the agency to engage stakeholders and consider their input in policies, rules and decisions.

Institutional providers have representation on the PIAC and the MFPDAC, and have been active participants in the development of both the MFP Demonstration and this *Operational Protocol*. As stated, Texas has a well established Money Follows the Person and Promoting Independence program, and administrators of nursing facilities, ICFs/IID and state supported living centers are aware of these programs, and have been involved in all aspects of MFP policies.

In addition to strategies developed for the overall MFP effort, the DSHS system will engage stakeholders of the Behavior Health Pilot through:

- Participation of external stakeholders as integral members of the DSHS project team.
- Provision of information and engaging its state and local advisory group processes through periodic updates and seeking assistance as needed. These groups include:
  - DADS Council, which is a nine-member, governor-appointed council that makes recommendations regarding DADS rules and policies.
  - DSHS Mental Health Program Advisory Council (MH-PAC), which includes state agencies consumers, family members, advocates and others stakeholders.
  - DSHS Agency Council, which is a nine-member citizen, governor-appointed advisory group which reviews and advises the DSHS Commissioner on mental health, substance abuse and public health policy and issues.
  - The Consumer Advisory Council for the local mental health authority in San Antonio.
  - The local BH Pilot planning and oversight team, which will include the MCO service coordinator, relocation specialist, local area agency on aging, University of Texas Health Science Center, Local Mental Health Authority the local OSAR and local DADS staff.

*Amendment # 5: The Promoting Independence Advisory Committee (PIAC) plays the advisory role for the demonstration. The PIAC's purpose is to assist HHSC develop a comprehensive working plan to ensure appropriate care settings for persons with disabilities. The HHSC executive commissioner appoints members to the PIAC. Texas Government Code Section 531.02441 specifies members must include representatives of consumer advocacy groups, service providers for individuals with disabilities,*

*appropriate health and human service agencies, and related workgroups. The PIAC meets on a quarterly basis to:*

- *Coordinate and oversee the implementation of the state's Promoting Independence Plan;*
- *Provide ongoing policy discussions on issues pertaining to community integration; and*
- *Recommend policy initiatives for the Promoting Independence Plan.*

#### **d. Consumers' and Institutional Providers' Roles and Responsibilities**

The purpose of the MFPDAC is to participate in the design of the *Operational Protocol* and monitor implementation of the MFP Demonstration throughout the five-year period.

The committee will guide *Operational Protocol* development, provide advice, monitor MFP Demonstration implementation and progress, and review the state in its obligation to meet its benchmark evaluative standards. In addition, the MFPDAC will help the state in building consensus for the MFP Demonstration and report to the Promoting Independence Advisory Committee. It is anticipated that the MFPDAC will meet quarterly to review the activities of the MFP Demonstration.

#### **e. Operational Activities with Consumers and Institutional Providers**

Once the application for the MFP Demonstration was approved by CMS, the MFPDAC was put in place. One of the functions of the MFPDAC was to assist in the development of the *Operational Protocol*. Participation was not limited only to MFPDAC members; anyone interested in participating in the MFP Demonstration was invited to assist in the development of the *Operational Protocol*. Because Texas is such a large state, individuals were able to participate in any of the meetings through scan-calls.

The sections of the *Operational Protocol* were assigned to various workgroups. Below are listings MFPDAC meetings and workgroups meetings that were held to prepare this *Operational Protocol*; all meetings were held in calendar year 2007.

- MFPDAC (4/13, 5/4, 5/18, 5.28, 6/1, 6/8, 6/15, 6/29, 7/27, 8/10, 8/17)
- Benchmarks/Evaluation/Quality Assurance (4/5, 4/11, 4/18, 4/30, 5/25)
- Transitional Services – Nursing Facilities (5/10, 5/25)
- Transitional Services – ICF/MF (4/11, 4/24, 5/17, 5/21, 5/22, 5/24, 6/12)
- Policies and Procedures (3/21,4/2, 4/5)
- Housing (3/28, 5/16, 6/27)
- Stakeholder Involvement (4/18, 5/22)

- Behavioral Health (4/4, 4/11, 4/18, 4/25, 5/2, 5/18, 6/6, 6/13, 6/28)

## 5. Benefits and Services

### a. Description of the Service Delivery System

***Provide a description of the service delivery system(s) used for each population that the State will serve through the Money Follows the Person Rebalancing Demonstration. Include both the delivery mechanism (fee-for-service, managed care, self-directed, etc.) and the Medicaid mechanism through which qualified HCBS will be provided at the termination of the demonstration period (waiver, 1115 demonstration, Medicaid State Plan, etc.). For all HCBS demonstration services and supplemental demonstration services, there is no Medicaid mechanism understanding that the services terminate with the 365 day demonstration period; however, the State must detail the providers or network used to deliver services.***

Texas uses both a fee-for-service and managed care service delivery system. The Texas MFP Demonstration will transition individuals into the existing 1915(c) home and community based waivers. A separate demonstration 1915(c) waiver will not be created for the MFP Demonstration. After the 12-month demonstration period, individuals will continue in the same 1915(c) waiver program as long as they meet the eligibility requirements of the program.

DADS operates two nursing facility 1915(c) waivers and four ICFs/IID 1915(c) waivers while HHSC operates one nursing facility waiver. Two additional 1915(c) waivers, the Consolidated Waiver Program, operate in Bexar County (San Antonio Area) and are administered as one program. All 1915(c) waivers are fee for service, with the exception of the Star+PLUS 1915 (b) and (c) waiver, which delivers managed care services and is operated by HHSC.

Texas assures CMS that all Demonstration participants will be eligible under the waiver cost limits approved by the State when transitioning from the Demonstration to the population at-large as long as they meet all the other eligibility criteria. Additionally, case management is reimbursed as an administrative service, not as targeted case management.

Provider manuals for all home and community based 1915(c) waivers can be accessed at the following website:

[http://www.dads.state.tx.us/news\\_info/publications/handbooks/index.html#handbooks](http://www.dads.state.tx.us/news_info/publications/handbooks/index.html#handbooks)

All aspects of the home and community based 1915(c) waiver programs are under continuous quality review. Accordingly, the websites have the most up to date program information.

## **b. Available Service Package**

**List the service package that will be available to each population served by the Demonstration program. Include only services that are provided through the demonstration (home and community-based long-term care services and supplemental services). Do not include acute care service or institutional services that will be paid for through the regular Medicaid program. Divide the service list(s) into Qualified Home and Community-Based Program Services, HCBS demonstration services, and supplemental demonstration services reflecting the categories of services that are listed in the solicitation. If any qualified Home and Community-based Services are not currently available to Medicaid recipients in the State (and are, therefore, not included in the State's maintenance of effort calculations), provide a detailed account of when and how they will be added to the Medicaid program. For HCBS demonstration services and supplemental demonstration services, indicate the billable unit of service and the rate proposed by the State. For supplemental demonstration services, provide any medical necessity criteria that will be applied as well as the provider qualifications.**

### **Qualified Home and Community Based Program Services**

Brief descriptions of the 1915(c) waiver programs that will be used in the MFP Demonstration program are identified below.

#### ***Medically Dependent Children Program (MDCP)***

**Eligibility:** Younger than 21 years of age, Medicaid financial determined by the Health and Human Services Commission (HHSC), individuals must meet the medical necessity requirements for nursing facility care.

**Services:** The MDCP is a fee for service 1915(c) waiver program that provides services and supports for families caring for children who are medically dependent as an alternative to residing in a nursing facility. Specific services include:

- Case management
- Adaptive aids
- Adjunct support services
- Minor home modifications
- Respite
- Transition assistance services.

**Case Management:** Case management is provided by DADS staff and is separate from direct services.

*Amendment # 5: As of November 2016, case management for MDPC was replaced by service coordination through the MCOs. MDPC was folded into managed care – in a 1915 (b) (c) waiver.*

### **Star+PLUS Managed Care**

**Eligibility:** Age 21 or older, Medicaid financial eligibility determined by HHSC, individuals must have a need for skilled nursing care and meet at least two of the nursing facility risk criteria.

**Services:** The Star+PLUS program is an 1115 waiver that provides both acute and long-term services and supports to individuals who have a physical disability or are elderly as an alternative to residing in a nursing facility. Long-term services include:

- Case management
- Adaptive aids
- Medical supplies
- Adult foster care
- Assisted living/residential care
- Emergency response
- Nursing Services
- Minor home modifications
- Occupational therapy
- Personal assistance (including consumer-directed personal assistance services)
- Home delivered meals
- Physical therapy
- Respite care
- Transition assistance services
- Speech language pathology

As the Star+PLUS program is a Managed Care Service, the following additional benefits and services are available to eligible participants:

- Prescription medication (no limits)

- Service Coordination (Acute and Long-Term Care)
- Adult well checks
- Disease Management
- Medical Home (Primary Care Physician)
- Acute care medical and behavioral health services, such as:
  - MH counseling by master's level therapists
  - psychiatry
  - psychological services
  - inpatient detoxification
- Value-added services (varies by MCO), such as:
  - partial hospitalization / extended day treatment
  - intensive outpatient treatment / day treatment
  - residential services
  - off-site services
  - health psychology interventions

*Amendment #5: In 2015, STAR+PLUS 1115 waiver added supported employment, employment assistance and cognitive rehabilitation therapy.*

### **Community Based Alternatives Program (CBA)**

**Eligibility:** Age 21 or older, Medicaid financial eligibility determined by HHSC, individuals must have a need for skilled nursing care and meet at least two of the nursing facility risk criteria.

**Services:** The CBA program is a fee for service 1915(c) waiver program that provides services and supports to individuals who have a physical disability or are elderly as an alternative to residing in a nursing facility. Services include:

- Case management
- Adaptive aids
- Medical supplies
- Adult foster care
- Assisted living/residential care
- Emergency response



- Nursing services
- Minor home modifications
- Occupational therapy
- Personal assistance (including consumer-directed personal assistance services)
- Home delivered meals
- Physical therapy
- Respite care
- Transition assistance services
- Speech language pathology

**Case Management:** Case management is provided by DADS staff and is separate from direct services.

*Amendment # 5: Texas ended the Community Based Alternatives waiver program.*

### ***Consolidated Waiver (CWP)***

**Eligibility:** No age limit, Medicaid financial eligibility determined by HHSC, individuals must have a need for skilled nursing care and meet at least two of the nursing facility risk criteria OR have either an intellectual disability or a related condition. Participants must reside in Bexar County.

**Services:** CWP is two 1915(c) waivers that are administered as a single program and operates in Bexar County for individuals on the interest lists for the CBA, CLASS, DBMD, HCS and MDCP Programs. The program provides an alternative to residing in a nursing facility or an ICF/IID. Services include:

- Case management
- Adaptive aids and medical supplies
- Adult foster care
- Assisted living/residential care
- Audiology
- Behavior communication
- Child support services
- Dental
- Dietary services

- Emergency response services
- Family surrogate services
- Habilitation
- Home-delivered meals
- Independent advocacy
- Intervener services (to facilitate communication and interaction)
- Minor home modifications
- Nursing services
- Orientation and mobility services
- Personal assistance services
- Transportation
- Psychological services
- Respite
- Social work
- Physical and occupational therapy
- Speech and language pathology

**Case Management:** Case management is provided by DADS staff and is separate from direct services.

*Amendment # 5: Texas ended the Consolidated Waiver program.*

### ***Home and Community-based Services (HCS)***

**Eligibility:** No age limit for enrollment, Medicaid financial eligibility determined by HHSC, individuals must have either intellectual disability or a related condition that results in deficits in adaptive behavior and full scale IQ of 75 or below.

**Services:** The HCS Program is a 1915(c) waiver that provides services and supports to individuals with intellectual disabilities and certain persons with a related condition, as an alternative to residing in an ICF/IID. Individuals enrolled in HCS may live in any one of four residential assistance types. Individuals receiving supported home living services live in their own home or their family's home. Individuals receiving foster/companion care live in the home of a foster care provider or in their own residence with a companion care provider. Individuals receiving supervised living services reside in a

three or four bed home that is owned or leased by the program provider and have overnight staff available if the individual needs assistance during the night. Individuals receiving residential support also live in a three or four bed home that is owned or leased by the program provider but require an awake staff while the individual is present in the residence. Other services in the HCS 1915(c) waiver program include:

- Case management
- Supported employment
- Day habilitation
- Respite
- Dental treatment
- Adaptive aids
- Minor home modifications
- Specialized therapies such:
  - Social work
  - Psychology
  - Occupational therapy
  - Physical therapy
  - Audiology
  - Speech and language pathology
- Dietary services
- Licensed nursing services
- Transition assistance services

**Case Management:** Both case management and direct services are provided by the same provider agency.

*Amendment #5: In 2011, Texas separated the service coordination function from the HCS program. As a result, LIDDA staff provided service coordination, funded as targeted case management, to HCS participants. Case management was removed as an HCS waiver service. In 2015, Supported Employment and Employment Support were added to the HCS waiver.*

### ***Community Living Assistance & Support Services (CLASS)***

**Eligibility:** No age limit, Medicaid financial eligibility determined by HHSC, individuals must have a related condition, reside in a CLASS catchment area, and require habilitation, as determined by the individual's service planning team.

**Services:** The CLASS program is a 1915(c) waiver that provides services and supports to individuals who have a related condition as a primary diagnosis, as an alternative to residing in an ICFs/IID. Individuals may live in their own or family home or in a residence with no more than three individuals with developmental disabilities who are receiving similar services. Services include:

- Adaptive aids and medical supplies
- Case management
- Habilitation
- Minor home modifications
- Nursing services
- Occupational and physical therapy
- Psychological services
- Respite
- Specialized therapies
- Speech and language pathology
- Transition assistance services
- Support family services (provided in foster family settings for individuals under 18 years of age.)

**Case Management:** Case management and direct services are provided by separate provider agencies.

### ***Deaf/Blind with Multiple Disabilities waiver (DBMD)***

**Eligibility:** Age 18 or older, Medicaid financial eligibility determined by HHSC, individuals must be deaf-blind and have another disability, such as intellectual disability or a related condition, that impairs independent functioning.

**Services:** The DBMD is a 1915(c) waiver that provides services and supports to individuals who are deaf-blind with one or more other disabilities as an alternative to residing in an ICFs/IID. Individuals may reside in their own or family home or in small group homes. Services include:

- Adaptive aids and medical supplies
- Assisted living
- Behavior communication services
- Case management
- Chore provider
- Environmental accessibility
- Habilitation
- Intervener services (to facilitate communication and interaction)
- Nursing services
- Occupational therapy
- Physical therapy
- Orientation and mobility
- Respite
- Dietary services
- Minor home modifications
- Transition assistance services
- Speech language pathology

**Case Management:** Case management and direct services are provided by the same provider agency.

*Targeted Case Management (TCM)*

- *Comprehensive encounter (Type A):* *A face-to-face contact with an individual to provide service coordination.*

*The comprehensive encounter is limited to one billable encounter per individual per calendar month. DADS will not authorize payment for a comprehensive encounter that exceeds the cap of one encounter per individual per calendar month.*

- *b) Supportive encounter (Type B): A face-to-face, telephone, or telemedicine contact with an individual or with a collateral contact on the individual's behalf to provide service coordination.*

*A Local Authority (LA) is allowed up to three Type B encounters per calendar month for each Type A encounter that has occurred within the calendar month.*

*The Type B encounters are not limited to three per individual. Rather, the allowed Type B encounters may be delivered to any individual who needs a Type B encounter. These Type B encounters are allowable as long as the individual who received the Type B encounter also received a Type A encounter that same month.*

*Payment for an individual's Type B encounter is contingent on that individual having a Type A encounter within the same calendar month. Within the calendar month, the Type A encounter does not have to occur on a date before any of the Type B encounters occur.*

*Amendment # 5: Target case management is not a waiver service.*

## **HCBS Demonstration Services**

### ***Behavioral Health Pilot***

The MFP BH pilot is designed to assist adults with behavioral health conditions who wish to relocate to the community from nursing facilities. Individuals with behavioral health conditions face additional barriers to community integration, including:

- Insufficient understanding and lack of long term care provider competency in dealing with psychiatric disorders, making providers reluctant to serve these individuals.
- Need for a process for identifying and connecting individuals with psychiatric or substance abuse disorders with appropriate long-term services and support options.
- Lack of long-term services and support options appropriate for individuals with co-occurring psychiatric disorders.
- Lack of availability of substance abuse services for adults under Medicaid.
- Lack of safe and affordable housing.

The BH pilot began upon approval of this *Operational Protocol* in Bexar County (San Antonio). *The third amendment to the Operational Protocol expanded the BH pilot to the*

*seven counties that make up the Bexar County Star+Plus service area and the Travis County Star+Plus service area. Up to fifty individuals will be served each year in the pilot. The pilot will also include training for long term service and support providers and relocation specialists in understanding and serving individuals with behavioral health disorders, and training for behavioral health providers in working with the relocation specialists, transition teams and long term care providers.*

The MFP BH pilot is designed to assist adults with behavioral health conditions who wish to relocate to the community from nursing facilities. Individuals with behavioral health conditions face additional barriers to community integration, including:

- Insufficient understanding and lack of long term care provider competency in dealing with psychiatric disorders, making providers reluctant to serve these individuals.
- Need for a process for identifying and connecting individuals with psychiatric or substance abuse disorders with appropriate long-term services and support options.
- Lack of long-term services and support options appropriate for individuals with co-occurring psychiatric disorders.
- Lack of availability of substance abuse services for adults under Medicaid.
- Lack of safe and affordable housing.

The BH pilot will begin upon approval of this *Operational Protocol* in Bexar County (San Antonio). Up to fifty individuals will be served each year in the pilot. The pilot will also include training for long term service and support providers and relocation specialists in understanding and serving individuals with behavioral health disorders, and training for behavioral health providers in working with the relocation specialists, transition teams and long term care providers.

The local Community Transition Team will work with the DSHS system to address difficult cases and systemic problems, and develop locally-focused solutions. The team in San Antonio includes the local *mental health authority*, relocation specialist, *Star+PLUS MCO administrative and care coordination staff*, advocacy organizations, and local DADS staff.

The local relocation specialist will work with the local DSHS system to identify and facilitate relocation for individuals from nursing facilities, help coordinate paperwork, secure housing, establish households, and be present for the actual move.

Individuals in the pilot will receive transitional assistance and ongoing acute and long term care services through the Star+PLUS program operated by the single state Medicaid Agency (Health and Human Services Commission – HHSC). Individuals will also have access to Medicaid state plan behavioral health benefits, such as psychosocial rehabilitative services administered by the local DSHS system, and two new MFP Demonstration services, *provided through a contract with the local Mental Health Authority*:

- Cognitive Adaptation Training.
- Adult Substance Abuse Treatment Services.



Cognitive Adaptation Training is a specialized, evidence-based service that provides community-based and in-home assistance to help individuals with psychiatric disorders establish daily routines, organize their environment and function independently. A key approach will be the use of motivational interviewing, as part of the overall Cognitive Adaptation Training, to engage the consumer in performing self-care, using environmental modifications to facilitate independence. For example, a system of reminders unique to the needs of the consumer may be implemented to assist with adherence to critical medication management.

Community-based substance abuse treatment for adults is not currently a Medicaid benefit in Texas and services may be difficult for long-term service and supports clients to access.

*Demonstration services will be initiated prior to relocation from the nursing facility when clinically indicated to help prepare the individual for community living and to establish the therapeutic relationship that will be continued in the community. This pre-relocation relationship is vital for the eventual success of the relocation and to establish the groundwork for efficient use of the behavioral health services post-relocation.*

At least a Master's Level qualified CAT therapist is required to perform CAT assessments, develop service plans, train *and supervise* CAT providers, educate Star+PLUS providers and monitor CAT service delivery to ensure quality. A qualified CAT therapist is an individual who is licensed to provide mental health therapy in Texas, has a master's level or higher who has been trained in CAT by the University of Texas Health Science Center in San Antonio (UTHSCSA).

A Bachelor's Level CAT provider is required to provide CAT interventions specified in the CAT plan. A qualified CAT provider is an individual who has a Bachelor's Degree in psychology or related field, a minimum of 2 years experience providing direct services to individuals with mental health or related issues and who has been trained by UTHSCSA to provide CAT services.

Substance abuse treatment providers will meet Texas (DSHS) licensure or certification standards for delivery of services.

### **Pilot Objectives**

- Improve coordination and education across DADS, HHSC and DSHS systems to more effectively identify, relocate, serve and measure the experience of adults with behavioral health conditions who move from nursing facilities.
- Determine the efficacy of the MFP Demonstration behavioral health services in supporting independence/decreasing inappropriate institutionalization. If successful,

Texas will consider these services for inclusion in DADS Community-based Alternatives 1915(c) and HHSC Star+PLUS 1915(c) waivers.

- Eliminate barriers that restrict individuals with BH disorders from getting HCBS services (e.g. personal care and other services appropriate to their needs).

### **Eligibility Criteria**

*Pilot participants must meet the following criteria.*

- *Adult – the primary target group is ages 21 through 64. Individuals over 65 may also be included, on a case-by-case basis.*
- *Individual has resided in an institutional setting for at least ninety days, excluding any days of rehabilitative services funded through Medicare, is Medicaid-certified, and living in licensed nursing facility at time of discharge (individuals may receive pre-transition services before the ninety day criteria is met if the anticipated discharge date meets the ninety day criteria and there is a reasonable expectation that the individual will secure community housing).*
- *Individual will reside in the community within Bexar County.*
- *Individual has signed the MFP Demonstration consent form and has met all MFPD and STAR+PLUS waiver criteria*
- *Individual is part of DSHS mandated adult population criteria:*
  - *Global Assessment of Functioning (GAF) score =<50 **and***
  - *Diagnostic and Statistical Manual of Mental Disorders (DSM) IV – R behavioral health (mental health or substance abuse) disorder, **or***
  - *Diagnosis of severe mental illness.*

### **Pilot Timeline**

- *Protocol Development – September – June 2007*
- *Protocol Submission to CMS – September 2007*
- *CMS Approval – January 2008*
- *Project, Phase 1: January – December 2008*
  - *Contract with local Mental Health Authority for CAT and substance abuse services (DSHS)*
  - *training for DADS relocation team, providers, DSHS team*
  - *identification and assessment of potential participants*
- *Project, Phase 2: April 2008 – September 2011*

- Service delivery
- Interim evaluation
- Project, Phase 3: September 2011 – September 2012
  - Cease intake
  - Phase-out activities
  - Final evaluation

The following services will be available through the DSHS system to pilot participants as specified in their individual plans of care:

<b>Substance Abuse Services (Demonstration)</b>	<b>Description</b>	<b>Rate/Unit</b>
<i>Adult Outpatient</i>	<i>An outpatient setting providing an average of 10 hours of structured services per week, often called intensive outpatient.</i>	<b>\$64/hr*</b> <i>individual</i>
	<i>* to be billed in 15 minute increments.</i>	<b>\$17/hr group*</b>
<i>Pharmacotherapy</i>	<i>A medically supervised outpatient setting designed for persons who are opioid/narcotic addicted. Services include methadone and/or LAAM (levo-alpha-acetyl-methadol) administration.</i>	<b>\$11 per day</b>

<b>Mental Health Services</b>	<b>Description</b>	<b>Rate</b>
<i>Cognitive Adaptation Training (CAT) - Demonstration</i>	<i>A service that addresses the cognitive deficits of the individual, assists the person to arrange their environment and provide tools to support skill acquisition, including improvement in medication</i>	<i>Psychosocial rehabilitative rates</i>

*adherence, personal care and activities of daily living, social skills, and integration into the community.*

### **Relocation Assistance**

DADS has entered into a contractual relationship with nine organizations throughout the state to provide relocation assistance to individuals residing in a nursing facility. The organizations include Centers for Independent Living and an Area Agency on Aging. Below is a description of the services they provide.

**Outreach:** Relocation specialists provide outreach, identification, information, and facilitation services for nursing facility residents. Relocation specialists work with nursing facility residents who will be relocating to either a fee-for-service or managed care community system. For purposes of the MFP Demonstration, individuals must have been in an institutional setting for at least *ninety days excluding any days of rehabilitative services funded through Medicare* and residing in a nursing facility at the time of relocation. Relocation contractors are required to utilize the Minimum Data Set (MDS), Section Q data provided by DADS to contact interested nursing facility residents.

**Identification and Assessment Process:** After a relocation request is made, the relocation specialist, an employee of the relocation contractor, must make initial contact with the individual within fourteen calendar days. The relocation specialist will administer an assessment that will be used to help determine the functional supports required for a successful relocation.

**Relocation Assistance:** Relocation specialists provide transition assistance and intensive service coordination to assist nursing facilities residents to transition to community settings of their choice. Relocation assistance includes:

- Providing information about Medicaid 1915(c) waiver and non-waiver services and supports (information is available at <http://www.dads.state.tx.us/services/index.html> and in DADS rules contained in 40 TAC Part 1).
- Providing Transition to Life in the Community (TLC), and for all program placements other than Adult Foster Care and Assisted Living, Transition Assistance Services (TAS).
- Development of individual-directed transition plans and arrangements.
- Advocacy for individuals making the transition and their families.
- Coordination of needed services and resources to transition into the community, with such entities as the local housing authority, the Mental Health Authority (MHA),

Texas Department of Assistive and Rehabilitative Services (DARS) in order to provide the following information or services:

- Housing.
- Mental health services.
- Transportation.
- Medical/dental services, including prescriptions.
- Durable medical equipment.
- Utilities/telephone.
- Banking/bill payment/direct deposit.
- Household items/furniture.
- Mainline, special transit and local transportation providers.
- Follow-up assessment after transition.
- Vocational Rehabilitation.

**Establishing Community Households:** Individuals transitioning to a community setting may need assistance establishing a community household. DARS will provide one-time start-up funds to help an individual establish a community residence. These start-up funds will be available through Transition Assistance Services (TAS) and/or Transition to Life in the Community (TLC) programs. TLC are general revenue funds and TAS is a Medicaid service which is part of the 1915(c) waiver array.

TLC may be used for expenses that are not covered by Medicaid or other long-term services programs. Start-up funds available through TAS are not allowed for individuals relocated to Adult Foster Care or Assisted Living facilities. The start-up funds can be used for expenses directly related to moving, including but not limited to paying others to move household belongings; rental security deposits; utility deposits; cooking utensils; other moving-related expenses and household start-up costs. For transition into community-based 1915(c) waiver programs, TAS funds must be accessed before TLC funds can be used, as TLC funds are to complement, not supplant, TAS funds.

**Post-Transition Services.** Relocation specialists are required to maintain contact with individuals relocated from nursing facilities for a minimum of seven post-transitional contacts, in compliance with the following schedule: one every week for the first month, every two weeks for the second month, once a month for the third month and thereafter as needed. The purpose of these contacts is to ensure that individuals are receiving appropriate services and to assist with adjustments in service needs. The type of contact (e.g., face-to-face, telephone, collateral) will be determined on an individual basis.

**Reimbursement Rate/Unit for Transitional Services.** Relocation services meet the September 2007 CMS guidance for *Reimbursement of Transition Service Costs* and will be matched at the enhanced rate of up \$2625 for pre-transition services and \$875 for post-transition services. This maximum reimbursement amount of \$3500 is based upon the historical cost of nursing facility transitions.

*Amendment # 5: The relocation contractor helps to provide outreach, education, and identification for potential nursing residents (NF) who want to relocate. Once identified, the NF resident is directed to the local DADS office for assistance in choosing a managed care provider. Upon that selection, a managed care service coordinator is provided who then takes the lead in relocation. However, the relocation contractor continues to have an important role in arranging housing and providing other relocation supports (and post-transition supports). It is the responsibility of the MCO service coordinator to coordinate all relocation activities with the relocation contractor.*

### **Overnight Companion Services**

Administration of Texas' MFP policy since 2001 has identified the need for overnight support as one of the barriers to a successful transition. Many of the home health providers have expressed their concerns about accepting clients with complex needs because of their overnight needs. For example, an individual may need assistance with ambulating to the bathroom, assistance with toileting, ventilation assistance, etc.

In April 2006, DADS convened a special workgroup to address the relocation issues of individuals with complex needs, which resulted in a several recommendations for change (most of which have been incorporated into DADS business practices). One of the recommendations made by advocates and providers was the need for overnight support.

Therefore, Texas proposes to offer a demonstration service for individuals who have specific functional needs and lack the informal supports to assist them during normal sleeping hours. The individual will remain eligible for this service for up to one year or until the individual, with the assistance of the case manager, is able to secure the informal supports necessary to meet their need, but not longer than one year.

During the MFP Demonstration project, Texas will evaluate this pilot service and, if considered successful, will consider amending its current adult nursing facility 1915(c) waivers (including CBA) to include this service.

### **Eligibility Criteria**

A person is eligible for this service if the individual:

- Has a cognitive impairment or physical disability.
- Is eligible for and choose to participate in the MFP Demonstration.
- Has a medical need for specific tasks to be performed during normal sleeping hours.

- Does not have someone currently available to meet these needs.
- Is willing to seek informal supports to meet these needs.
- Understands and agrees that this service is limited to a 365 day demonstration period.

*Texas Operational Protocol Amendment Number 3 still allows someone who is not capable of providing information supports to reside in the household with the MFPD participant. To help increase enrollment in the OCS pilot, the attendant will also be allowed to reside in the same household as the MFPD participant, subject to the Qualifications of the OCS attendant noted in the next paragraph.*

### **Qualifications of the Overnight Companion Services Attendant**

This demonstration service will require an attendant to meet the same qualifications as Texas' 1915(c) waiver Personal Attendant Services program (PAS). The individual receiving OCS may select to receive these services from an agency or may select the consumer directed services option. PAS provides non-medical in-home attendant services to individuals. The basic qualifications are:

- Be an employee of the provider agency (unless the MFPD participant uses the consumer directed services option).
- Be 18 years of age or older.
- Pass all registry checks.
- Not be a legal or foster parent of a minor who receives the service.
- Not be the spouse of a client who receives the service.

*Amendment # 5:*

*As of September 1, 2014, Overnight Support Service was discontinued.*

### **Qualifications of the Provider**

To ensure service plan coordination, the actual providers of this service will be 1915(c) waiver providers and will meet all of the licensure and operational requirements for PAS.

### **Location of the Demonstration Service**

*This Demonstration service will be limited to all fee-for-service counties in Region 11 (Brooks, Cameron, Duval, Hidalgo, Jim Hogg, Kenedy, Live Oak, McMullen, Starr, Webb, Willacy, and Zapata) and all counties in Region 4 (Anderson, Bowie, Camp, Cass, Cherokee, Delta, Franklin, Gregg, Harrison, Henderson, Hopkins, Lamar, Marion, Morris, Panola, Rains, Red River, Rusk, Smith, Titus, Upshur, Van Zandt, and Wood).*

## **Unit/Cost of Service**

A unit of service is defined as eight to 12 hours, during normal sleeping hours, within 24 hour period. The reimbursement rate for this service is \$44.17 per unit.

## ***HCBS Demonstration Services***

### **Transition to Life in the Community (TLC)**

Individuals who reside nursing facilities and wish to receive their long-term services and support in a community setting may need assistance setting up residence in the community. DADS will provide one-time start-up funds to help an individual establish a community residence.

TLC funds may be used for expenses that are not funded by Medicaid or other long-term services programs. Start-up funds can be used for expenses directly related to moving, including but not limited to:

- Expenses directly related to moving, such as the cost of paying others to move household belongings, the cost of moving cartons, and the cost of transporting the individual to the community setting.
- Rent deposits, limited to the first and last month's rent plus reasonable damage and security deposits.
- Utility deposits, including deposits required by electricity, gas, water, wastewater, telephone, and sanitation companies.
- Cooking utensils, dishes, cleaning supplies, furniture, appliances, towels, sheets, blankets, and other items needed to set up a household.
- Other moving-related expenses and household start-up costs approved by the case manager and DADS.

A MFP Demonstration participant must utilize Transition Assistance Services (TAS) funds, a 1915(c) waiver service, before TLC can be utilized. TLC will not be used unless an individual has exceeded the amount allowable under TAS or the item to be purchased is not allowable under TAS.

Availability of funds and approval of benefits must be confirmed by DADS before commitment is made to disburse funds. Additionally, the TLC program will not provide benefits that the individual is eligible for and able to receive through any other program.

### **Eligibility Criteria**

To be eligible to receive benefits from the TLC program, the individual must:

- not have received prior benefits through the TLC program.



- be a Texas Medicaid recipient who resides in a licensed nursing facility.
- be expected to be able to move to a community setting within 60 days after transition funds are made available to the individual.
- participate in developing a budget that indicates the financial ability to maintain ongoing household expenses after the temporary TLC assistance, including any temporary rental assistance, has been exhausted.
- need assistance with relocation expenses that cannot be met by other resources owned by, or available to, the individual.
- be accepted for services in one of the following service programs:
  - Community Based Alternatives (CBA);
  - Community Living Assistance and Support Services (CLASS);
  - Medically Dependent Children Program (MDCP);
  - Deaf-Blind with Multiple Disabilities (DB-MD);
  - other DHS community care service programs; or
  - other Medicaid-funded community-based service program offering ongoing services.

#### **Qualifications of the TLC Provider**

A TLC provider must be contracted with DADS as a Relocation Contractor.

#### **Cost of Service**

The maximum amount for TLC is \$2,500 per individual or actual costs, whichever is less.

## 6. Consumer Supports

***Describe the process and activities that the state will implement to ensure that the participants have access to the assistance and support that is available under the demonstration including back-up systems and supports, and supplemental support services that are in addition to the usual HCBS package of services. Please provide:***

### **Education Materials**

***A copy of the educational materials used to convey procedures the State will implement in order for demonstration participants to have needed assistance and supports and how they can get the assistance and support that is available;***

DADS has two documents that are currently used to provide information on the process and services available for an individual desiring to transition from an institutional setting. The *Explanation of Services and Supports* (Appendix F) is provided to individuals residing in an ICF/IID or state school. The *Money Follows the Person to Community Living* brochure (Appendix F) is provided to individuals wanting to transition from a nursing facility. Each of these brochures explains how to obtain additional information and provides contact telephone numbers.

DADS and DSHS will design an informational brochure that describes each of the demonstration services.

### **24-Hour Back Up Systems**

***A description of any 24 hour back up systems accessible by demonstration participants including services and supports that are available and how the demonstration participants can access the information (such as a toll free telephone number and/or website).***

Texas takes its responsibility for protecting health and welfare as one of its most important functions. Unless otherwise noted, the information presented in this *Consumer Supports* section pertains to both fee-for-service and Managed Care Waiver programs.

Each of the waiver programs require that an agency be responsive to a telephone call after business hours and procedures to respond to an individual's urgent call. Agency staff will triage the situation and make an appropriate decision for a successful outcome. The case manager will take immediate action to call 911 when there is an immediate threat to health or welfare as precious time could be lost in responding to such an

emergency. In other cases, the issue may be able to be resolved during the next business day or the situation may require an amendment to the plan of care, etc.

Fee-for-Service Waivers. Texas has standardized public policies and expected outcomes for back-up plans. These policies place the responsibility at the local provider agency level. Texas is too large of a state to have all consumers contact an office in Austin. The answer to this question and subsequent questions concerning consumer supports will help clarify Texas' policies concerning 24 hour back-up systems.

Under licensing rules, an agency must adopt and enforce a written policy to ensure that backup services are available when an agency employee or contractor is not available to deliver services. Additionally, an agency must adopt and enforce a written policy to ensure that clients are educated in how to access care from the agency or another health care provider after regular business hours.

At the time the Plan of Care (POC) is initiated, the individual is provided with the names and telephone numbers for all agencies which will provide services under that POC. They are also provided with information on complaint procedures, their rights and responsibilities, their service delivery schedule, and the names and telephone numbers of the people delivering services. If an individual is scheduled to receive services and the worker fails to show up, the individual has been instructed to call the agency which is required to provide a back up worker.

Managed Care Waivers. The HHSC Uniform Managed Care Contract requires that all covered services as specified in the service array must be available to members on a timely basis in accordance with medically appropriate guidelines and consistent with generally accepted practice parameters, The HMO must provide coverage for emergency services to members 24 hours a day and 7 days a week, without regard to prior authorization or the emergency service provider's contractual relationship with the HMO. The HMO's policy and procedures, covered services, claims adjudication methodology, and reimbursement performance for emergency services must comply with all applicable state and federal laws and regulations, whether the provider is in-network or out-of-network. A HMO is not responsible for payment for unauthorized non-emergency services provided to a Member by Out-of-Network providers.

The HMO must also have an emergency and crisis Behavioral Health Services Hotline available twenty-four hours/seven days a week, toll-free throughout the service area. For Medicaid Members, a HMO must provide coverage for emergency services in compliance with 42 Code of Federal Regulations. §438.114. The HMO may arrange emergency services and crisis Behavioral Health Services through mobile crisis teams.

For the STAR, STAR+PLUS, and CHIP Programs, and for CHIP Perinatal Newborns, HMO must require, and make best efforts to ensure, that PCPs are accessible to members twenty-four hours/seven days a week and that its Network Primary Care Providers (PCPs) have after-hours telephone availability. CHIP Perinatal HMOs are not required to establish PCP Networks for CHIP Perinatals.

The HMO must provide that if medically necessary covered services are not available through Network physicians or other Providers, the HMO must, upon the request of a Network physician or other provider, within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation, allow a referral to a non-network physician or provider.

The HMO must fully reimburse the non-network provider in accordance with the out-of-network methodology for Medicaid as defined by HHSC, and for CHIP, at the usual and customary rate defined by Texas Department of Insurance in 28 Texas Administrative Code Section 11.506.

*Amendment #5: Texas requires provider agencies to develop a backup plan for each individual enrolled in the fee for service or managed care waivers. Each back up plan is to be reviewed annually and updated if the individual's condition changes.*

***Include information for back-up systems including but not limited to:***

### ***Transportation***

Texas' Medicaid entitlement programs authorize a medical transportation program (MTP) to provide eligible individuals with the most cost-effective means of transportation for allowable medical and dental care services within reasonable proximity of their residence. The case manager, service coordinator, or relocation specialist will provide all MFP participants with telephone numbers and contact names on how they can access transportation in their community.

### ***Direct service workers***

Under existing program rules, a home health agency must ensure that any authorized or scheduled personal assistance services are delivered in accordance with the plan of care and special attendants may be used to prevent a break in service and provide ongoing service coverage for the individual. The case manager, service coordinator, or relocation specialist will provide all MFP participants with the telephone numbers and contact names of state and provider staff in case they experience an interruption in community-based services so that appropriate action can be taken.

As stated previously, all agencies must adopt and enforce a written policy to ensure that backup services are available when an agency employee or contractor is not available to deliver the services. The backup services may be provided by an agency employee, a contractor, or the individual's designee who is willing and able to provide the necessary services. (If the individual's designee has agreed to provide backup services, the designee is required to sign a written agreement to be the backup service provider.) Further, the Texas Administrative Code requires that an agency must ensure that clients are educated in how to access care from the agency or another health care provider after regular business hours.

Licensed home health agencies must have a telephone number where an individual receiving 1915(c) services can reach a person during the agency's operating hours. After normal business hours, the home health agencies must have call back or on-call systems in place to respond to messages left on a machine or answering services. If there were an essential equipment failure after hours that could be a threat to their health or safety, the individual should call 911 for immediate assistance. If the individual were to call the licensed home health agency under such circumstances, the agency representative would triage the situation and take the appropriate action, including calling 911 for emergency assistance. If services were scheduled to be provided after normal business hours, a replacement would be dispatched.

### ***Repair and replacement DME/Equipment***

The case manager, service coordinator, or relocation specialist will provide all MFP participants with the telephone numbers and contact names of who they should contact when they experience a problem with durable medical equipment or other equipment.

### ***Access to medical care***

***An individual is assisted with initial appointments, how to make appointments and deal with problems and issues with appointments and how to get care issues resolved.***

Any of the following provide the above assistance to individuals in need of medical care: the DADS case manager, MCO service coordinator, relocation specialist, LIDDA service coordinator, and home health agency case manager.

### ***Complaint Resolution Process***

***A copy of the complaint and resolution process when the back-up systems and supports do not work and how remediation to address such issues will occur.***

An individual receiving any 1915(c) waiver service can file a complaint with HHSC, DADS, or any of the MCOs. The contacts can be through toll-free telephone access or to HHSC's or DADS websites.

DADS has an established Consumer Rights division which has a twenty-four hour complaint hotline. This line is answered by in-office employees from 8 a.m. to 5 p.m. Monday through Friday; voice mail is available twenty-four hours a day, seven days a week. Voice mail is monitored by in-office employees from 8 a.m. to 5 p.m. on Saturday, Sunday, and holidays.

Both DADS and the MCOs have developed, implemented, and maintain systems for tracking all complaints and appeals from long-term services and support (LTSS) providers and individuals/LAR's enrolled in any Medicaid 1915(c) waiver. Depending upon the nature of the complaint, LTSS providers must respond fully and completely to each complaint and appeal. All complaints are tracked to document the status and final disposition of each complaint and appeal.

Complaints are logged with a priority assigned. Priority is assigned based on the circumstances and the threat to an individual's health and welfare. The priority may be assigned upon intake or by the investigating staff. The priority level of a complaint determines the timeframes for completing the investigation.

The complaint is referred to the appropriate staff for investigation based on the allegation. Complaints may also be referred to multiple departments or divisions, which coordinate investigations when applicable.

Complaint investigations are unannounced. The LTSS provider's complaint history is reviewed prior to the on-site visit. During the on-site investigation, a sample of participant records is reviewed. The sample may or may not be random, based on the nature of the allegation. The investigation may include interviewing participants, LTSS provider staff and others as necessary.

Upon completion of the investigation, the investigator determines if the allegation can be substantiated. The investigator then determines which, if any, areas of non-compliance with rules and regulations will be cited and recommends appropriate action. There are state rules and policies which go into effect if the violations are not cleared within the promulgated timeframe.

The provider must document, investigate, and resolve all complaints that are reported to them within five workdays from receipt of the complaint report unless a different time frame is found in the service-specific program requirement. Finally, the provider must maintain a log of consumer complaints and must ensure that:

- All written complaints are stamped with the date of receipt;

- All verbal complaints are documented with the date of receipt and a narrative of the allegation(s); and
- The complaint log is accessible to DADS staff.

Additionally, all documentation of complaint investigations must contain the following information:

- Who conducted the investigation;
- Who was contacted during the investigation;
- The findings of the investigation; and
- Any actions taken as a result of the investigation.

Finally, when a consumer-initiated complaint is resolved, the provider agency must obtain the individual's (or LAR's) initials or a witness's signature if the individual (or LAR) refuses to sign. (Texas Administrative Code)

These complaint logs are reviewed by DADS during the on-site provider review. If it is determined that the provider has not properly followed these investigation procedures, a corrective action plan will be required and monitored by DADS. Information gathered by DADS concerning complaint information will be reviewed as part of its evidence-based continuous quality improvement process.

## 7. Self-Direction (See Appendix G)

***Appendix A (renamed and placed at Appendix G of this MFP Protocol) is considered part of the Operational Protocol and is required for States using self-direction for MFP demonstration participants. An electronic copy of the form is available at [http://www.cms.hhs.gov/DeficitReductionAct/20\\_MFP.asp](http://www.cms.hhs.gov/DeficitReductionAct/20_MFP.asp) or can be e-mailed directly by your CMS project officer. CMS requires that adequate and effective self-directed supports are in place. Provide a description of the self-direction opportunities under the demonstration before the Institutional Review Board (IRB) approval. In addition to completing Appendix A, please respond to the following:***

### **Self-Direction Opportunities**

All of the 1915(c) waivers and Medicaid State Plan services either currently have or will soon have self-direction options for individuals. The consumer directed services (CDS) option for the Home and Community-based Services 1915(c) waiver is scheduled for implementation in February 2008. DADS is currently conducting statewide training to prospective providers on this option. (Currently, self-directed services include attendant and respite services. Texas is working towards including other services such as therapies and nursing.)

Individuals who live in their own residences or the home of a family member may choose to self-direct some or all of their services. Individuals who choose to self-direct will assume and retain responsibility to:

- Recruit their service providers.
- Conduct criminal history checks.
- Determine the competency of service providers.
- Hire, train, manage and fire their service providers.

The individual/legal authorized representative (LAR) may appoint a designated representative (DR) to assist with or perform employer responsibilities to the extent approved by the individual. In addition, the individual has budget authority over the services being directed. The individual's LAR or DR, however, cannot be paid to deliver the services.

Another option currently available is the Service Responsibility Option (SRO). Under this option the individual/LAR selects, trains, and supervises the attendant.

The traditional home health agency option, where the agency is responsible for all employer functions, is available to provide authorized services to individuals who decide not to self-direct services.



Each individual who chooses to direct their own services will receive support from a Financial Management Service (FMS) provider also referred to as a CDSA, chosen by the individual. The individual develops a budget, with assistance from the CDSA, for each service to be self-directed based on the plan of care (called the Individual Plan of Care or Plan of Care, depending on type of 1915(c) waiver).

The individual's case manager (or service coordinator, depending upon the type of program) informs the individual about the option to self-direct 1915(c) waiver or Medicaid State Plan services at the time of enrollment and at least annually thereafter. At anytime, the individual may elect to self-direct services or to terminate self-direction of services, or to change the CDSA. If the participant chooses to terminate self-direction, the case manager revises the POC to have the services provided through a home health agency.

The individual, LAR and/or the DR are responsible for developing the backup plan with assistance and input from others. A backup plan may include the use of non-1915(c) waiver services, non-state services, other service providers, family members and friends, use of other professionals, and informal supports in the absence of the regular service provider.

### **Voluntary Termination of Self-Direction**

***Describe how the State accommodates a participant who voluntarily terminates self-direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from self-direction to the alternative service delivery method.***

An individual or LAR may voluntarily terminate participation in the CDS option at anytime. The individual's case manager (or service coordinator) assists the individual in revising the individual's service plan for the transition of services previously delivered through the CDS option to be delivered by the 1915(c) waiver or Medicaid State Plan program provider chosen by the individual, LAR and/or DR.

The CDSA closes the employer's payroll and payable accounts and completes all deposits and filings of required reports with governmental agencies on behalf of the individual. The continuity of service is assured by authorizing services to be provided under the new plan to begin right after the CDS services are terminated. An individual may always reconsider the CDS option in the future.

### **Involuntarily Termination of Self-Direction**

***Specify the circumstances under which the State will involuntarily terminate the use of self-direction and thus require the participant to receive provider-managed***

***services instead. Please include information describing how continuity of services and participant health and welfare will be assured during the transition.***

Involuntary termination of the CDS option may occur when:

- The individual's service planning team, in conjunction with the CDSA, case manager (or service coordinator) or DADS staff, determines that continued participation in the CDS option would not permit the individual's health and welfare needs to be met.
- The individual's service planning team, in conjunction with the CDSA, or case manager (service coordinator) or DADS staff determines that the individual or the individual's LAR and/or DR, when provided with additional support from the CDSA or through support consultation, has not carried out employer responsibilities in accordance with requirements of the option.

The individual's case manager (service coordinator) and service planning team will assist the individual to ensure continuity of all 1915(c) waiver/ Medicaid State Plan services through a home health agency service delivery option and maintenance of the individual's health and welfare during the transition from the CDS option.

The CDSA closes the employer's payroll and payable accounts, and completes all deposits and filing of required reports with governmental agencies on behalf of the individual. Similar to the voluntary termination of CDS services, the continuity of service is assured by authorizing services to be provided under the new plan to begin right after the CDS services are terminated. Again, the individual may always reconsider the CDS option in the future.

### **Self-Direction Demonstration Goals**

***Specify the State's goal for the unduplicated number of demonstration participants who are expected to avail themselves of the demonstration's self-direction opportunities.***

The decision to self-direct services can only be made by the individual/LAR. Texas will educate, explain, and offer the option of self-directing services to every MFP participant. As noted in Appendix G, Texas estimates that 578 individuals will participate in one of the self-direction options.

## 8. Quality

***Provide a description of the State's quality management system (QMS) for demonstration participants during the demonstration year and a description of what system they will be transitioned to after the 12-month demonstration period. Regardless of the financing and/or service delivery structure proposed under the demonstration, states must demonstrate how services during the 12-month transition period will:***

- ***Be utilized to inform the CMS evaluation of the state's MFP demonstration; and***
- ***Meet or exceed the guidance for a QMS set forth under Appendix H of the 1915(c) HCBS waiver program.***

### **Description of Texas' Quality Management System**

Texas will provide a MFP-specific Quality Management Strategy for Medicaid 1915(c) waivers that do not currently utilize the new Appendix H, version 3.4 requirements. The quality management strategies have been developed to meet the MFP Operational Review Criteria, Quality Section I.B.8 Addendum, furnished by CMS.

Texas currently utilizes Appendix H, version 3.4, for the following Texas 1915(c) Medicaid waivers:

- Community Based Alternatives (CBA), waiver number TX-2066
- **Integrated Care Management (ICM), waiver number TX-19**
- Medically Dependent Children's Program (MDCP), waiver number TX-0181
- Texas Home Living (TxHmL), waiver number TX-0403
- Deaf-Blind with Multiple Disabilities (DBMD), waiver number TX-0281, has been submitted to CMS.

A MFP specific Quality Management Strategy is attached at Appendices J, K, L, and M for the following Texas 1915(c) Medicaid waivers:

- Community Living and Assistance Support Services (CLASS), waiver number TX-0221.
- Consolidated Waiver Program (CWP), waiver number TX-0373.
- **STAR+Plus, waiver number TX-0325.90**

- Home and Community-Based Services (HCS), waiver number TX-0110.

As required by the *Operational Protocol* and Appendix H of the 1915(c) Home and Community Based Services (HCBS) waiver application, the required assurances will focus on the following issues:

- Level of care determinations
- Services plan description
- Identification of qualified HCBS providers for those participants being transitioned
- Health and Welfare
- Administrative authority
- Financial accountability

Quality Management staff from HHSC, DADS and DSHS will also coordinate oversight of incidents and service delivery issues/risks to determine how to improve services to participants. Consistent with HHSC and DADS practice, DSHS will conduct desk reviews of individual participant records maintained by a behavioral health provider as warranted by findings from an administrative data review. The Local Mental Health Authority will also provide ongoing oversight through its quality management program.

The quality management strategy specifically identifies:

- Each discovery process
- All responsible entities
- The frequency of various processes
- Data and type of information used
- Generated reports

In addition, the quality management strategy will measure the following:

- Participant access
- Participant-centered service planning and delivery
- Provider capacity and capability
- Participant safeguards
- Rights and responsibilities
- System performance

- Participant outcomes

MCOs (MCOs) maintain a quality improvement program that includes the following elements:

- Measure long-term service and support (LTSS) provider performance.
- Identify opportunities for improving performance
- Develop and implement action steps to improve performance
- Measure whether the targeted improvements have been achieved.
- Inform long-term service and support providers about the quality assurance program and related activities.
- Conduct utilization review activities on a sample of individuals receiving long-term services and supports.

HHSC contracts with an External Quality Review Organization (EQRO) to assist in improving the services delivered by MCOs through the following activities:

- Measuring and monitoring quality of care for Medicaid.
- Measuring and monitoring consumer and provider satisfaction.
- Monitoring the accessibility of care for eligible recipients.
- Monitoring Medicaid Star+PLUS participating managed care organizations' (MCOs) quality assurance and performance improvement plans and projects.
- Measuring financial performance and cost-effectiveness of the Medicaid MCOs.
- Conducting focused studies and special ad hoc analyses.
- Maintaining a data analysis platform and system to enable all functions.
- Performing MCO data validation, certification, and support activities for HHSC rate setting purposes.

An individual's initial POC is developed after a complete assessment has been conducted to assess the individual's health needs. The type and amount of each service component is supported by:

- Documentation that other sources for the service component are unavailable and the service component does not replace existing supports;
- Assessments of the individual that identify specific service components necessary for the individual to live in the community, to ensure the individual's

health and welfare in the community, and to prevent the need for institutional services; and

- Documentation of the deliberations and conclusions of the service planning team that the services components are necessary for the individual to live in the community, to ensure the individual's health and welfare in the community, and are appropriate to ensure the individual's health and welfare in the community, and to prevent the need for institutional services. (40 Texas Administrative Code 97.157)

All providers are required to develop and maintain a Quality Assessment and Performance Improvement Program (QAPI) that is implemented by a QAPI committee. Some of the elements of a QAPI Program must include an analysis of a representative sample of services furnished to clients contained in both active and closed records; review of negative client outcomes, effectiveness and safety of all services provided, the promptness of service delivery, and the appropriateness of the agency's responses to client complaints and incidents; a determination that services have been performed as outlined in the POC, etc. (40 TAC 97.287).

## **Complaint and Incident Reporting Management**

Please see Appendix N for complaint and incident management procedures.

## **Current Data Systems**

Texas has mechanisms in place to monitor service utilization, enrollment data, billed services, planned services, and promptness of service initiation. These mechanisms include the Client Assessment, Review, and Evaluation (CARE) Form System (CFS), the Service Authorization System (SAS), the Quality Assurance and Improvement (QAI) Data Mart, and the EQRO's data system.

### ***Client Assessment, Review, and Evaluation Form System***

The Client Assessment, Review, and Evaluation (CARE) Form System (CFS) is used by the Home and Community Support Services Agency (HCSSA) to submit CARE forms to the Texas Medicaid and Healthcare Partnership (TMHP, the state's MMIS contractor) for the determination of medical necessity (MN) and the Texas Index for Level of Effort (TILE – provider reimbursement calculation) scores. DADS staff may generate reports on MN and TILE scores in CFS.

### **SAS**

SAS is used by DADS staff to authorize services and collect, process, and report participant authorization data. SAS maintains participant information, provider

information, billing and payment information, and participant satisfaction interviews. Codes defining specific programs, services, and TILE scores drive the functionality of the system. A wide variety of reports can be generated from the data.

### ***Medicaid Eligibility Service Authorization Verification Reports***

HHSC MCOs and their long-term services and supports providers have access to the Medicaid Eligibility Service Authorization Verification (MESAV) report to request information about participants they are authorized to serve. This information can include Medicaid eligibility, medical necessity, co-payment, level of service, and service authorization.

### ***Quality Assurance and Improvement Data Mart***

The QAI unit of the Center for Policy and Innovation (CPI) of DADS will also use the QAI Data Mart designed as a result of funds received from the 2003 Quality Assurance/Quality Improvement (QA/QI) Real Choice Systems Change grant. The QAI Data Mart produces standardized reports and has the capacity to generate ad hoc reporting of provider performance and consumer outcome data. The QAI Data Mart provides an automated system to trend and analyze individual assessment data Intellectual Disability/Related Conditions [IDRC] and Minimum Data Set [MDS]) measures, performance indicators, and plan of care data in order to monitor trends.

### ***EQRO Data System***

HHSC employs the services of an EQRO to conduct some of its quality improvement activities. The EQRO has its own data system to identify and analyze the following types of events: Medicaid fee-for-service claims, all current and historical Medicaid encounter data submitted from the MCOs, Medicaid enrollment data, and Medicaid Behavioral Health Data from the Department of State Health Services (DSHS).

### ***Plans for Future Enhancement of Mechanisms for Meeting Assurances***

Texas is committed to continuous quality enhancement for 1915(c) waiver programs. As each 1915(c) waiver is renewed, a quality management strategy will be identified through the Appendix H portion of the Application for a 1915(c) HCBS waiver template.

### ***Quality Review through Annual Surveys***

Texas is using quality inventory tools for all community-based 1915(c) waiver and ICF/IID services. DADS joined the National Core Indicators Project and has contracted with an external entity to conduct both face-to-face and mail experience surveys of program participants on an annual basis. The project uses the National Core Indicators tool developed by the Human Services Research Institute (HSRI), as well as the Participant Experience Survey (PES) tool developed by MEDSTAT for the Centers for

Medicare and Medicaid Services (CMS). Texas is one of the few states in the country that undertakes a survey of this size and scope.

The purpose of the project is to obtain information from the participant's perspective about his or her experiences receiving DADS services. The first phase was conducted in 2005 and provided an initial baseline of data that DADS will build upon. Future surveys will provide additional data that will enable DADS staff to complete trend analysis to identify areas for improvement, and to measure if improvement strategies are effective. The results provide an important discovery method for areas of improvement as identified by the participants receiving services.

The DADS QAI unit anticipates conducting pre-transition surveys of MFP participants and incorporating the MFP Demonstration participants in future annual experience surveys. Individuals receiving services under the Star+PLUS 1915(c) waiver will be included in the survey activities.

*Amendment # 5:*

*Pursuant to final HCBS rules issued by CMS in 2014, Texas has initiated efforts to survey providers and individuals receiving 1915(c) waivers to ensure individuals are afforded the opportunity to be fully integrated into the community. Surveys were completed in 2016.*

***Please follow the guidelines set forth below for completion of this section of the OP:***

- a. If the State plans to integrate the MFP demonstration into a new or existing 1915(c) waiver or HCBS SPA, the State must provide written assurance that the MFP demonstration program will incorporate, at a minimum, the same level of quality assurance and improvement activities articulated in Appendix H of the existing 1915(c) HCBS waiver application during the transition and during the 12 month demonstration period in the community.***

***The state need not provide documentation of the quality management system already in place that will be utilized for the demonstration. But, rather provide assurances in the OP that:***

- i. This system will be employed under the demonstration; and***
- ii. The items in section (C) below are addressed.***

***In addition, the state should provide a brief narrative regarding how the existing waiver QMS already or will be modified to ensure adequate***



***oversight/monitoring of those demonstration participants that are recently transitioned.***

## **MFP Assurances**

- a. Texas can assure that the MFP Demonstration will meet the existing level of quality assurance and improvement activities of the current 1915(c) waivers. Texas' MFP Demonstration will utilize existing 1915(c) waiver services as currently approved by CMS.
- ai. Texas can assure that the same level of quality assurance and improvement activities as articulated in Appendix H will occur for the existing 1915(c) waivers during the transition and during the 12 month demonstration period.
- aii. With respect to items in section (c), below, Texas is not offering any supplemental demonstration services. Texas can assure that the quality assurance process of its current 1915(c) CMS approved waivers have adequate remediation and improvement processes.

The *Quality Section* of this *Operational Protocol* (Section 8) describes how Texas' existing waiver quality management strategies will ensure adequate oversight and monitoring of demonstration participants.

***If the State plans to utilize existing 1915(b), State Plan Amendment (SPA) or an 1115 waiver to serve individuals during and after the MFP transition year, the State must provide a written assurance that the MFP demonstration program will incorporate the same level of quality assurance and improvement activities required under the 1915(c) waiver program during the individual's transition and for the first year the individual is in the community. The state must provide a written narrative in this section of the OP regarding how the proposed service delivery structure (1915(b), SPA, or 1115) will address the items in section (c) below.***

## **1915(b), State Plan Amendments, or 1115 Waivers.**

Texas will not use a Medicaid 1115 waiver for purposes of this MFP Demonstration. The only 1915(b) waiver to be used is for managed care (Star+PLUS) in order to waive freedom of choice and limit the number of MCOs.

There is sufficient capacity in Texas' Medicaid 1915(c) waivers for MFP participants. The Texas Legislature (2005) codified the MFP policies and created a separate line item for NF residents who want to relocate. This appropriation does not take away from other community slots appropriated by the Legislature.

For individuals with intellectual and developmental disabilities, there are specifically funded Home and Community-based Services (HCS) slots for individuals wanting to leave large (14+ bed) ICFs/IID and state supported living centers, and well as a priority set from slots abandoned by current users of HCS slots (referred to as “attrition slots”) due to death, leaving state, etc.

*Amendment #5: Managed care STAR+ PLUS HCBS services are delivered under an 1115 waiver. The Texas Quality Management plan for the 1115 applies the same level of quality assurance and improvement activities required under the 1915 (c) waiver program.*

***b. The Quality Management System under the MFP demonstration must address the waiver assurances articulated in Appendix H of the 1915(c) HCBS waiver application and include:***

- i. Level of care determinations;***
- ii. Service plan description;***
- iii. Identification of qualified HCBS providers for those participants being transitioned;***
- iv. Health and welfare;***
- v. Administrative authority; and***
- vi. Financial accountability.***

Texas’ 1915(c) waivers meet all of CMS assurances. This information was provided in the description earlier in this section of the *Operational Protocol*.

***c. If the State provides supplemental demonstration services (SDS), the State must provide:***

- 1. A description of the quality assurance process for monitoring and evaluating the adequacy of SDS service(s) to manage the barrier it was selected to address; and,***
- 2. A description of the remediation and improvement process.***

Texas is not proposing to offer supplemental demonstration services during the MFP Demonstration. However, Texas will be providing Demonstration Services.

## 9. Housing

a. ***Describe the State's process for documenting the type of residence in which each participant is living (See chart for examples in Appendix B). The process should categorize each setting in which an MFP participant resides by its type of "qualified residence" and by how the State defines the supported housing setting, such as:***

- i. ***Owned or rented by individual,***
- ii. ***Group home,***
- iii. ***Adult foster care home,***
- iv. ***Assisted living facility, etc.***

***If appropriate, identify how each setting is regulated.***

### **Documentation of Qualified Residence**

Information on the type of qualified residence that an individual chooses is verified at the time the participant is enrolled in a 1915(c) waiver. This information can be accessed by one of the data base systems (SAS or CARE) currently utilized by DADS.

Texas will only enroll an individual in the MFP Demonstration to a setting that meets the definition of a "qualified residence" as defined in Section 6071(b) (6) of the Deficit Reduction Act. For the individuals transitioning from a nursing facility, Texas licenses the following types of residential living arrangements that meet this definition.

- Assisted living apartment.
  - An assisted living apartment is a living unit that is a private space with living and sleeping areas, a kitchen, a bathroom and adequate storage space. The bedroom must be single occupancy unless the participant requests double occupancy. The living unit must have a private kitchen and bath.
- Residential care apartment.
  - A residential care apartment is a living unit that is a private space with connected sleeping, kitchen, and bathroom areas and adequate storage space. The bedroom must be double occupancy. The living unit must have private kitchen and bathroom facilities.
- Adult foster care.
  - Adult foster care is a setting that provides a twenty-four hour living arrangement in a DADS enrolled foster home for persons who, because of physical or mental limitations, are unable to continue independent functioning in their own homes. Services may include meal preparation, housekeeping, personal care and

nursing tasks, help with activities of daily living, supervision and the provision of or arrangement of transportation.

- Texas does not license or regulate a home owned or leased by the individual or the individual's family member.

For individuals transitioning out of an ICF/IID or state school, the following identify the types of residences that meet the definition of a qualified residence according to Texas rules.

- An individual's own home or family home.
  - Foster Companion Care home.
    - A care provider who lives in the residence in which no more than three individuals or other persons receiving similar services are living at one time and in a residence in which the provider does not hold a property interest.
  - Three person group home.
    - A residence in which no more than three individuals receiving supervised living or other persons receiving similar services are living at any one time; provides services as needed by individuals and is present in the residence at any one time; the program provider holds a property interest.
  - Four person group home.
    - A residence in which no more than four individuals and other persons receiving similar services are living at any one time; the provider is present in the residence and is awake whenever an individual is present in the residence; the program provider holds a property interest.
- b. ***Describe how the State will assure a sufficient supply of qualified residences to guarantee that each eligible individual or the individual's authorized representative can choose a qualified residence in which the individual will reside.***

### **Assurance of Sufficient Supply of Qualified Residences**

Historically, approximately eighty percent of individuals transitioning from ICFs/IID and state supported living centers have successfully transitioned into the residential model of HCS (definitions provided in the previous section); the other twenty percent return to family living arrangements. Accordingly, at this time, Texas can state that there are adequate housing opportunities for individuals in these transition situations. Additionally, the state has a sufficient provider base to serve all individuals who relocate back into the community.

With respect to nursing facility transitions, Texas is dependent on adequate additional funding from the Department of Housing and Urban Development (HUD) to meet all current and future demand for safe, affordable, and accessible housing for individuals who desire to participate in the MFP Demonstration. Without this support, Texas cannot make such an assurance. It must be noted that Texas has successfully transitioned more than 13,000 individuals into community residences.

However, as noted in the *Benchmarks* section of this *Operational Protocol* and restated below, Texas intends to carry out activities to expand housing opportunities and awareness of housing needs throughout the state. It is a goal of this MFP Demonstration to be able to make the global assurance.

- i. ***Describe existing or planned inventories and/or needs assessments of accessible and affordable community housing for persons with disabilities/chronic conditions; and***

### **Planned Inventories of Accessible and Affordable Housing**

DADS will work with the TDHCA, the Texas Council on Developmental Disabilities, United Cerebral Palsy of Texas, and the Texas Low-Income Housing and Information Services to develop a housing inventory that will be linked on each agency's website. Individuals interested in looking for affordable housing will be able to search these websites. These activities will begin in 2007 and will be an ongoing effort to provide the following information from state and local PHAs and public and private owners of rental stock.

In addition, DADS and the above organizations will organize a housing summit in early 2008 with a goal to generate recommendations to increase affordable housing opportunities for Texas. The first planning meeting held on September 5, 2007.

- ii. ***Explain how the State will address any identified housing shortages for persons transitioning under the MFP demonstration grant, including:***
- iii. ***Address how the State Medicaid Agency and other MFP stakeholders will work with Housing Finance Agencies, Public Housing Authorities and the various housing programs they fund to meet these needs; and***

### **Working with Housing Finance Agencies and Public Housing Authorities**

The recent activities of the PIAC and TDHCA have brought attention to the continued need for health and human service agencies and advocates to work closely with the state and local PHAs. The efforts necessary to increase the stock of affordable and accessible housing and rental assistance must come through mutual cooperation, identification of housing need and education by all parties involved.

The MFP Demonstration Coordinator will act as the housing liaison for the Health and Human Services Enterprise housing related issues. Furthermore, Texas will build upon its recent preliminary successes to establish more comprehensive working relationships with its state housing finance agency and its PHAs. Texas will begin this process with the subsequent activities.

- Targeting of out-of-compliance PHA's.
- Visits to the ten largest PHAs in year one of the MFP Demonstration.
- After the first year, DADS will visit twenty-five additional PHAs per year.
- Review and comment on PHA Consolidated Housing Plans.

DADS is currently working with the Fort Worth Public Housing Authority to establish a model working collaborative to be replicated elsewhere in Texas.

- iv. ***Identify the strategies the State is pursuing to promote availability, affordability or accessibility of housing for MFP participants.***

### **Strategies to Promote Availability, Affordability or Accessibility of Housing**

There is recognition of the importance of educating all stakeholders about housing and about Medicaid services. Therefore, DADS, in conjunction with its partners, will:

- Collect and distribute basic information on housing and housing plans. Information collected and shared will include: the most recent Consolidated Housing Plan and Annual Action Plan to identify priorities for HOME, Low Income Housing Tax Credit, Community Development Block Grant and other programs used to develop affordable housing.
- Develop a Computer Based Training (CBT) curriculum for PHAs regarding the HHS Enterprise home and community-based services. This project will begin in state fiscal year 2008.
- Create a Housing Advocacy E-mail Distribution list to distribute housing related information. As an example, federal Notice of Funds Availability (NOFA) and draft housing/action plans can be distributed in a more expedient manner.
- Provide linkages to the DADS Promoting Independence website for individuals who want more information about Texas' Public Housing Authorities (housing plans, rental application requirements, housing availability, etc.).

#### ***Amendment #5***

*HHSC is collaborating with the state housing agency to administer the Section 811 Housing program. This program is expected to create over 600 affordable housing units for individuals with disabilities, with a focus on those exiting institutions through Money*

*Follows the Person.*

## 10. Continuity of Care Post the Demonstration.

***To the extent necessary to enable a State initiative to meet the demonstration requirements and accomplish the purposes of the demonstration, provide a detailed description of how the following waiver provisions or amendments to the State plan will be utilized to promote effective outcomes from the demonstration and to ensure continuity of care:***

### **Continuity for Demonstration MFP Participants**

Texas has methodically worked with stakeholders to develop its long-term services and supports system to include community-based programs and services to meet the needs of individuals who want to remain in their communities. 1915(c) waiver service arrays were carefully selected in order to promote community living and help to ensure a successful relocation.

MFP Demonstration participants will be accessing established 1915(c) waivers. They will continue to be served through these waivers in the post-demonstration period as long as they continue to meet the eligibility criteria. Therefore, there will not be a lapse in services for MFP Demonstration participants and a transition plan is not required.

After the MFP Demonstration period, if an individual does not meet the institutional level of care requirement or medical necessity, that individual would not be eligible to participate in any of the Medicaid 1915(c) waiver programs. However, if the individual met Medicaid financial eligibility, and the functional eligibility criteria for Texas' state plan programs, then the state will assist that individual in the enrollment of one of those programs (attendant supports or adult day care). If Medicaid financial eligibility is not met, the individual will be assessed to determine eligibility for services available under the Older American Act programs, Title XX block grant services, and/or Texas' general revenue funded services.

***Managed Care/Freedom of Choice (Section 1915(b)) – for participants eligible for managed care/freedom of choice services, provides evidence that:***

- i. ***Services are ensured for the eligible participants; or***
- ii. ***A new waiver will be created.***

### **Managed Care/Freedom of Choice**

As stated in the Part B, Section 8 of this *Operational Protocol* concerning quality issues related to the MFP Demonstration, HHSC currently operates Star+PLUS 1915(b) and (c) managed care waivers. These managed care services cover a significant percentage of the aged and physically disabled population in Texas. Individuals who



live in managed care catchment areas will receive managed care 1915(c) waiver services.

***Home and Community-Based (Section 1915(c)) – for participants eligible for “qualified home and community-based program” services, provide evidence that:***

- i. ***Slots are available under the cap;***
- ii. ***A new waiver will be created; or***
- iii. ***There is a mechanism to reserve a specified number of slots via an amendment to the current 1915(c) waiver.***

### **Home and Community-Based**

All necessary waiver slots are currently available as Texas’ Promoting Independence Initiative has its own legislatively approved budget strategy for individuals transitioning from institutional settings to the community.

No new waiver will be created, as MFP participants will transition from a qualified institution back to the community with long-term services and supports provided through one of the existing 1915(c) Medicaid waivers. Services will continue for MFP participants as long as they desire to remain on the 1915(c) waiver and meet the eligibility criteria.

No new 1915(c) waivers will be created.

***a. Research and Demonstration (Section 1115) – for participants eligible for the research and demonstration waiver services, provide evidence that:***

- i. ***Slots are available under the cap;***
- ii. ***A new waiver will be created; or***
- iii. ***There is a mechanism to reserve a specified number of slots via an amendment to the current Section 1115 waiver.***

### **Research and Demonstration**

Section 1115 waivers will not be utilized for the MFP Demonstration.

***b. State Plan and Plan Amendments - for participants eligible for the State plan option services, provide evidence that there is a mechanism where there would be no disruption of care when transitioning eligible participants to and from the demonstration program***

## **State Plan and Plan Amendments**

As noted above, MFP participants will remain on the appropriate Medicaid 1915(c) waiver as long as they meet the appropriate program requirements. No state plan or 1915(c) waiver amendments are anticipated during the MFP Demonstration.

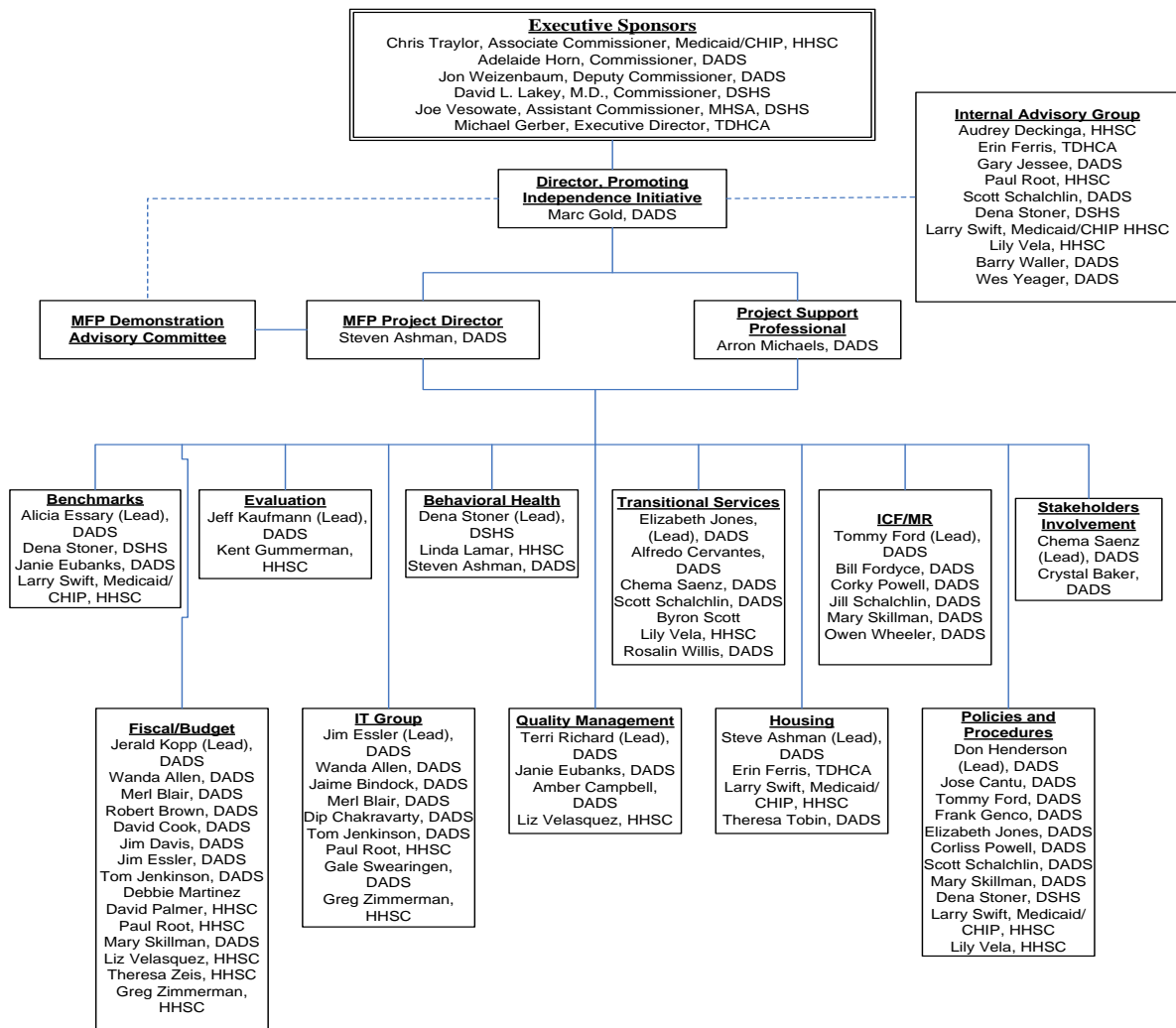
As discussed elsewhere in this *Operational Protocol*, DADS will introduce Overnight Support Services and DSHS will provide Cognitive Adaptive Training and an array of substance abuse services as demonstration services for the MFP Demonstration. If these pilot projects prove effective, Texas will consider these services for an amendment to the Community-based Alternatives (CBA) and Star+PLUS 1915(c) waiver programs.

## Part C - Organization and Administration

***Provide a description of the organizational and structural administration that will be in place to implement, monitor, and operate the demonstration. Please include the following:***

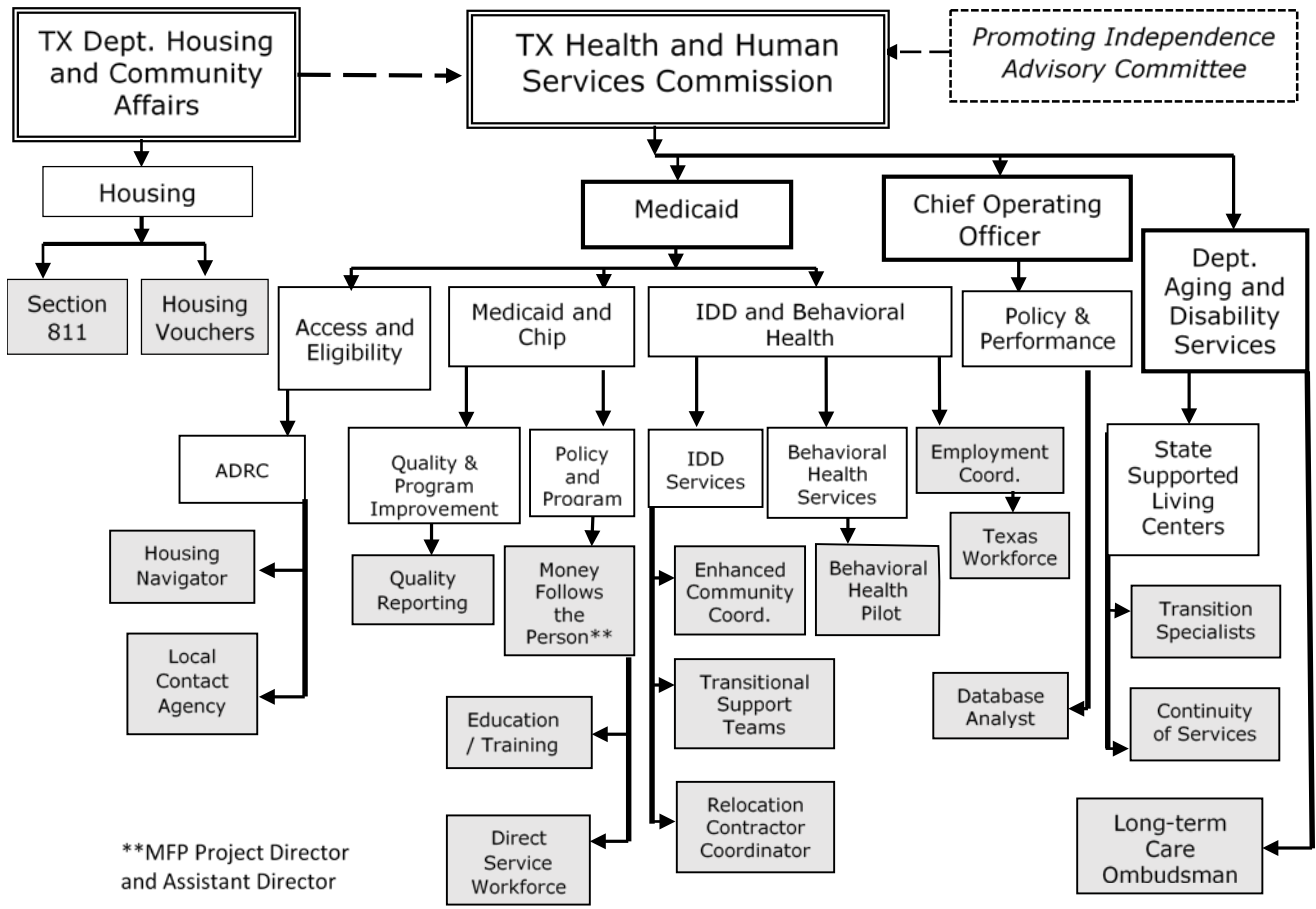
### Organizational Structure

***Provide an organizational chart that describes the entity that is responsible for the management of this grant and how that entity relates to all other departments, agencies and service systems that will provide care and services and have interface with the eligible beneficiaries under this grant. Show specifically the relationship of the organizational structure to the Medicaid Director and Medicaid agency.***



CHIP Children's Health Insurance Program  
 DADS Texas Department of Aging and Disability Services  
 DSHS Texas Department of State Health Services  
 HHSC Texas Health and Human Services Commission  
 MHSA Mental Health and Substance Abuse Services  
 TDHCA Texas Department of Housing and Community Affairs

*Amendment # 5: The organizational structure as of 2017 is consolidated under Health and Human Services, with regulatory and SSLCs remaining at DADS.*



## Staffing Plan

**Provide a staffing plan that includes:**

- a. A written assurance that the Project Director for the demonstration will be a full-time position and provide the Project Director's resume.**

Texas assures that the Project Director for the MFP Demonstration is a full time position. A copy Mr. Ashman's resume is located at Attachment \_.

*Amendment # 5:*

*In April of 2016, Elizabeth Jones assumed the full-time position of Project Director.*

- b. The number and title of dedicated positions paid for by the grant. Please indicate the key staff assigned to the grant.**

Mr. Ashman's position title is MFP Project Director and the only position paid for by this grant.

**Amendment # 5:**

*Elizabeth Jones serves as the MFP Project Director and Joyce Pohlman serves as the Assistant Project Director. Both positions are paid by the grant.*

*Other positions paid for by the grant:*

*SSLC Transition Specialists: 15 FTEs, comprised of 13 Transition Specialists, 1 Transition Coordinator and 1 Administrative Assistant.*

*Behavioral Health Pilot: 2.4 FTEs comprised of a 0.4 Senior Policy Advisor, 1 Program Manager and 1 Program Specialist.*

*Customized Employment: One FTE Employment Specialist. This position was converted from a contract position to FTE in 2014. The position will be transferred to the Employment Service Coordinators project in CY 2017.*

**c. Percentage of time each individual/position is dedicated to the grant.**

Please see below narrative.

**Amendment # 5:**

*Both the Project Director and Assistant Project Director dedicate 100% of their time to the grant.*

*SSLC Transition Specialists: The 13 Transition Specialists, 1 Transition Coordinator and 1 Administrative Assistant dedicate 100% of their time to the grant.*

*Behavioral Health Pilot: The Senior Policy Advisor dedicates 40% of her time to the grant. The one Program Manager and one Program Specialist dedicate 100% of their time to the grant.*

*Employment Specialist: The one FTE dedicates 100% of his time to the grant.*

**d. Brief description of role/responsibilities of each position.**

Please see below narrative.

**Amendment # 5:**

*Project Director: Responsible for daily management of the MFP Demonstration; preparation of the Operational Protocol; liaison with CMS; preparing and submitting CMS and state required reports; convening and monitoring internal and external workgroups; supporting all Promoting Independence Initiative activities; analyzing state/federal legislation and public policy; preparing internal communications; and presenting information to internal/external stakeholders.*

*Assistant Project Director: Provides program, policy and budget support to MFP Demonstration. Monitors expenditures; coordinates annual budget submission to CMS,*

*drafts and monitors contracts; coordinates with TDHCA staff in administering Section 811 PRA housing program; conducts training, research and data analysis.*

*SSLC Transition Specialists:* *These staff assist in transitioning individuals with IDD from State Supported Living Centers (SSLCs) to the community. Specialists train SSLC staff, residents and their families and representatives on community options; identify appropriate supports and services in the community and assist with relocation planning.*

*SSLC Transition Coordinator:* *Supervises and supports SSLC Transition Specialists.*

*SSLC Transition Administrative Assistant:* *Provides administrative support to the SSLC Transition Coordinator and staff.*

*Behavioral Health Pilot Senior Policy Advisor:* *Provides program and policy guidance and oversight to the Behavioral Health Pilot. Develops policy options for integrating behavioral health demonstration services into the Medicaid-funded long term care system and for effectively coordinating behavioral health services with long term care and acute care systems.*

*Behavioral Health Pilot Program Manager:* *Provides program, policy and budget support to Behavioral Health Pilot. Monitors expenditures; drafts and monitors contracts; documents community relocation and community support practices, provides research and analysis for policy development; conducts site visits for quality assurance; and oversees development of training resources.*

*Behavioral Health Pilot Program Specialist:* *Provides programmatic support to Behavioral Health Pilot. Reports data related to the number of pilot participants who have relocated from a nursing facility to the community, collects and reports data on trainings.*

*Customized Employment Specialist: This position oversees an initiative to help service providers to transform from reliance on day program services to community-based, integrated employment.*

***e. Identify any positions providing in-kind support to the grant.***

There are no positions providing in-kind support for the MFP Demonstration.

***f. Number of contracted individuals supporting the grant.***

The only contracted individuals supporting the grant are providers of MFP Demonstration 1915(c) services.

The relocation contract is held in DADS Provider Services Division. However, the Director of the Promoting Independence Initiative (PII) is also part of the Executive Staff which provides significant interaction. PII provides leadership in the area of the relocation contractor activity and conducts monthly scan calls with the contractors to ensure that contract benchmarks are being met and to provide a forum to discuss

common issues. PII will participate during any re-procurement of the relocation contract.

Relocation contractors are paid on a cost reimbursement basis so any additional caseload increase will be compensated and they are being trained on Demonstration requirements.

*Amendment # 5: The following are contracted staff funded with 100% MFPD administrative funds.*

*Continuity of Services Specialist: Conducts on-site assessment of processes related to transitioning individuals from SSLCs to the community, including providing recommendations regarding transition processes, monitoring changes to process, reviewing Settlement Agreement Monitoring Reports and coordinating responses, and reviewing transition plans, post-move monitoring reports, and interdisciplinary team meeting summaries for individuals with delayed transitions. 100%*

*Relocation Contractor Program Quality Management Specialist: Responsible for day to day activities associated with management, oversight, and technical assistance to relocation contractors. This position will develop relocation contractor policy and procedure, training manuals, data systems, contract monitoring and program analysis for quality management and improvement of the program. 100%*

*Research Quality Reporting: 5.4 contract employees, described below:*

*Business Analyst. This position manages, maintains, and enhances data analysis and reports on MFPD transitions, prepares monthly, quarterly, and semi-annual reports to CMS and provides data to the Behavioral Health Pilot. The analyst also automates reporting for relocation contractors who assist in transitioning individuals from institutions to the community. One contractor at 90%.*

*Performance Analysts: Organize and track CMS required performance metrics and reporting for 1915(c) waivers. Two contractors at 100%.*

*Database Analyst and Developer: This position evaluates database and reporting systems used for CMS required performance metrics and reporting for the 1915(c) waivers. Based on this information, the position will recommend and develop solutions that allow for an interface with all divisions of HHSC and DADS to increase efficiency and reduce the potential for data errors. One contractor at 100%.*

*PASSR Quality Assurance Application Developer/Administrator: This position focuses on designing and implementing a new web-based quality assurance*



application, PASSR Individual Review Monitoring, to record and review data collected during individual reviews, score answers provided during interviews and report on the completed reviews. The new application will be capable of receiving data regarding the target population and enable users to electronically capture quality assurance results. One contractor at 50%.

Research Specialist. This positions plans, develops and monitors research projects for the MFPD. The position evaluates and reviews the scope and methodologies of research projects and areas to be evaluated. The position prepares reports and detailed data analyses and presents findings. One contractor at 100%

Office of Long-Term Care Ombudsman: 1 contractor to coordinate training and oversight of local ombudsman working to assist residents of nursing facilities seeking to relocate to the community. Reviews and approves reimbursement of local long-term care ombudsman programs for approved MFP services. Develops materials to increase MFP and Promoting Independence awareness. The functions of this position will be absorbed by other staff in CY 2017. 100%.

Customized Employment: 1.5 FTEs

Employment Specialist: One contract staff to improve employment services for individuals with IDD and establish employment related training to direct service workers who assist these individuals. This position will be transferred to the Employment Service Coordinators project in CY 2017. 100%

Vocational Services Coordinator: This staff is contracted half-time from the Texas Workforce Commission to train TWC staff on Employment First, train HHSC providers and individuals on TWC employment services and provide information and referral on work incentives, planning supports and services. This position will be transferred to the Employment Service Coordinators project in CY 2017. 50%.

Texas Department of Housing and Community Affairs (TDHCA) staff positions: 2 FTEs

Housing Program Specialist: HHSC contracts with TDHCA to administer the Section 811 PRA program. This program provides affordable housing to individuals with disabilities exiting institutions. The Housing Program Specialist is devoted primarily to Money Follows the Person and facilitates coordination between service providers funded by HHSC and properties hosting the Section 811 PRA units. Other responsibilities include training service providers and properties, monitoring rents and income limits and reporting. One contracted position at 100%.

Housing Programs Coordinator: This position is devoted primarily to Money Follows the Person and is comprised of the following functions: 50% overseeing

*administration of Project Access, 25% administering the HOME Program for Persons with Disabilities and 25% for the Section 811 PRA Program. Project Access provides tenant based Section 8 vouchers for individuals exiting institutions. The HOME Program provides temporary Section 8 vouchers to individuals exiting institutions who are on the Project Access waiting list, but have not yet been issued a voucher. The Section 811 position provides critical data analysis tools to track program performance. Equivalent of one contracted position at 100%.*

*ADRC Housing Navigators: Housing Navigators help increase the availability of affordable, accessible, and integrated housing options for individuals transitioning from institutional settings to the community. Tasks include creating an inventory of integrated, accessible and affordable housing; advocating for changes in housing policies and procedures that will help expand housing opportunities; reviewing and responding to housing policies at the local level; identifying and initiating local coalitions; and working with private housing developers. Twenty-two contracted positions at 100%.*

*ADRC Local Contact Agencies: ADRCs serve as the local contact agencies for non-Medicaid NF residents who express an interest in relocating to the community through the Minimum Data Set (MDS) 3.0 Section Q. ADRCs provide "options counseling" system for people who are not eligible for Medicaid or who are in a spend-down status and wish to relocate. Each of the 22 ADRCs dedicate a different percentage of staff time to this position. Allocations of staff time range from 10% to 100%.*

***g. Provide a detailed staffing timeline.***

All staff have been hired for the MFP Demonstration.

***h. Provide in a timeline format a brief description of staff that have been hired and staff that still need to be hired.***

Please see below for the responsibilities of the staff member that has been hired for this position. No additional staff are anticipated.

*Amendment # 5:*

*All staff have been hired for the MFP Demonstration. Staff job descriptions are provided in sections d and f.*

***i. Specify the entity that is responsible for the assessment of performance of the staff involved in the demonstration.***

Texas has reconfigured its health and human services system to an organizational umbrella with an oversight agency, the Health and Human Services Commission (HHSC) that also functions as State Medicaid Agency. HHSC has direct authority over

four HHSC operating agencies; DADS is one of these agencies. HHSC has delegated the operational activities of the MFP Demonstration to DADS.

Marc Gold, Director of the Promoting Independence (PI) Initiative for Texas, has overall responsibility for the PI Initiative and the MFP Demonstration and will assess the performance of staff involved in the MFP Demonstration.

### **Responses to questions c and d.**

All necessary staff for successful operation of the MFP Demonstration have been hired. Marc Gold, Director of the Promoting Independence Initiative for Texas, will dedicate 50 percent of his time to managing the project director, providing overall leadership for the MFP Demonstration, and assessment of the performance of the staff involved in the MFP Demonstration.

Steve Ashman has been hired as the MFP project director and will dedicate 100 percent of his time to the MFP Demonstration. Mr. Ashman's duties and responsibilities include: daily management of the MFP Demonstration activities; preparation of the *Operational Protocol*; liaison with the Centers for Medicare and Medicaid Services in all grant-related activities; preparation and submittal of all CMS and state required reports; convening and monitoring the internal and external workgroups; staff support to the MFP Demonstration Advisory Committee; support for all Promoting Independence Initiative activities; analysis of state/federal legislation and public policy; preparation of internal communications; present information to internal/external stakeholders. The position will also be the liaison with the Texas Department of Housing and Community Affairs and function as the health and human services housing coordinator. A copy of Mr. Ashman's resume is located at Appendix H.

The chief liaison with the State Medicaid Director's Office will be Larry Swift, HHSC Policy Analyst, who will dedicate five percent of his time to ensure coordination and State Medicaid Office oversight. Dena Stoner, Senior Policy Advisory to the Assistant Commissioner for the Department of State Health Services, Mental Health and Substance Abuse Services, will dedicate five percent of her time to ensure the coordination of behavioral health supports. Tommy Ford, Section Director for Institutional Services, DADS Provider Services Division, will dedicate five percent of his time for working with facility closures and resident community transfers. Jeff Kaufmann, Manager of Policy Analysis and Support, and Terri Richard, Manager of Quality Assurance and Improvement, within the Center for Policy and Innovation, will each dedicate five percent of their or their staff's time for this project. Mr. Kaufmann will be involved in MFP evaluation while Ms. Richard will be responsible for the MFP quality assurance and improvement activities. Many other DADS and HHSC staff that oversee current operation of 1915(c) waivers and programs will continue their current roles and contribute support for the MFP Demonstration on an as needed basis. DADS will

continue its current contracts with relocation specialists to assist individuals with transitioning from nursing facilities to the community.

*Amendment # 5:*

*Effective September 1, 2016, Texas enacted a legislatively directed change to its health and human services system by combining functions from several agencies into one Health and Human Services agency. As a result, all Medicaid services, with the exception of the State Supported Living Centers (SSLCs), are in located in a single agency. The SSLC along with the Long-term Care Ombudsman functions will be transferred to HHSC in state fiscal year 2018. HHSC is now responsible for the operational activities of the MFP Demonstration.*

*Staff listed in the original description for this section are no longer with the project.*

## Billing and Reimbursement Procedures

***Describe procedures for insuring against duplication of payment for the demonstration and Medicaid programs; and fraud control provisions and monitoring.***

The state uses the MMIS claims processing system to verify that the participant was Medicaid-eligible on the date of service delivery specified in the request for reimbursement and allows payment only on claims for services provided within the eligibility period.

Prior to processing claims, the automated claims management system edits claims for validity of the information and compliance with business rules for the service/program, and calculates the payment amount and applicable reductions for claims approved for payment. For example, unless the system verifies that a participant's current authorized plan of care has sufficient units in the plan of care to cover amounts claimed or that an authorized level of care is registered in the claims management system, the claim will be rejected.

Texas uses a fiscal review process to ensure that providers for the various Medicaid 1915(c) waivers are complying with program requirements. The methods used in the fiscal review process include: examination of financial and service records as well as plans of care and other records; comparison of provider billings to service delivery and other supporting documentation.

Current procedures provide for on-site fiscal reviews to examine the provider agency's service delivery and financial records and verify that all payments made to the provider

agency were supported with documentation. Typically, a one-month sample of the provider's records is reviewed unless an increase in the review is deemed necessary. Examples of records reviewed include assessment documents, service delivery documents, and complaints.

The provider must maintain documentation that supports the claims. If the provider fails to maintain the required documentation, all improper payments are recovered. The state also recovers payments when it verifies the provider was overpaid because of improper billing. The state may take adverse action against the provider's contract or require a corrective action plan for any fiscal review finding.

## Part D - Evaluation

***Although not required as a component of the MFP demonstration, States may propose to evaluate unique design elements from their proposed MFP program. If these activities are undertaken by the State, the following information must be provided to CMS:***

This section is not applicable. Texas does not plan to contract for an evaluation of the MFP Demonstration nor propose any evaluation activities. At this time, Texas will rely on the activities of the national evaluator, Mathematica. After reviewing Mathematica's final evaluation plan, Texas will meet with the Money Follows the Person Demonstration Advisory Committee and the Texas Promoting Independence Advisory Committee to determine if there are any other unmet evaluation needs unique to Texas. If there are any other evaluation requirements, Texas will then propose an amendment to this *Operational Protocol*.

## Part E - Final Budget

1. ***MFP Budget Form:*** Utilizing the MFP Budget Form provided in Appendix C (relocated to Appendix I in the Operational Protocol), include an annual budget divided into the categories described below. The MFP Budget Form is set up to have the states fill in necessary information and then CMS can use the information to automatically calculate several indicators. The only cells that should be filled in by the States are those highlighted in yellow. Most of these cells represent total cost measures. This means that the number filled in should be the total costs of the service or administrative expense (not just the enhanced portion and not just the state or federal share).

*Amendment # 5: For the approved Supplemental Budget for FY2016-2020, See Attachment D.*

Please see Appendix I for the MFP Demonstration budget related information.

- a. **Enrollees:** An unduplicated count of individuals the State proposes to transition under the demonstration. Please count the person in the year that he or she will physically transition.

*Amendment No. 3 revisions for this benchmark have increased the number of relocations for each target group, include all community ICFs/IID that close regardless of size, and add children under the age of 22, a Texas Promoting Independence Priority Population, as an eligible person for the Money Follows the Person Demonstration. The changes to enrollment estimates in years 2008-2010 are to correct mathematical errors (i.e. in year 2008 the total was reported as 572 individuals but should have been 587).*

*Texas has been very successful with the ICF/IID voluntary closure target group but at the time of Amendment #3 of the OP, there are no new applicants. Accordingly, the revised estimate is based on 237 individuals relocated through the voluntary closure target group in 2011 and another 100 in 2012. After 2012, Texas will revise these estimates annually during the supplemental funding request.*

- b. **Services:** In each service costs section, provide cost estimates for the maximum number of participants in the demonstration project and their projected annual service costs.

- i. **“Qualified home and community-based program” services (eligible for enhanced FMAP);**
- ii. **Home and community-based demonstration services (eligible for enhanced FMAP); and**
- iii. **Supplemental** demonstration services (those eligible for the regular FMAP).

This information on the MFP Budget form located in Appendix I.

- c. **Administrative Budget:** Please include projections for annual costs regarding the routine administration and monitoring activities directly related to the provision of services and benefits under the demonstration. Indicate any additional actions that are required to secure State funding (e.g., appropriation by the legislature, etc.), as well as costs associated with participation with the National Evaluation and Quality initiatives implemented by CMS.

This information on the MFP Budget form located in Appendix I.

- d. **Evaluation Budget:**

Texas will work with the national evaluation organization selected by CMS and will not expend funds for program evaluation contracts.

- 2. **Budget Presentation and Narrative:** Please provide a budget presentation and narrative that provides justification for items E.1.c. and E.1.d. above. Please address the following items:

- a. **Personnel**

One (1) full time employee as MFP Project Director

- b. **Fringe benefits**

Retirement, OASI, Group Insurance

- c. **Contractual costs, including consultant contracts**

No contractual costs.

- d. **Indirect Charges, by federal regulation**

None

- e. **Travel**

Out of state travel to attend required MFP Demonstration related meetings and in-state travel to attend meetings to discuss, promote, and educated people and organizations about the MFP Demonstration, including representatives from public housing authorities.



**f. Supplies**

Paper, pencils, etc.

**g. Equipment**

Office furniture, telephone hook-up, annual lease payment for computer, non-pool per capita expenses.

**h. Other costs**

IT consulting services (500 hrs/year @\$100/hour), and central cost pools.

**3. The operational protocol should be submitted with a final budget. Below are links to the required forms to include with the protocol:**

- <http://www.whitehouse.gov/omb/grants/sf424.pdf> (Application for Federal Assistance SF-424)
- <http://www.whitehouse.gov/omb/grants/sf424a.pdf> (Budget Information Sheets)
- <http://www.whitehouse.gov/omb/grants/sf424b.pdf> (Assurances-Non Construction SF-424B)
- <http://www.cms.hhs.gov/states/letters/certns.pdf> (Additional Assurances)
- <http://www.whitehouse.gov/omb/grants/sflll.pdf> (Disclosures for Lobbying Activities)

DADS Project Director, Steve Ashman, contacted the CMS Project Officer, Kate King, on September 5, 2007, to discuss submission of the above documents. A copy of the SF424a is attached at Appendix I and identifies projected MFP Demonstration expenditures throughout the remainder of this grant period.

The SF424, Application for Federal Assistance, is on file with CMS and will be updated when requested by Ms. King. The other two documents are also on file with CMS and will be updated or resubmitted at the request of CMS.

## **Appendix A – Glossary of Terms**

## **Appendix B – Provider Letter to Nursing Facilities**

## **Appendix C – Community Living Options Instrument**

## **Appendix D - List of Nursing Facilities, ICFs/IID, and State Supported Living Centers**

## Appendix E – MFP Informed Consent Form

## Appendix F – Informational Brochures

## **Appendix G – Self-Direction Appendix**



## Appendix H – MFP Project Director Resume

## Appendix I – MFP Budget Information

## **Appendix J – CLASS MFP Quality Management Strategy**

## **Appendix K – Consolidated Waiver Program MFP Quality Management Strategy**

## **Appendix L – Star+Plus MFP Quality Management Strategy**

## **Appendix M – Home and Community-Based Services MFP Quality Management Strategy**

## Appendix N – Complaint and Incident Management Procedures

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<sup>i</sup> [http://www.lbb.state.tx.us/Documents/GAA/General\\_Appropriations\\_Act\\_2016-2017.pdf](http://www.lbb.state.tx.us/Documents/GAA/General_Appropriations_Act_2016-2017.pdf) Page II-16