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

As Required by
Texas Government Code,
Section 534.054

Health and Human Services

September 2019
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1. Executive Summary

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

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

HHSC has made substantial progress on the IDD system redesign. Cumulative milestones achieved include:

- For acute care services only, between 2014-2016 completed the transition of all eligible recipients of Medicaid IDD waiver programs and intermediate care facilities for individuals with intellectual disabilities (ICF/IID) from Medicaid fee-for-service (FFS) to the following capitated managed care programs: STAR+PLUS, STAR Kids, and STAR Health.
- Implemented the CFC option in Texas in 2015 to increase access to services for individuals with IDD, particularly those currently on interest lists for IDD waiver programs.
- Used Money Follows the Person Demonstration (MFPD) funding to increase and enhance community supports to promote independence and prevent institutionalization of individuals with IDD. Examples of MFPD funded initiatives include employment and housing opportunities and trainings, transition support teams to help community providers deliver supports for individuals with complex needs, and transition specialists in the State Supported Living Centers.
- Completed and published evaluations to inform managed care transitions of LTSS in early 2019.
- Completed initial deployment of the first two phases of the new complaints process and published the Office of the Ombudsman quarterly complaints report to the HHS website.

House Bill (HB) 4533, 86th Legislature, Regular Session, 2019, amends Government Code Chapter 534 and requires HHSC to establish a pilot program prior to the transition of LTSS to managed care for individuals with IDD. HB 4533 also establishes a Pilot Program Workgroup to provide assistance in developing and advising HHSC on the operation of the pilot program. In the coming year, HHSC is focused on development of HB 4533 in collaboration with the IDD SRAC and Pilot Program Workgroup; and continued monitoring of the acute care transition to managed care and utilization of CFC services in collaboration with the IDD SRAC.
2. Introduction

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

The report must include:

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

Further, Section 534.112 is added by H.B. 4533 and requires HHSC, in collaboration with the IDD SRAC and pilot program workgroup, to report by September 1, 2026, an analysis and evaluation of the pilot program and recommendations for improving the program. The pilot program evaluation report will be included as part of the annual report required by Section 534.054 and must include:

- An assessment of the effect of the pilot on elements of the system such as access and quality, person-centeredness, integration, employment, appeals, self-direction, and attendant workforce;
- An analysis of the experience and outcome of the following systems changes:
  - Comprehensive assessment instrument under Section 533A.0335,
  - 21st Century Cures Act,
  - Implementation of Home and Community-Based Services (HCBS) settings rules,
  - Provision of basic attendant and habilitation services required under Section 534.152; and
  - Benefits of providing STAR+PLUS Medicaid managed care services to persons based on functional needs;
- Feedback based on the personal experiences of pilot participants to include the individuals and families served and the providers; and
• Recommendations about a system of programs and services for consideration by the legislature, including recommendations for needed statutory changes and whether to transition the pilot to a statewide program under STAR+PLUS.
3. Background

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

1. Provide Medicaid services to more individuals in a cost-efficient manner by providing the type and amount of services most appropriate to the individuals' needs;
2. Improve individuals' access to services and supports by ensuring that the individuals receive information about all available programs and services, including employment and least restrictive housing assistance, and how to apply for the programs and services;
3. Improve the assessment of individuals' needs and available supports, including the assessment of individuals' functional needs;
4. Promote person-centered planning, self-direction, self-determination, community inclusion, and customized, integrated, competitive employment;
5. Promote individualized budgeting based on an assessment of individuals’ needs and person-centered planning;
6. Promote integrated service coordination of acute care services and LTSS;
7. Improve acute care and LTSS outcomes, including reducing unnecessary institutionalization and potentially preventable events;
8. Promote high-quality care;
9. Provide fair hearing and appeals processes in accordance with applicable federal law;
10. Ensure the availability of a local safety net provider and local safety net services;
11. Promote independent service coordination and independent ombudsmen services; and
12. Ensure that individuals with the most significant needs are appropriately served in the community and that processes are in place to prevent inappropriate institutionalization of individuals.¹

¹ [https://statutes.capitol.texas.gov/Docs/GV/htm/GV.534.htm#534.051](https://statutes.capitol.texas.gov/Docs/GV/htm/GV.534.htm#534.051)
In Spring 2018, HHSC contracted for evaluations to inform the statutorily required carve-in of LTSS for people with IDD to Medicaid managed care. HHSC engaged Deloitte Consulting LLP (Deloitte) to evaluate the cost-effectiveness of transitioning the current fee-for-service (FFS) programs for IDD LTSS to Medicaid managed care. HHSC engaged The University of Texas, School of Public Health (UTHealth) to research and report on existing models in other states for providing Managed Long-Term Services and Supports (MLTSS) to people with IDD and to obtain stakeholder feedback on the potential impact of MLTSS for people with IDD in Texas. The IDD SRAC collaborated with HHSC, Deloitte, and UTHealth to inform areas of research, assessment, and stakeholder engagement for the evaluations.

The 86th Texas Legislature amended Texas Government Code, Chapter 534\(^2\), through HB 4533 and directed HHSC to establish a pilot program prior to the transition of LTSS to managed care for individuals with IDD. The pilot program will operate through the STAR+PLUS Medicaid managed care program and test the delivery of LTSS for people with IDD or people with similar functional needs through managed care. The pilot must implement by September 1, 2023, operate for at least 24 months, and include an evaluation. HB 4533 establishes a pilot program workgroup to work in collaboration with HHSC and the IDD SRAC. The information gained through the pilot will be used to inform the final stage of the IDD LTSS system redesign (the transition of some or all Medicaid IDD waiver and ICF/IID services into managed care), ensuring the best possible outcomes for individuals with IDD and the most efficient use of Medicaid resources.

Additionally, HB 4533 updates the timeline for the phased transition of IDD LTSS and requires a plan for the transition of all or a portion of services provided through IDD waivers and ICF/IID services to managed care.\(^3\) HB 4533 directs HHSC to transition all or a portion of the Texas Home Living (TxHmL) waiver program to managed care by September 1, 2027; the Community Living Assistance and Support Services (CLASS) waiver program by September 1, 2029; and nonresidential services in the Home and Community-based Services (HCS) waiver

\(^2\) Texas Government Code, Chapter 534, SUBCHAPTER C was not updated at the time this report published. However, new requirements will be available at: https://statutes.capitol.texas.gov/Docs/GV/htm/GV.534.htm

\(^3\) Texas Government Code, Chapter 534, SUBCHAPTER E was not updated at the time this report published. However, new requirements will be available at: https://statutes.capitol.texas.gov/Docs/GV/htm/GV.534.htm
program and the Deaf-Blind with Multiple Disabilities (DBMD) waiver program by September 1, 2031. HHSC must conduct a second pilot to test the feasibility and cost efficiency of transitioning HCS and DBMD residential services and ICF/IID services to managed care.⁴

4. Implementation Activities

**STAR+PLUS Transition**

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

In fiscal year 2018, an average of 564,628 individuals were enrolled in STAR+PLUS each month. Of that total, approximately 16,913 individuals were also enrolled in an IDD waiver or ICF/IID each month.

**Eligibility**

Adults with IDD were eligible to transition to STAR+PLUS for their regular health care benefits if they:

- Participated in the CLASS, HCS, TxDmL, or DBMD waiver programs; or
- Were in a community-based ICF/IID and not a state supported living center (SSLC); and
- Did not receive Medicare Part B and Medicaid benefits. These individuals are also known as dual eligibles and receive their acute care services through Medicare.

**Services**

Adults with IDD who transitioned to STAR+PLUS receive acute care services through one of five Medicaid managed care organizations (MCOs) contracted to operate the program. These adults continue to receive LTSS services through FFS.
STAR+PLUS Re-procurement

To ensure that MCOs are prepared and able to meet the specific needs of individuals with IDD for whom they provide services, IDD stakeholders, including the IDD SRAC, informed the addition of an IDD LTSS section to the STAR+PLUS request for proposal (RFP). The STAR+PLUS RFP was issued October 1, 2018.

STAR Kids Transition

STAR Kids is the Texas Medicaid managed care program for children and adults ages 20 and younger who have disabilities. STAR Kids members receive a full package of health care benefits, along with LTSS (for those who are not receiving LTSS through an IDD waiver program). In alignment with the requirements in Texas Government Code, Section 534.051, STAR Kids provides person-centered service coordination for children with disabilities and their families to support their needs related to health and independent living.5

In state fiscal year 2018, an average of 162,636 eligible children and young adults were enrolled in STAR Kids each month. Of that total, an average of 5,652 eligible children and young adults were enrolled in an IDD waiver or community-based ICF/IID each month.

Eligibility

Children and adults ages 20 and younger with disabilities were eligible to transition to STAR Kids if they:

- Receive Supplemental Security Income (SSI);
- Receive SSI and Medicare;
- Receive services through the Medically Dependent Children Program (MDCP) waiver;
- Live in an ICF/IID or nursing facility;
- Receive services through a Medicaid Buy-In program;
- Receive services through the Youth Empowerment Services waiver; or
- Receive services through the following waiver programs:
  - CLASS;

5 https://hhs.texas.gov/services/health/medicaid-chip/programs/star-kids
Services

Children and young adults who transitioned to STAR Kids receive acute care services and some Medicaid state plan and comprehensive care program services, such as private duty nursing and personal care services, through one of 10 Medicaid MCOs contracted to operate the program. Children and young adults receiving IDD waiver or ICF/IID services continue to receive LTSS services, including CFC, through FFS.

STAR Kids Report

In Summer 2016, the external quality review organization (EQRO) for HHSC began a multi-year study to evaluate the implementation of STAR Kids and develop a set of quality measures for the STAR Kids population. Prior to implementation, the EQRO completed a background report and a descriptive report based on caregiver surveys and quality measure results of children expected to be enrolled in STAR Kids. Post-implementation, the EQRO conducted MCO interviews, caregiver surveys, a quality measure feasibility study, and reviewed a sample of completed assessment instruments and individual service plans.

The post-implementation report is still in development and relevant findings for individuals with IDD will be reported once published.

**STAR Health Transition**

STAR Health is the Medicaid managed care program for children in Department of Family and Protective Services (DFPS) conservatorship, called foster care, and children who are transitioning out of foster care.\(^6\)

STAR Health is a statewide program that began April 1, 2008. STAR Health members receive a full package of health care and dental benefits, along with LTSS (for those who are not receiving LTSS through an IDD waiver program). STAR Health provides the same LTSS as STAR Kids. Superior Health Plan is the single MCO serving all children in STAR Health.

During fiscal year 2018, an average of 35,491 children and young adults were enrolled in STAR Health each month. Of that total, approximately 141 were enrolled in an IDD waiver or community-based ICF/IID each month.

**Community First Choice**

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

\(^6\) [https://www.dfps.state.tx.us/Child_Protection/Medical_Services/](https://www.dfps.state.tx.us/Child_Protection/Medical_Services/)
Eligibility

Individuals may be eligible for CFC services if they:

- Are eligible for Medicaid;
- Meet an institutional level of care;\(^7\) and
- Have functional needs that can be addressed by CFC services.

Services

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

- Personal assistance services
- Habilitation services
- Emergency response services
- Support management

Assessment

Since the initial implementation of CFC, HHSC collaborated with stakeholders to develop a revised uniform CFC assessment tool to serve multiple waivers and programs and achieve a streamlined and consistent assessment process. HHSC has developed a draft CFC Personal Assistance Services/Habilitation assessment form, which identifies the individual’s need for personal assistance and habilitation services, the amount of services, and service delivery preferences. HHSC obtained stakeholder feedback to improve the tool and researched how other states have implemented CFC to better inform the draft tool. HHSC is exploring how to best move forward with the assessment of CFC services.

\(^7\) Meeting an institutional level of care means needing the level of care provided in a nursing facility, ICF/IID, or Institution for Mental Disease.
CFC for Non-Waiver Recipients

CFC provides an opportunity for individuals with IDD not currently receiving services in an IDD waiver to receive personal assistance and habilitation services. Eligible Medicaid beneficiaries no longer wait to receive these services through the waiver programs, which have interest lists. In fiscal year 2018, a total of 94,788 individuals were concurrently enrolled in Medicaid and on HCS, TxHmL, CLASS, and DBMD interest lists.\(^8\)

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

In fiscal year 2018, there were 2,138 non-waiver recipients receiving CFC services through STAR, STAR Kids, STAR Health, STAR+PLUS and Dual Demonstration. These individuals meet at least one of the eligibility criteria for institutional services: nursing facility, ICF/IID, or Institution for Mental Disease.

\(^8\) Unduplicated total of individuals on HCS, TxHmL, CLASS and DBMD interest lists in fiscal year 2018 with concurrent Medicaid eligibility in TIERs.
Table 1. Average Monthly Enrollment for Non-Waiver Recipients by Age Group, and Unduplicated CFC Services Provided in Fiscal Year 2018⁹

<table>
<thead>
<tr>
<th>Program</th>
<th>Age Group¹⁰</th>
<th>Average Monthly Unduplicated Enrollment¹¹</th>
<th>Average Monthly Unduplicated Individuals Utilizing CFC Services¹²</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAR¹³</td>
<td>0-20</td>
<td>N/A</td>
<td>89</td>
</tr>
<tr>
<td>STAR Kids</td>
<td>0-20</td>
<td>150,453</td>
<td>656</td>
</tr>
<tr>
<td>STAR Health</td>
<td>0-20</td>
<td>35,484</td>
<td>84</td>
</tr>
<tr>
<td>STAR+PLUS</td>
<td>21+</td>
<td>400,962</td>
<td>1,259</td>
</tr>
<tr>
<td>Dual Demonstration</td>
<td>21+</td>
<td>33,474</td>
<td>50</td>
</tr>
</tbody>
</table>

⁹ The current codes used for submitting managed care CFC service encounters may not be reported consistently to HHSC. As a result, the CFC data presented may not show the full CFC service utilization. Beginning September 1, 2019, new codes will be used by MCOs that HHSC anticipates will improve CFC reporting accuracy.

¹⁰ An individual was counted as under 21 through the end of the month of their 21st birthday.

¹¹ The average enrollment members do not include members concurrently enrolled in a waiver, ICF/IID, or nursing facility. The STAR Kids, STAR Health, STAR+PLUS, and Dual Demonstration average enrollment numbers do not match the members in the body of the text on pages 8-11 because earlier enrollment numbers represent the entire managed care program, and the numbers in table 1 reflect members who utilized non-waiver CFC services.

¹² CFC utilization counts for all managed care programs (excluding STAR) based on encounter records from the TMHP Vision 21 Enc. Best Picture universe. All counts are unduplicated by client Medicaid number.

¹³ CFC utilization counts for STAR based on acute care fee-for-service claims (CFC is carved out of managed care for children in STAR). All counts are unduplicated by client Medicaid number.
<table>
<thead>
<tr>
<th>Program</th>
<th>Age Group</th>
<th>Average Monthly Unduplicated Enrollment</th>
<th>Average Monthly Unduplicated Individuals Utilizing CFC Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Programs Combined</td>
<td>0-20</td>
<td>185,937</td>
<td>829</td>
</tr>
<tr>
<td></td>
<td>21+</td>
<td>434,436</td>
<td>1,309</td>
</tr>
<tr>
<td>All Ages Combined</td>
<td></td>
<td>620,373</td>
<td>2,138</td>
</tr>
</tbody>
</table>

**CFC for Waiver Recipients**

HCBS 1915(c) waivers allow states to provide home and community-based services as an alternative for people who meet eligibility criteria for care in an institution (nursing facility, intermediate care facility for individuals with an intellectual disability or related condition, or hospital). A Section 1115 Demonstration Waiver allows Texas to operate and expand Medicaid managed care by providing health care and LTSS, including home and community-based services as an alternative to nursing facility. Individuals with IDD in Texas receive waiver services through both 1915(c) waivers and an 1115 waiver. CFC for waiver recipients is presented below based on the type of institutional level of care.

**Intermediate Care Facility – Level of Care**

HCS, TxHmL, CLASS, and DBMD waivers provide home and community-based services as an alternative to residing in an intermediate care facility. As outlined in Table 2, an average of 39,348 individuals with IDD were enrolled in the four IDD waiver programs each month during fiscal year 2018, with nearly three-quarters of the individuals served enrolled in HCS.

CFC services were utilized at the highest rate by all ages in CLASS, with approximately 5,297 individuals in CLASS receiving CFC services each month out of the total 12,336 individuals each month across all four waiver programs.
Table 2. Average Monthly Enrollment in IDD Waivers by Age Group, and CFC Services Provided by Age Group to Individuals Enrolled in an IDD Waiver in Fiscal Year 2018

<table>
<thead>
<tr>
<th>Waiver Program</th>
<th>Age Group(^{14})</th>
<th>Average Monthly Unduplicated Individuals Enrolled in IDD Waivers(^{15})</th>
<th>Average Monthly Unduplicated Individuals Utilizing CFC Services (^{16})</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLASS</td>
<td>0-20</td>
<td>1,991</td>
<td>1,748</td>
</tr>
<tr>
<td></td>
<td>21+</td>
<td>3,670</td>
<td>3,549</td>
</tr>
<tr>
<td></td>
<td>All Ages Combined</td>
<td>5,661</td>
<td>5,297</td>
</tr>
<tr>
<td>DBMD</td>
<td>0-20</td>
<td>163</td>
<td>111</td>
</tr>
<tr>
<td></td>
<td>21+</td>
<td>189</td>
<td>111</td>
</tr>
<tr>
<td></td>
<td>All Ages Combined</td>
<td>352</td>
<td>222</td>
</tr>
<tr>
<td>HCS</td>
<td>0-20</td>
<td>2,112</td>
<td>645</td>
</tr>
<tr>
<td></td>
<td>21+</td>
<td>24,866</td>
<td>2,368</td>
</tr>
<tr>
<td></td>
<td>All Ages Combined</td>
<td>26,978</td>
<td>3,013</td>
</tr>
</tbody>
</table>

\(^{14}\) An individual was counted as under 21 through the end of the month of their 21st birthday.

\(^{15}\) Enrollment counts for HCS and TxHmL based on data from the CARE system. Enrollment counts for CLASS and DBMD based on data from SAS system. All counts are unduplicated by client Medicaid number.

\(^{16}\) CFC utilization counts for CLASS, DBMD, HCS, and TxHmL based on LTSS fee-for-service claims. All counts are unduplicated by client Medicaid number.
### Nursing Facility and Institution for Mental Disease - Level of Care

Medically Dependent Children Program (MDCP) is a 1915(c) waiver that provides home and community-based services as an alternative to a nursing facility. Youth Empowerment Services (YES) is a 1915(c) waiver that provides home and community-based services to children as an alternative to an institution for mental disease. The STAR+PLUS HCBS and Dual Demonstration HCBS programs operated through the 1115 waiver provide a cost-effective alternative to living in a nursing facility to clients who are elderly or who have disabilities.

As indicated in Table 3, an average of 9,453 individuals received CFC services in fiscal year 2018 across MDCP, YES, STAR+PLUS HCBS, and Dual Demonstration HCBS.
Table 3. Average Monthly Enrollment in LOC Nursing Facility & IMD Waivers by Age Group, and CFC Services Provided by Age Group to Individuals Enrolled in Fiscal Year 2018

<table>
<thead>
<tr>
<th>Program</th>
<th>Age Group</th>
<th>Average Monthly Unduplicated Enrollment</th>
<th>Average monthly Unduplicated Individuals Utilizing CFC Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDCP</td>
<td>0-20</td>
<td>5,275</td>
<td>1,319</td>
</tr>
<tr>
<td>YES</td>
<td>0-20</td>
<td>1,361</td>
<td>31</td>
</tr>
<tr>
<td>STAR+PLUS HCBS</td>
<td>21+</td>
<td>55,688</td>
<td>7,805</td>
</tr>
<tr>
<td>Dual Demonstration HCBS</td>
<td>21+</td>
<td>3,965</td>
<td>298</td>
</tr>
<tr>
<td>All Waivers Combined</td>
<td>0-20</td>
<td>6,636</td>
<td>1,350</td>
</tr>
<tr>
<td></td>
<td>21+</td>
<td>59,653</td>
<td>8,103</td>
</tr>
<tr>
<td></td>
<td>All Ages Combined</td>
<td>66,289</td>
<td>9,453</td>
</tr>
</tbody>
</table>

CFC for All Programs

In fiscal year 2018, an average of 23,927 individuals utilized CFC services for all programs including waiver and non-waiver recipients. Of the 23,927, 5,738 were 20 years old or younger and 18,189 were 21 years old or older.

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

18 Enrollment counts for the YES waiver and all managed care programs based on data from PPS compiled in the CADS 8-month eligibility file. All counts are unduplicated by client Medicaid number.

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

Per Chapter 534, the LTSS transition to managed care will occur in two stages. Stage one\(^{20}\) directs the following activities related to the pilot program:

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

Stage two\(^{21}\) includes development and implementation of a plan to transition all or a portion of services provided through community-based ICF-IID or a Medicaid waiver program to a Medicaid managed care model.

The results of stage one will be used to inform stage two. The program transitions in stage two are staggered in phases beginning with TxHmL in September of 2027, CLASS by September 1, 2029, and non-residential HCS and DBMD services by September 1, 2031.

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

\(^{20}\text{Texas Government Code, Chapter 534, SUBCHAPTER C was not updated at the time this report published. However, new requirements will be available at: }
https://statutes.capitol.texas.gov/Docs/GV/htm/GV.534.htm\)

\(^{21}\text{Texas Government Code, Chapter 534, SUBCHAPTER E was not updated at the time this report published. However, new requirements will be available at: }
https://statutes.capitol.texas.gov/Docs/GV/htm/GV.534.htm\)
HHSC is collaborating with the IDD SRAC and developing a project plan to implement the pilot program and pilot program workgroup requirements. The IDD SRAC requested additional subcommittee meetings to begin enhanced collaboration with HHSC to inform the pilot program.

**IT Modernization**

An exceptional item for IT modernization was funded during the 86th session to support the future transition of the IDD waiver programs. The first phase is currently underway with a focus on transitioning the HCS and TxHmL interest list processing; forms for enrollment, individual plans of care, and transfers; and claims from the legacy mainframe to modern technology systems. The new web-based, service-oriented systems are utilizing the same technology platforms as other Medicaid Management Information System (MMIS) systems. Planning is underway for the second phase which will automate the manually processed CLASS and DBMD forms into the MMIS using the same technology platform. Utilizing the existing MMIS will position all four programs for eventual transition of individuals to Managed Care.

**IDD Carve-in Evaluations Findings**

HHSC contracted with two vendors, Deloitte and UTHealth, in Spring 2018 to conduct evaluations to inform the IDD LTSS transitions to managed care. Deloitte and UTHealth coordinated to ensure a cohesive evaluation.

- Deloitte conducted an analysis of cost-effectiveness for the transition of IDD LTSS from the current fee-for-service (FFS) programs to managed care.

  Although all scenarios resulted in claims savings from utilization management, when administrative costs were considered all scenarios resulted in net cost increases related to premium taxes paid by the state and by HHSC.

- UTHealth conducted a national review and comparison of other states’ managed care delivery models for individuals with IDD; analysis of past IDD transitions to managed care in Texas, including STAR Health, STAR Kids, and STAR+PLUS programs; analysis of impacts of the transition to managed care for individuals and providers; analysis of the experience of CFC in managed
care, including in the STAR+PLUS program; and analysis of service coordination provided for individuals with IDD.

Fifteen states deliver some LTSS for people with IDD through managed care. Of these states, three deliver all LTSS for people with IDD through managed care (Arizona, Kansas, Wisconsin).

UTHealth identified four key lessons from the national review:

1. The transition of individuals with IDD should move slowly, with clearly defined stages of initiation.

2. It is worthwhile to pilot the approach to transitioning individuals with IDD to MLTSS to build stakeholder buy-in and prove value and have ongoing, comprehensive stakeholder engagement as MLTSS programs are refined or new populations are included in existing programs.

3. The state and the contracting MCOs should be well prepared in advance of the transition. This means that the state needs to be clear on its expectations regarding cost, quality measures, and outcome measures. The MCOs should be required to validate their degree of readiness to provide MLTSS services and the state should consider requiring that the contracted MCOs be required to be NCQA accredited and attain MLTSS distinction.

4. The transition to MLTSS for individuals with IDD requires that MCOs comply with CMS LTSS network adequacy standards which may reduce number of providers. Some licensed and/or certified professionals may opt out of participating through an MCO. Since network adequacy standards limit the time and distance that beneficiaries must travel to providers and providers travel to beneficiaries, geographic access, particularly in rural areas, can make it hard to meet these standards. Network adequacy standards may need to be flexible to the extent that the program allows for client choice.

Additional evaluation findings are listed in Section 8. Challenges and Areas for Further Consideration.
5. Effects on the System

Complaints, Appeals, and Fair Hearings

Complaints, appeals, and state fair hearings data provide information about access to and quality of acute care services following the transition of acute care services to managed care. Complaints are filed by contacting the managed care organizations (MCO), the HHSC Office of the Ombudsman, or HHSC’s Managed Care Compliance and Operation (MCCO) team.

Complaints Data Trending and Analysis Initiative

HHSC has identified opportunities to improve the member managed care complaints process and data collection. A cross divisional workgroup was formed in July 2018 to address this effort. Activities align with the Rider 61 report recommendations regarding strengthening oversight of the Texas Medicaid program. The Rider 61 report resulted from an 85th Legislature requirement for HHSC to conduct an evaluation of Medicaid managed care and report on the findings. HHSC engaged with Deloitte Consulting LLP to conduct the evaluation.

The project is working to streamline the member complaint process; standardize definitions and categorizations of complaints within HHSC and MCOs; improve data analysis to efficiently recognize patterns and promote early issue resolution; and provide greater transparency about complaints. HHSC is reviewing and improving the member complaints process with a no-wrong-door approach to ensure all staff quickly assist individuals.

Accomplishments include:

- Documented the HHS member managed care complaints process, identifying entry points and opportunities to streamline.
- Initial deployment of the first two phases of the new complaints process and published the Office of the Ombudsman quarterly complaints report to the HHS website.

Upcoming milestones:

- Implement complaint category standardization across HHSC and MCOs.
- Revise MCO reporting requirements from quarterly to monthly to aid in early issue detection.
- Execute contract changes related to complaints definitions.
  - This includes clarifications that complaints resolved within 24 hours of contact are considered complaints.
- Deploy client-facing changes to the new complaints process including a communications plan.

**Managed Care Organizations**

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

Complaint means an expression of dissatisfaction expressed by a Complainant, orally or in writing to the MCO, about any matter related to the MCO other than an Adverse Benefit Determination. Complaint has the same meaning as grievance, as provided by 42 C.F.R. § 438.400(b). Possible subjects for Complaints include the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member’s rights.

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23 An Adverse Benefit Determination means: the denial or limited authorization of a Member or Provider requested services, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized service; the denial in whole or in part of payment for service; the failure to provide services in a timely manner as determined by the State; the failure of an MCO to act within the timeframes set forth in the Contract and 42 C.F.R. § 438.408(b); for a resident of a rural area with only one MCO, the denial of a Medicaid members’ request to obtain services outside of the Network; or the denial of a member’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.
regardless of whether remedial action is requested. Complaint includes the member’s right to dispute an extension of time (if allowed by law) proposed by the MCO to make an authorization decision.

Complainant’s oral or written dissatisfaction with an Adverse Benefit Determination is considered a request for an MCO Internal Appeal.

**Table 4. Average Monthly Number of Individuals in an IDD Waiver or ICF/IID Receiving Services in STAR+PLUS, STAR Kids, and STAR Health and Complaints Received by MCOs from these Members in Fiscal Year 2018 regarding Acute Care**

<table>
<thead>
<tr>
<th>Managed Care Program</th>
<th>Average Monthly Number of Individuals Receiving Services who were in an IDD Waiver or ICF/IID</th>
<th>Number of Complaints Received by Members in an IDD Waiver or ICF/IID</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAR+PLUS</td>
<td>16,913</td>
<td>88</td>
</tr>
<tr>
<td>STAR Kids</td>
<td>5,652</td>
<td>37</td>
</tr>
<tr>
<td>STAR Health</td>
<td>144</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22,709</strong></td>
<td><strong>126</strong></td>
</tr>
</tbody>
</table>

The top three reasons for complaints from members in an IDD waiver in fiscal year 2018 were quality of care or services, accessibility/availability of services, and utilization review (UR)/utilization management (UM). All reasons for complaints in fiscal year 2018 from members in an IDD waiver are listed below.

- Quality of care or services
- Accessibility/availability of services
- UR/ UM
- Billing issues
- Eligibility
- Quality of service practitioner
- Plan Administration
- Physical therapy
- Claims processing
- Prior authorization
Table 5. Number of MCO Internal Appeals Upheld, Overturned, or Withdrawn for Recipients in an IDD Waiver or ICF/IID Enrolled in STAR+PLUS, STAR Kids, and STAR Health in Fiscal Year 2018

<table>
<thead>
<tr>
<th>Program</th>
<th>Total Number of AppealsFiled</th>
<th>Number of Appeals Upheld by MCO(^{24})</th>
<th>Number of Appeals Overturned by MCO(^{25})</th>
<th>Number of Appeals Withdrawn by Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAR+PLUS</td>
<td>202</td>
<td>97</td>
<td>88</td>
<td>17</td>
</tr>
<tr>
<td>STAR Kids</td>
<td>265</td>
<td>167</td>
<td>93</td>
<td>5</td>
</tr>
<tr>
<td>STAR Health</td>
<td>12</td>
<td>8</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>479</td>
<td>272</td>
<td>185</td>
<td>22</td>
</tr>
</tbody>
</table>

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

The top three reasons for State Fair Hearings in fiscal year 2018 for members enrolled in an IDD waiver related to reduction or denial of durable medical equipment, Private Duty Nursing, and therapy. All reasons for State Fair Hearings in 2018 for members enrolled in an IDD waiver related to reduction or denial of services and supports are listed below.

- Durable medical equipment
- Therapy – Treatment
- Private Duty Nursing
- Genetic Testing
- Sleep Study
- Inpatient
- Home Health

\(^{24}\) Indicates that the MCO investigated, reviewed, and ruled in favor of the Adverse Benefit Determination taken by the MCO.

\(^{25}\) Indicates that the MCO investigated, reviewed, and overturned the Adverse Benefit Determination taken by the MCO.
• Transportation

**Office of the Ombudsman**

The Office of the Ombudsman received seven complaints, four substantiated\(^{26}\) and three unsubstantiated\(^{27}\), in fiscal year 2018 for STAR+PLUS, STAR Kids, and STAR Health members with IDD. Access to dental and access to care coordination were the top two complaints. All complaints received are listed below.

• Access to dental services
• Access to care coordination
• Access to provider
• Prescription – non-Medicaid provider
• Delay of referral or authorization
• Therapy – lack of occupational therapy provider

**Managed Care Compliance & Operations**

The MCCO unit tracks complaints received from members, LARs or family members, providers, and other interested entities. Individuals may contact MCCO if they have been unable to resolve a complaint, MCO Internal Appeal, or State Fair Hearing with their MCO. Individuals unsatisfied with the solution may appeal through a State Fair Hearing, which involves a private proceeding held before an impartial HHSC hearings officer.

In fiscal year 2018, MCCO received a total of four complaints from STAR+PLUS, STAR Kids, and STAR Health members with IDD, but agency staff were unable to substantiate any of the complaints.\(^{28}\)

Types of complaints received in fiscal year 2018 included:

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\(^{26}\) Substantiated complaint--A complaint for which research clearly indicates HHS policy was violated or HHS expectations were not met.

\(^{27}\) Unsubstantiated complaint--A complaint for which research clearly indicates HHS policy was not violated or HHS expectations were met.

\(^{28}\) It is possible that MCCO received additional complaints from individuals with IDD that are not reflected in this amount, due to not having identified IDD status.
• Benefit issues
• Prescription coverage
• Prior Authorization
• Denial of claim
6. Initiatives to Improve Access and Outcomes

**Person-Centered Planning**

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

To comply with federal and state regulations, HHSC requires people who facilitate person-centered service plans for CFC and HCBS to complete training within six months of hire, as of September 1, 2019. The state and its partners, including local intellectual and developmental disability authorities (LIDDA), The University of Texas Center for Disability Studies, and The Learning Community for Person-Centered Practices (TLCPCP), have been working to build the infrastructure to successfully comply by training more certified Person-Centered Thinking trainers.

**Training**

An additional three trainers are now certified by TLCPCP as Person-Centered Thinking (PCT) trainers, with one additional trainer pending certification, bringing the total to 19 trainers who train on behalf of the state. According to TLCPCP, one trainer is the first known employee of a state child protection agency in the nation to become a certified PCT trainer. Trainers are state employees and employees of LIDDA, Councils of Governments, and provider agencies.

Through the Money Follows the Person Demonstration (MFPD) grant funding, two HHSC staff and one private provider staff became certified PCT Mentor Trainers in December 2018. The two HHSC certified PCT Mentor Trainers were certified as PCT Coaching Trainers in October 2017. The MFPD grant funded an initiative to certify six People Planning Together (PPT) co-facilitators who receive services for IDD. PPT co-facilitators with lived experience partner with a PCT trainer to train people with
IDD to create their own person-centered plans and better communicate and partner with service providers.

In the past three years, more than 1,605 service coordinators and case managers from LIDDAs, MCOs, and private providers have completed a two-day face-to-face PCT Training. This training continues to be offered in collaboration with community partners. Overviews of person-centered practices have been provided to various groups, including potential and current providers for the Consumer Directed Services (CDS) option for service delivery, CLASS, and DBMD services, and at conferences upon request. As of December 13, 2018, 5,816 people, including people from other states, had successfully completed the online PCP Training that launched in February 2017. The free training is accessible at: https://hhs.texas.gov/services/disability/person-centered-planning/person-centered-planning-waiver-program-providers/person-centered-planning-pcp-training-providers.

PCT training continues to expand to other state staff, such as social workers and case managers, Child Protective Services (CPS) employees, and now nursing staff within utilization review teams. PCT training also continues to be offered at nursing facilities across the state. PCT Coaching training is scheduled, with up to 10 sessions statewide to be completed by December 2019. PCT Coaches participate in a six-month mentored process and learn how to provide informal training and support others within their organizations to identify naturally occurring opportunities to practice and improve PCT skills. PCT Coaching is meant to help embed person-centeredness within the operation of any organization.

**Other Initiatives**

In March 2019, HHSC was awarded one of 15 three-year technical assistance grants by the National Center on Advancement of Person-Centered Practices and Systems (NCAPPS) to align policy and practice across the state for all populations across the lifespan. By March 2020, HHSC will establish a person-centered steering committee and strategic plan to ensure person-centered thinking, planning, and practice throughout the HHSC system. By September 2022, HHSC will create a PCP framework and accompanying tools, guidance, rules, policies and procedures, including adaptations for use with all HHSC populations.

On-going stakeholder engagement activities provided the foundation to participate in the NCAPPS grant person-centered improvement efforts. Five external stakeholders in Texas also applied for the NCAPPS technical assistance grant.
Subsequently, HHSC coordinated with the five other applicants and submitted a second application with unified goals inclusive of the needs of all applicants.

NCAPPS has approved the three-year Texas technical assistance plan and activities have begun. (See Appendix B: NCAPPS Texas Technical Assistance Plan)

**IDD Assessment Tool Pilot**

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

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

HHSC selected the International Resident Assessment Instrument Intellectual Disability (interRAI ID) Assessment System to pilot with a sample population to determine appropriateness for use in Texas. The IDD assessment tool pilot project will test and evaluate the tool in three phases across Texas IDD waiver programs:

- Phase 1: This phase began in spring 2017 and included automating and piloting interRAI with a volunteer sample. Phase 1 was completed on August 31, 2017.

- Phase 2: This phase included the evaluation and comparison of the interRAI with the currently used assessment, the Inventory for Client and Agency Planning (ICAP). Phase II was completed in December 2018, with the final report received in late February 2019. The results will inform the determination of the appropriateness of statewide implementation.
• Phase 3: HHSC is considering the results from Phase II and will work with external stakeholders and the Legislature on any Phase III activities, which would involve developing a resource allocation process. It is expected that development of the resource algorithm would take up to a year to complete. As implementation of the assessment and resource allocation process is subject to available funding, HHSC would require an appropriation from the Legislature to move forward with Phase III.

The IDD SRAC and HHSC are exploring possible opportunities to utilize the interRAI with the HB 4533 pilot program.

**Home and Community-Based Services Settings Requirements**

In March 2014, federal regulations became effective governing HCBS settings and laying out expectations for states’ implementation of person-centered service planning. The regulations support individuals’ rights to:

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

States must comply with these rules by March 2022.

In the 2020-21 General Appropriations Act, the Texas legislature directed HHSC to develop a plan to replace current day habilitation services in waiver programs for individuals with IDD with more integrated services (HB 1, 86th Legislature, Regular Session, 2019). HHSC must submit a plan to state leadership by January 1, 2021 for approval.

HHSC is determining the next steps for the Statewide Transition Plan (STP). States are required to file an STP with CMS which provides assurances of compliance or sets forth the actions that the state will take to bring HCBS programs into compliance.
Texas identified the need to develop a Statewide IDD Strategic Plan to unify state agency leaders and stakeholders to identify and prioritize goals and make improvements in the IDD system. The framework used to develop the IDD Strategic Plan is modeled after the successful coordination and unified approach of the Texas Statewide Behavioral Health Strategic Plan.

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

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

HHSC is currently embarking on the second phase for development of the Statewide IDD Strategic Plan. This phase includes development of a second more in-depth survey to analyze strengths, weaknesses, opportunities, and risks through gathering comprehensive stakeholder input. The plan will outline the vision, mission, goals, and objectives of the IDD strategic plan. The plan will propose strategies to make improvements and identify short and long-term opportunities. Lastly, the plan will establish a timeline for implementation by stakeholders and the development of mechanisms to track outcomes.

The third phase will include implementation and monitoring of the plan.
7. Promoting Independence and Preventing Institutionalization

Money Follows the Person Demonstration (MFPD)

MFPD is a federal demonstration project designed to increase the use of home and community-based services and to reduce the use of institutional-based services. In August 2019, the President signed the Sustaining Excellence in Medicaid Act of 2019 (Public Law 116-39). Specifically, the Act increases appropriations for the Money Follows the Person Rebalancing (MFP) Demonstration Program to $245.5M and extends the program through Federal Fiscal Year 2024.

The following is a summary of the MFPD-funded projects in Texas designed to promote independence for individuals with IDD.

Integrated and Competitive Employment

“Employment First” is an approach to facilitating the full inclusion of individuals with disabilities in the workplace. Under this approach, integrated, competitive employment should be the first option considered for individuals with disabilities and should be the expected outcome of education and publicly-funded services for working-age youth and adults. Where we work is often where we make friends, demonstrate our abilities, and earn enough disposable income to enjoy other opportunities. Individuals with disabilities are much less likely to have a job than individuals without disabilities.

Beginning in 2018, HHSC began offering regional trainings that focus on sharing the Employment First principles; educating providers, family members, and program participants about the employment services currently provided in waiver programs; and addressing the misconception that working will cause program participants to

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29 hhs.texas.gov/doing-business-hhs/provider-portals/resources/promoting-independence/money-follows-person-demonstration-project

lose their benefits. These regional trainings are funded by MFPD and will continue during Fall 2019.

In addition to the regional trainings, HHSC has several other employment initiatives funded through MFPD.

- **Employment Recruitment Coordinator** – The Employment Recruitment Coordinator furthers the state’s Employment First principles with continued field work across the state, directly working with employers and presenting to civic organizations to expand awareness and generate additional integrated employment opportunities for persons with disabilities.

- **Employment First Coordinators** - Employment First Coordinators assist with the implementation of the HHSC Supported Employment Initiative\(^\text{31}\) and conduct other activities as necessary to improve employment services for individuals with developmental disabilities served by HHSC.

- **HHSC Employment First Webpage** – A HHSC webpage serves as a resource for individuals with disabilities seeking employment information and employers who are seeking to hire persons with disabilities. [https://hhs.texas.gov/services/disability/employment/employment-first](https://hhs.texas.gov/services/disability/employment/employment-first)


- **HHSC Employment Guide** – A guide (formerly the DADS Guide to Employment) designed to assist with improving employment outcomes for persons with disabilities. (The guide is currently under revision.)

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\(^{31}\)HHSC supportive employment initiatives assist with the promotion and utilization of community-based services, as opposed to institutional-based services, and will assist with the transition into community life activities for participants departing institutional settings. The initiatives involve working with civic organizations, employers, providers and other agencies to increase integrated employment opportunities for people with disabilities.
Hiring People with Disabilities Video – This video targets employers and provides information related to the benefits of hiring persons with disabilities. As of November 2018, this video has been viewed by more than 14,000 people. [https://hhs.texas.gov/services/disability/employment/employment-first/employment-guide-people-disabilities](https://hhs.texas.gov/services/disability/employment/employment-first/employment-guide-people-disabilities)

HHSC and Texas Workforce Commission (TWC) Partnership – In September 2018, HHSC partnered with TWC to provide information and training on Employment First principles to TWC regional staff, including training for vocational rehabilitation services counselors who work with individuals with disabilities receiving both TWC and HHSC services. This initiative also provides training and technical assistance on TWC employment services for HHSC providers.

**Transition Support Teams**

Transition Support teams help community providers and LIDDAs deliver adequate support to individuals with significant medical, behavioral, and psychiatric challenges transitioning from institutional settings or who are at risk of admission to an institution. Eight LIDDAs and community provider consultative support teams provide educational activities and materials, technical assistance, and consultative case reviews.

From September 1, 2017, through August 31, 2018, the teams provided:

- 1,394 educational opportunities and 12,155 LIDDA employees and contractors attended.
- 1,545 opportunities for technical assistance and 4,391 employees/contractors attended.
- 641 peer review/case consultations and 3,667 employees/contractors attended.

**Enhanced Community Coordination**

The LIDDA Enhanced Community Coordination (ECC) service coordinators provide intense monitoring and flexible support to individuals to support success in the community. The ECC service coordinator ensures individuals are linked to critical
services and receive person-centered services for up to one year following a transition or diversion. From September 1, 2017, through August 31, 2018, 3,438 people received enhanced community coordination.

**Transition Specialists in the State Supported Living Centers**

MFPD funds transition specialists and a continuity of services specialist at the State Supported Living Centers (SSLCs). Transition specialists employed at the SSLCs provide training to SSLC staff, residents, LARs, and family members about the community relocation process and planning. They also serve as a resource for personal support teams to help identify services and supports for individuals in the community, to identify obstacles to community transition, and to develop strategies to mitigate barriers. The continuity of services specialist monitors the final community living discharge plan (CLDP) and post-move support to assure quality and make suggestions for improvement. From September 2018 through June 2019, there have been 62 transitions from SSLCs to community settings.

**Mental Health Wellness for Individuals with IDD**

In December 2017, the State of Texas contracted with University of Texas Health Science Center at San Antonio to develop web-based training modules to educate health care practitioners on best practices in treating individuals with IDD and behavioral health needs. Initial topics included trauma-informed care, the importance of interdisciplinary team work, and communicating with people with IDD and co-occurring behavioral health needs.

In February 2019, with funding from MFPD, HHSC launched three additional modules featuring integrated approaches for working with people who have IDD and co-occurring behavioral health challenges. The new modules expand the knowledge and skills of healthcare professionals including physicians, physician assistants, and nurse practitioners by discussing evidence-based techniques to improve the delivery of health care to individuals with IDD, maximize outcomes, and enhance quality of life.

The project also includes expanding the existing website to include continuing education credits for licensed professional counselors, licensed marriage and family
therapists, licensed social workers, peer support specialists and licensed psychology professionals.\textsuperscript{32}

**Crisis Intervention and Crisis Respite Services**

The 84\textsuperscript{th} Legislature, Regular Session, 2015, allocated $18.6 million over the 2016-17 biennium for LIDDAs to provide crisis intervention and crisis respite support to individuals with IDD who have behavioral health or mental health support needs. Currently, all 39 LIDDAs statewide provide crisis intervention and crisis respite services to support individuals to maintain independent lives in the community, and to avoid unnecessary institutionalization. The 85\textsuperscript{th} Legislature allocated an additional $6.0 million for the 2018-19 biennium to maintain crisis and respite service levels. The 86\textsuperscript{th} Legislature appropriated an additional $4.0 million to support existing crisis intervention services and expand behavioral supports for individuals who have co-occurring mental health and IDD (i.e., a total of $28.6 million).

From September 1, 2017, through August 31, 2018:
- 2,760 individuals were served in crisis intervention services,
- 8,502 received Crisis Respite services,
- 433 individuals went to a Psychiatric Hospital,
- 135 went to a jail,
- 159 went to a hospital, and
- 130 went to other facilities.

**Housing Initiatives**

**Innovation Accelerator Program**

From August 2018 through June 2019, Texas participated in a CMS-sponsored Innovation Accelerator Program (IAP) to promote community integration for Medicaid beneficiaries through improved partnerships between state Medicaid and housing agencies. Building on its successful engagement, Texas was one of five states chosen to participate in a Housing and Health Institute technical assistance project sponsored by the National Academy for State Health Policy (NASHP).

\textsuperscript{32} [www.mhwidd.com](http://www.mhwidd.com)
Although the Texas IAP focused on individuals with behavioral health needs, it provided information valuable to expanding community opportunities for all individuals with disabilities. The process included development of a Medicaid crosswalk to identify current Medicaid services that support people with disabilities in housing and a housing gap analysis to identify key resources for expanding housing opportunities in Texas. The IAP also resulted in an improved partnership with the Texas State Affordable Housing Corporation, which has the potential to create additional housing for Medicaid beneficiaries in the future.

**Section 811 Project Rental Assistance Program Pilot**

In January 2019, HHSC implemented a Section 811 Project Rental Assistance Program pilot with the LIDDA, Nueces County MHMR Community Center, acting as the Section 811 referral agent and service coordinator for persons residing in the Corpus Christi State Supported Living Center (CCSSLC) who have been referred for community placement.

In November 2019, the LIDDA will complete the Texas Department of Housing & Community Affairs Section 811 Referral Agent Training. From January 2019 to June 2019, the LIDDA conducted outreach activities, such as presenting and providing Section 811 marketing material to CCSSLC’s admission and placement coordination staff; contacting the CCSSLC’s Qualified Intellectual Disability Professionals for persons being referred for community placement to determine interest in the housing program; and attending the community living options provider fair.

The Pilot continued through August 31, 2019. Although no referrals were submitted, HHSC is reviewing data collected from both LIDDAs and participating SSLC to make a determination about future activities.
8. IDD System Redesign Advisory Committee

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

IDD SRAC meets quarterly and subcommittees meet bi-monthly. IDD SRAC subcommittees include:

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

Many IDD SRAC recommendations require a multi-year focus due to required funding and the complexity of policy and system changes recommended. As a result, IDD SRAC decided to carry forward fiscal year 2018 recommendations to the fiscal year 2019 report with some updates. During fiscal year 2019, IDD SRAC worked to enhance and build upon recommendations, major achievements, and areas of focus, including:

- addressing barriers to transition IDD LTSS to managed care;
- improving quality and continuity of services and supports;
- increasing independence and community inclusion; and
- addressing barriers to system adequacy including rates, interest list allocation, and network adequacy.

Since the passage of HB 4533, IDD SRAC members have been prioritizing upcoming efforts to collaborate with HHSC on the formation of the pilot program workgroup and development of the pilot program. IDD SRAC subcommittees scheduled additional meetings to work on pilot development, including pilot program eligibility, services, assessment, and service coordination. The pilot program workgroup solicitation for membership was posted for the public to apply in September 2019. HHSC is reviewing applications and anticipates the pilot program workgroup will begin meeting in January 2020.
9. Challenges and Areas for Further Consideration

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

**Transition of IDD LTSS to Managed Care**

The studies conducted by UTHealth and Deloitte illustrate challenges and areas for consideration as Texas plans for the pilot program and transition of some or all Medicaid IDD waiver and ICF/IID services into managed care. The study findings on the effects of transitioning services to managed care considered the following:

- Lessons learned in other states that have implemented a managed care system for individuals with IDD;
- Impacts of the transition to managed care for all involved stakeholders; and
- Cost-effectiveness of potential models for carving in services to managed care.

Operational considerations include:

- States who have or are transitioning IDD services from FFS to MLTSS have struggled with the complexity and scope of the necessary information technology system changes. This is of particular importance for Texas because the current FFS IDD structure uses different systems.

- Continuity of care during transition from FFS to managed care is critical. This includes communications with providers and recipients and continuation of provider contracts and service authorizations. This is consistent with how Texas has approached other managed care carve-ins.

- States recognize the need for specific outcome measures for MLTSS for people with IDD and are proposing or beginning to track additional measures.
Overarching themes from the interviews and focus groups with multiple Texas stakeholder groups about experiences with managed care include:

- Widespread uncertainty among key stakeholders as to how LTSS services can be integrated into a managed care model, which has historically focused on medical care. Texas’ STAR+PLUS managed care program currently provides LTSS to people who are aging and people who have disabilities.

- A disruption in services, lack of continuity of providers, and alterations in access were expressed as common fears.

- Prior experience with transitions to acute care managed care was noted for access and communication issues.

- A need for service coordination in LTSS was repeated with an emphasis on collaboration among service providers, family members, and recipients.

- There is high awareness of the needs of the IDD population and the complexity of services required to meet those needs, with a strong commitment that self-advocacy and stakeholder support is required to allow the IDD voice to be heard.

HB 4533 provides additional time to transition IDD LTSS to managed care and a structure for robust stakeholder engagement through the IDD SRAC and pilot program workgroup. HHSC will work with stakeholders to ensure these considerations are addressed through development and implementation of the pilot and subsequent transitions of IDD LTSS to managed care.

**Person-Centered Practices**

A lack of understanding of benefits and the PCP process was previously identified as a barrier to achieving more person-centered outcomes for people receiving Medicaid waiver services. The current People Planning Together initiative, together with additional systemic improvements that will be part of the NCAPPS activities, is expected to help address this challenge.

**STAR+PLUS**

Currently, individuals with IDD in STAR+PLUS can file complaints with their MCO, MCCO, and/or the Office of the Ombudsman. Stakeholders have conveyed that this
can be confusing for individuals with disabilities. To address this challenge, the IDD SRAC Transition to Managed Care subcommittee worked to make recommendations for a webpage for individuals with IDD that explains the processes for filing complaints related to managed care. Additionally, a workgroup of staff from across HHSC is assessing current processes and identifying opportunities for improvement and to remove barriers for members.\textsuperscript{33} To date, the workgroup has documented member managed care complaints processes and deployed the beginning phases of the new complaint process. The workgroup also collaborated with the IDD SRAC to obtain feedback for an updated member complaint webpage that is intended to be accessible for all members.

Further work is needed to identify quality metrics to measure outcomes of health initiatives that address acute care health needs common to individuals with IDD.

**Rider 42 Interest List Study**

HB 1, Rider 42, 86th Legislature, Regular Session, 2019, directs HHSC to work in consultation and collaboration with the IDD SRAC to conduct a study of the interest lists and develop strategies to eliminate the interest lists for STAR+PLUS HCBS and the HCS, CLASS, DBMD, MDCP, and TxHmL waivers. As part of the study, information on the experiences of other states in reducing or eliminating interest lists will be obtained, factors that have affected the interest lists for the five most recent biennia will be identified, and existing data on persons on the interest list for each waiver program will be gathered. Based on the information obtained for the study, strategies and cost estimates to eliminate the interest list for each program will be developed. A report with the results of the study is due by September 1, 2020, to the Governor and the Legislative Budget Board. Additionally, HHSC is required to update the Statewide IDD Strategic Plan to include strategies identified in the interest list report.

HHSC is currently determining a project plan for the interest list study. Collaboration with the IDD SRAC will begin in Fall 2019.

**STAR Kids**

Lessons learned from the STAR Kids transition planning and implementation will be used to inform the transition of IDD LTSS to managed care. Additionally, HHSC is working with the STAR Kids Advisory Committee to optimize the SK-SAI and to align any changes with the requirements of Senate Bill (SB) 1207 related to streamlining the tool and processes. HHSC is also implementing and prioritizing the committee’s recommendations and developing implementation plans to comply with recent legislation relating to prior authorization, consumer directed services, and statewide MCOs for STAR Kids.

The STAR Kids Post-implementation report includes recommendations for MCOs and HHSC. HHSC is reviewing the recommendations for applicability to the pilot program and transition of IDD LTSS to managed care.

**CFC**

Many individuals not enrolled in an IDD waiver may be eligible for or receiving CFC services. To ensure that everyone entitled to receive CFC services is able to access them, improved data is needed to track CFC services when they are authorized and provided for individuals with IDD who are receiving managed care services and are not enrolled in an IDD waiver.

HHSC is considering options to increase the accessibility and utilization of CFC services, including:

- Developing a plan to target and assess individuals with IDD currently on an IDD waiver interest list;
- Exploring how to best move forward with the assessment of CFC services; and
- Introducing habilitation training for providers who have not previously provided services for individuals with IDD.
IDD Assessment Pilot

The timing of the IDD LTSS carve-ins was adjusted by HB 4533 and will begin September 1, 2027. However, the implementation date for Phase 3 of the assessment pilot and statewide implementation of the new assessment has not yet been determined. Use of the interRAI as the assessment tool for the future IDD LTSS transitions to managed care has not been determined. The HB 4533 pilot program may provide an opportunity for an additional limited roll-out of the interRAI.
10. Conclusion

HHSC has made significant progress on the IDD system redesign. With the passage of HB 4533, outstanding tasks required by statute were amended and now allow time to pilot LTSS in managed care before the transition. Opportunities exist for systemic improvement, as outlined in the previous section and appendices of this report, and as expressed by members of the IDD SRAC and other stakeholders. HHSC is committed to continuing to work with stakeholders to improve programs and services for Texans with IDD.

Milestones

- 2014-2016 HHSC transitioned acute care services in STAR+PLUS, STAR Kids, and STAR Health to managed care for eligible individuals with IDD.
- 2015 the CFC option was implemented in Texas to increase access to services for individuals with IDD, particularly those currently on interest lists for IDD waiver programs.
- 2014-present increased and enhanced community support services to promote independence and prevent institutionalization of individuals with IDD.
- 2018-2019 HHSC documented the member managed care complaints process, identifying entry points and opportunities to streamline.
- 2018-2019 HHSC completed initial deployment of the first two phases of the new complaints process.
- 2018-2019 evaluations conducted by Deloitte and UTHealth are complete and the findings will be used to inform the statutorily required carve-in of LTSS for people with IDD to Medicaid managed care.

Next Steps

- Planning for implementation and evaluation of pilot program, including coordination with the IDD SRAC and pilot program workgroup.
- Continued efforts to simplify and streamline the member managed care complaints process and data collection.
• Continue to collaborate with IDD SRAC to assess access to IDD services and supports and review outcomes related to transitioning acute care services to managed care and implementing CFC.
• Coordinate with the IDD SRAC to inform the HB 1, Rider 42 Interest List Study.
• Complete the IDD assessment tool pilot and determine appropriateness of implementation.
List of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Name</th>
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<tbody>
<tr>
<td>CDS</td>
<td>Consumer-Directed Services</td>
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<tr>
<td>CFC</td>
<td>Community First Choice Option</td>
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<tr>
<td>CLASS</td>
<td>Community Living Assistance and Support Services</td>
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<tr>
<td>CLDP</td>
<td>Community Living Discharge Plan</td>
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<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid</td>
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<td>CAHPS</td>
<td>Consumer Assessment of Healthcare Providers and Services</td>
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<tr>
<td>CPS</td>
<td>Child Protective Services</td>
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<tr>
<td>DADS</td>
<td>Department of Aging and Disability Services</td>
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<tr>
<td>DBMD</td>
<td>Deaf Blind with Multiple Disabilities</td>
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<tr>
<td>DME</td>
<td>Durable Medical Equipment</td>
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<tr>
<td>DSHS</td>
<td>Department of State Health Services</td>
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<tr>
<td>ECC</td>
<td>Enhanced Community Coordination</td>
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<td>EQRO</td>
<td>External Quality Review Organization</td>
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<td>FFS</td>
<td>Fee-for-service</td>
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<td>HCBS</td>
<td>Home and Community Based Services</td>
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<tr>
<td>HCS</td>
<td>Home and Community-based Services</td>
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<td>Health and Human Services Commission</td>
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<td>HPM</td>
<td>Health Plan Management</td>
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<td>IAP</td>
<td>Innovation Accelerator Program</td>
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<td>ICF</td>
<td>Intermediate Care Facility</td>
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<tr>
<td>ICF/IID</td>
<td>Intermediate Care Facility for an Individual with an Intellectual Disability</td>
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<td>IDD</td>
<td>Intellectual and Developmental Disabilities</td>
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<td>Intellectual and Developmental Disabilities System Redesign Advisory Committee</td>
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<tr>
<td>interRAI ID</td>
<td>International Resident Assessment Instrument Intellectual Disability Assessment</td>
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<td>LAR</td>
<td>Legally Authorized Representative</td>
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<tr>
<td>LIDDA</td>
<td>Local Intellectual and Developmental Disability Authority</td>
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<td>LTSS</td>
<td>Long-Term Services and Supports</td>
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<td>Managed Care Compliance and Operation</td>
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<td>Managed Care Organization</td>
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<td>Mobile Crisis Outreach Team</td>
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<td>MDCP</td>
<td>Medically Dependent Children Program</td>
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<tr>
<td>MFPD</td>
<td>Money Follows the Person Demonstration</td>
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<td>MHW-IDD</td>
<td>Mental Health Wellness for Individuals with Intellectual and Developmental Disabilities</td>
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<td>MMIS</td>
<td>Medicaid Management Information System</td>
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<td>NSCH</td>
<td>National Survey of Children’s Health</td>
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<td>Personal Care Services</td>
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<td>Person-Centered Planning</td>
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<td>Person-Centered Thinking</td>
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<td>Potentially Preventable Event</td>
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<td>PPV</td>
<td>Potentially Preventable Emergency Department Visit</td>
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<td>Service Authorization System</td>
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<td>Single Service Authorization System</td>
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<td>Supplemental Security Income</td>
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<td>State Supported Living Center</td>
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<td>TWC</td>
<td>Texas Workforce Commission</td>
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<td>TxEmL</td>
<td>Texas Home Living</td>
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<td>UM</td>
<td>Utilization Management</td>
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<td>UR</td>
<td>Utilization Review</td>
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Appendix A. IDD System Redesign Advisory Committee Recommendations

Transition to Managed Care Subcommittee

Simplify Accessing Dental Services

Background

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

Table 1. Requirements for Accessing Dental Services by Waiver or Program

<table>
<thead>
<tr>
<th>Waiver or ICF/IID Program</th>
<th>Benefit Limit</th>
<th>Unique Rules</th>
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<tr>
<td>HCS</td>
<td>$2000</td>
<td>Specific dental limit. Built into initial and renewal plan of care based on need.</td>
</tr>
<tr>
<td>TxHmL</td>
<td>$1000</td>
<td>Specific dental limit. Built into initial and renewal plan of care based on need.</td>
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</table>

34 The recommendations in this appendix were written by members of the advisory committee and were lightly edited for formatting and punctuation by HHSC.
As reflected above, current HHSC rules apply different requirements to the IDD waivers and ICF/IIDs related to accessing dental services. With the addition of anesthesia for some dental procedures now being covered under Medicaid managed care, coordinating and accessing dental services has become more complicated, thus needing clarification and clear guidance from HHSC. This includes explaining how a dental value-added benefit impacts limits and processes in each of the programs. To streamline the requirements and to allow easy access

to dental services for this population, the SRAC has the following recommendations.

**Recommendations**

1. For each HCBS waiver, include in the individual’s yearly plan of care the amount of services needed for dental for the year.
2. For CLASS, if the amount exceeds $2,000, the request for services will be reviewed by HHSC Utilization Review (UR).
3. As part of the development of the plan of care, HHSC will not ask for information on how much primary insurance will pay prior to services being rendered. However, once the claim has occurred, the dentist will include the amount paid by primary dental to assure there is no overpaid amount from Medicaid.
4. If using an anesthesiologist, the anesthesiologist and/or the facility will be paid by acute Medicaid or Medicaid managed care. The health plan must allow for an out of network (OON) anesthesiologist and facility to allow access to dental services. Clear guidance is needed to describe facilities allowed to bill including the dental office, outpatient facilities, and inpatient facilities. Clear guidance is also needed when the dentist as part of the dentist’s license applies anesthesiology services.
5. For any prior authorizations needed for dental services reviewed by HHSC, HHSC will provide a response within three business days.
6. If the dental procedure exceeds the approved amount in the initial budget for the individual, the excess amount will be reviewed and approved if determined medically necessary without requiring the individual receiving the services to return for another procedure under anesthesia.
7. For TxHM and HCS, HHSC should expand the approved list of covered Adaptive Aids to include dentures and implants with prior approval from HHSC.
8. Some services deemed as cosmetic should be reviewed to determine medical necessity, such as chipped teeth in a person who bites, has feeding challenges or other complications related to the needed cosmetic procedures.
9. HHSC should align policies across HCBS programs to allow for ease in access to services.
10. HHSC and the IDD SRAC shall work to build access to services for this population by working with dental schools across Texas.
11. HHSC and IDD SRAC shall develop methods to address accessing services through sedation early for a child through such strategies as Practice without Pressure to save Medicaid future dollars or NAIP funds and result in better outcomes for the member.

**Education on Transportation Benefits**

**Background**

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

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

**Recommendations**

1. Provide a clear understandable brochure to persons with IDD on how to access nonemergency medical transportation.
2. Finalize and distribute the brochure to the public (completed, awaiting distribution).
3. In the brochure:
   a. Provide information on who to contact and their contact information;
   b. Inform persons with disabilities on how to set up a ride;
   c. Provide information on how to be reimbursed when using a personal car; and
   d. Answer FAQs identified by the committee.

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

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

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

2016-17 General Appropriations Act, S.B. 1, 85th Legislature, Regular Session, 2017, Article II, Health and Human Services Commission, Rider 51 (formerly Rider 194) directs HHSC to develop community integration measures for STAR+PLUS and STAR Kids programs.

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

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

The Rider 51 – Community Integration Measures project is designed to gather data to assess the STAR+PLUS HCBS and STAR Kids MDCP program compliance with federal HCBS rules concerning community integration in areas such as: community participation, community presence, well-being, and recovery. HHSC is working with stakeholders to identify measures and establish methods of data collection. With stakeholder agreement, HHSC will collect data for measure reporting and publish final data on these measure on the HHSC website annually.
This process is currently conceptualized in two phases:
- Phase I will utilize currently available data streams and data elements from data sources available to the state as of January 2019.
- Phase II will expand upon Phase I measures to include measures derived from data elements that will become available after January 2019.
- These phases are somewhat distinct and yet the analysis is being conducted somewhat in tandem, to the extent that is possible.

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

**Recommendations**
1. Establish IDD population tracking codes within managed care.
2. Continue to seek and monitor IDD data on acute care and LTSS quality measures using encounter data from Medicaid managed care organizations and National Core Indicators to obtain participant experience. In addition to NCI–AD, measures should include sufficient NCI IDD measures.
3. Once the data has been gathered, the committee will review the results with HHSC to determine if the data is valid and can be used as baseline data for the future.
4. The committee will continue to work with HHSC to refine the measures; and determine LTSS measures that should be added and used to identify and address opportunities for improvement.
Identify and Develop Health Initiatives

Background

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

According to a November 2017 Policy Data Brief titled Health and Healthcare Access among Adults with Autism Spectrum Disorder (ASD) and Intellectual Disability (ID) by the Lurie Institute for Disability Policy, adults with ASD and IF reported poorer general health than the general adult population of the United States. About 29 percent or 2,390 surveyed using National Core Indicators (NCI) with individuals who receive state developmental disability services reported at least one chronic health condition such as diabetes, hypertension or high cholesterol. More than half of the respondents to their survey reported at least one diagnosis of mental illness/psychiatric condition (anxiety disorders, mood disorders, schizophrenia, etc.). Among those, three out of five took medication to treat those conditions and 24 percent who reported taking medications have no diagnosis on file. Most had access to primary care doctors, annual health exams, dental care and vision care. However, access to different types of preventive health screenings were uneven. Among women ages 21 to 65, 70 percent had a mammogram within the past 2 years, while 18 percent never had one. Among adults (men and women) ages 50 and above, 27 percent had never received a colon cancer screening.36

Recommendations

1. Expand quality based outcome and process measures to include health care concerns impacting individuals with IDD such as obesity (due to medications), recovery based mental health services for individuals with

36 http://lurie.brandeis.edu/pdfs/policy-briefs/OlderYouthSSI2.pdf
IDD and co-occurring mental illness, early onset Alzheimer’s/dementia, heart disease, health literacy for self-care and decision making.

2. Improve access to preventive health services and access to timely and accurate psychiatric diagnoses and appropriate treatments.

3. To encourage health and wellness that may result in reduction of obesity rates, which are not always due to low physical activity levels, develop and implement easily understandable, targeted health promotion policies and practices that focus on nutrition, healthy lifestyle and diet.

4. Analyze data and, if needed, expand data collection to include access, availability, experience, utilization, and the results of health care activities (outcomes) and patient perception of care including use of NCI health and wellness data for individuals with ASD, ID and other developmental disabilities.

**Develop and Implement a Regional Partnership**

**Background**

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

Individuals with IDD may struggle to find services, receive coordinated care, understand benefits, develop a plan for the future, and have opportunities within the community including living in the least restrictive environment and working in an integrated setting. The IDD SRAC has recommended that Texas HHSC develop regional partnerships throughout the state of Texas. The goal is to have better outcomes for persons with IDD.

**Recommendations**

1. Develop and implement a regional partnership throughout Texas for LIDDA, Medicaid MCOs, providers and persons with IDD to better coordinate care for persons with IDD, to develop local solutions, develop strong partnerships resulting in better health outcomes for persons with IDD.

2. Fund support for staffing, securing locations for meeting and meeting
materials are need to assure that the regional partnerships are developed and continue to operate.

**Improve the IDD Assessment Process**

**Background**

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

Like any tool, the ICAP has strengths and weaknesses. After years of experience with the ICAP, stakeholders identify strengths as its relative speed and ease of administration. The ICAP can be performed by non-clinical staff, allowing for Local IDD Authority case managers who are familiar with clients and experienced with person-centered planning to administer the tool. Weaknesses include the ICAP’s focus on recent behavior to the exclusion of past history and traumatic events. The striations within the tool are limited to only four generally available LONs (five including the highest, LON 9, which is rarely assigned). The four commonly assigned LONs are too broad to account for the tremendous variations in abilities and needs from person to person and to capture differences in a single individual’s needs in different settings (e.g. an individual may have much higher needs when in a crowded, unpredictable community setting such as a shopping mall than in a familiar, controlled setting such as a day habilitation site).

In recognition of these and other challenges, Senate Bill 7 (2013) directed DADS/HHSC to develop and implement a comprehensive, functional assessment instrument for individuals with IDD to ensure each individual receives the type, intensity, and range of services appropriate and available. In April 2015, legacy DADS determined it would pilot the International Resident Assessment Instrument (interRAI) Intellectual Disability assessment.

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

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

**Recommendations**

As the State moves forward with statutorily directed changes to the assessment process, the IDD SRAC recommends a focus on:

1. Person-centered, individualized assessments;
2. Assessment tools and resource algorithms that account for high support needs, whether physical, medical, or behavioral;
3. Flexibility in service planning and resource allocation, including for, but not limited to, individuals transitioning to community settings from institutional settings who may need higher levels of support during periods of transition; and
4. Acknowledgment of the important role an individual’s natural supports can play and a willingness to provide justified family support services, including additional respite, at the level necessary to support an individual to remain at home.

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

1. Modify ICAP scoring requirements to allow for assignment of LON 9 to individuals without a behavior management plan in place if other evidence justifies assignment of LON 9 for a period of 12 months.
2. Automatically assign at least an LON 6 for a period of at least 12 months to all individuals transitioning from institutional settings (already in place for individuals transitioning from SSLCs, but not in place for individuals transitioning from Nursing Facilities and other settings) and aging out
from CCP skilled nursing.
3. Investigate adjustments to the ICAP and other assessment tools to better account for high support needs, including physical, behavioral, and medical needs that enable the assignment of an appropriate LON, including LON 9.
4. Review adequacy and accuracy of current assessment processes for CLASS and DBMD.
5. Streamline Determination of Intellectual Disability (DID) process and study how other states complete this determination.

**Day Habilitation and Employment Services Subcommittee**

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

**Background**

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

**Recommendations**

1. Require a person-centered plan for all individuals that addresses individualized employment and other meaningful day activity goals.
   a. Include self-advocates in the discovery process to assist individuals in identifying their meaningful day (peer to peer model).
   b. Review and develop recommendations to ensure that assessment and service planning questions are meaningful to individuals.
   c. The service planning discovery tool currently in development should include a specific module on employment.
2. Require case managers, service coordinators and all waiver providers (DSAs- direct service agencies) to receive training in the principles of Employment First, employment services and the transition of services from TWC to the LTSS/waivers.
3. Include employment service providers in service planning when an
individual indicates their desire to work.

4. Require all TWC Vocational Rehab counselors to receive training regarding Employment first principles, waiver employment program services and the process to transition employment services from TWC to long term services and supports/waivers.

5. Explore HHSC regulatory staff reviewing for compliance to Department of Labor standards for all sheltered based employment services paying less than minimum wages.

6. Explore additional strategies to increase competitive integrated employment as per the Texas Employment First policy including utilization of transitioning from the use of 14c waiver certificates.

7. Increase additional strategies that lead to skill development to increase competitive employment.

Increase Utilization of Employment Services

Background

Despite the availability of Social Security Administrations (SSA) initiatives, work incentives and the Ticket to Work program, these employment services remain underutilized nationally and in Texas, particularly for individuals with IDD. In addition, Texas Medicaid waiver employment services of Employment Assistance and Supported Employment are grossly underutilized.

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

Recommendations

1. Require all waiver providers of LTSS services to have a strong provider base of Supported Employment and Employment Assistance providers.
2. Develop a network of employment specialists.
   a. Similar to HUBs for behavior, medical, psychiatric supports and consultations.
3. Develop and facilitate regularly scheduled regional and/or local collaboration on employment issues, including state agencies that provide employment services (LIDDA, TWC and HHSC).
4. Provide training for all IDD LTSS providers and day habilitation
providers to become successful employment services providers (as the Employment Service Providers - ESPs in TWC) in order to have a "pool" of providers for EA and SE services.

a. Encourage LIDDAs and other Employment Services waiver providers to become ESPs for TWC to assist in a smooth transition from VR services to waiver services.

b. Allow ESPs contract open enrollment to be available year round.

c. Examine the current state contracts for training providers of EA and SE to reduce the overall time required for them to qualify as a credentialed provider.

5. Educate providers, service coordinators, case managers, individuals, and families on work incentives and other resources to maintain benefits while working.

6. Increase the number of certified social security benefits counselors by providing the necessary training in SS benefits. Currently there are less than 30 state certified benefits counselors in Texas.

7. Identify state agency staff to assist individuals understand, maintain and manage their social security benefits, including assistance in maintaining benefits while employed.

8. Require and allow billing in the IDD waivers for EA providers to be present with an individual when a SE staff is being trained to ensure the transition from EA to SE is successful.

9. Explore mechanisms for HHSC to support employment for individuals with IDD.

10. Identify barriers and develop solutions regarding transportation to and from work related activities.

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

**Background**

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

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

**Recommendations**

1. Pilot or phase in an hourly community integration service available to individuals regardless of their residential arrangement.
2. Develop and promote pooling of day services dollars to participate in shared interests in the community for up to three individuals to provide staff and transportation.
3. Provide funds to incentivize or reward creative service models that increase flexibility and support individualized, person-centered, lifespan goals to assist the state to come into compliance with HCBS requirements. (For instance: competitive/integrated employment, integrated retirement, community recreation, volunteering, or other activities identified as meaningful by the individual.)
4. Incentivize waiver providers (DSAs-direct service providers) and day habilitation providers to become employment providers. (such as ESPs in TWC)
5. Seek input from stakeholders in various settings with varying services to increase awareness of barriers to community inclusion.
6. Fully implement the ISS service proposed by the IDD SRAC supported workgroups to allow for choice of meaningful day providers and day activities across settings in order to comply with the federal HCBS regulations.
7. Allow for flexibility of transportation services to support community participation activities.
8. Pursue funding for a grant program to ensure accessible transportation is available for individuals receiving day habilitation services. The grant would be similar to the Amy Young Barrier Removal grant program, and would allow the day habilitation provider to modify their van using grant funds once the provider accepts an individual that uses a wheelchair.

**System Adequacy Subcommittee**
**Access to Services**

**Background**

Timely access to IDD Medicaid-waivers is limited and interest lists are extremely long, in many cases they wait more than fourteen years. As of June 2019, the IDD Medicaid-waiver interest list included the following number of individuals: 73,039 for CLASS; 636 for DBMD; 101,501 for HCS; and 82,314 for TxHmL.37 In 2019 the 86th Legislature funded new waivers slots for 1628 individuals on the interest list and zero Promoting Independence waiver slots for individuals seeking diversion from admission to an institution or transition from institutions to the community. [See charts below.]

It is Texas policy that children belong in families. The Texas Legislature historically had funded waivers to support children and adults moving from facilities and divert them from facility admission as part of its commitment to Olmstead and the Texas Promoting Independence Plan.

The Texas Legislature historical funding for HCS and TxHmL waiver services, interest list reduction for HCS, and HHSC appropriation & attrition for HCS waiver slot utilization for the 2018-2019 biennium are outlined in the charts below.

37 [https://hhs.texas.gov/about-hhs/records-statistics/interest-list-reduction](https://hhs.texas.gov/about-hhs/records-statistics/interest-list-reduction)
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Crisis Diversion</td>
<td>To prevent institutionalization/crisis</td>
<td>300</td>
<td>400</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nursing Facility Diversion</td>
<td>For persons with IDD diverted from nursing facility admission</td>
<td>150</td>
<td>600</td>
<td>150</td>
<td>0</td>
</tr>
<tr>
<td>Nursing Facility Transition</td>
<td>For persons with IDD moving from nursing facilities</td>
<td>360</td>
<td>700</td>
<td>150</td>
<td>0</td>
</tr>
<tr>
<td>Child Protective Services Aging Out</td>
<td>For children aging out of DFPS foster care</td>
<td>192</td>
<td>216</td>
<td>110</td>
<td>0</td>
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</table>

38 Crisis Diversion was known as SSLC Diversion in FY14-15 and FY16-17.
39 FY14-15 HHSC (Prior to Transformation Department of Aging and Disability Services (DADS) used resource allocations to designate 150 slots for the purpose of diverting admission to nursing facilities.
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<tbody>
<tr>
<td>Nursing Facility Transition for Children</td>
<td>For children moving from nursing facilities</td>
<td>0</td>
<td>20</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Large or medium ICF/IIDs</td>
<td>For persons moving out of an ICF/IID, including an SSLC</td>
<td>400</td>
<td>500</td>
<td>325</td>
<td>0</td>
</tr>
<tr>
<td>DFPS General Residential Operations (GROs)</td>
<td>For children moving out of a DFPS GRO</td>
<td>25</td>
<td>25</td>
<td>0</td>
<td>0</td>
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Note: None specified in appropriations, but HHSC historically provides about 20 slots per biennium to help transition children from nursing facilities.
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<tbody>
<tr>
<td>State Hospital (MDU)</td>
<td>For persons moving out of state hospitals</td>
<td>0</td>
<td>120</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>HCS Interest List Reduction</td>
<td>Statewide interest list reduction</td>
<td>1,324</td>
<td>2,134</td>
<td>0</td>
<td>1,320</td>
</tr>
<tr>
<td>TxHmL Interest List Reduction</td>
<td>Statewide interest list reduction</td>
<td>3,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TxHmL NF Diversion(^{41})</td>
<td>For persons with IDD diverting from nursing facility admission</td>
<td>125</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**HCS Appropriated & Attrition Slot utilization for the 2018-2019 Biennium (as of July 31, 2019)**

\(^{41}\) FY14-15 HHSC (Prior to Transformation DADS) used resource allocation to designate 125 slots for the purpose of diverting admission to nursing facilities via the TxHmL waiver.
<table>
<thead>
<tr>
<th>Attrition Target Group</th>
<th>Purpose</th>
<th>2016-17 Carry-Over slots&lt;sup&gt;42&lt;/sup&gt;</th>
<th>2018-19 Appropriated Slots</th>
<th>FY 2018-19 Total Released</th>
<th>FY 2018-19 Appropriated Enrollment&lt;sup&gt;43&lt;/sup&gt;</th>
<th>FY 2018-19Attrition Enrollment&lt;sup&gt;44&lt;/sup&gt;</th>
<th>FY 2018-19 Total Enrollment</th>
<th>FY 2018-19 Total Pending Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis Diversion</td>
<td>To prevent institutionalization/crisis</td>
<td>10</td>
<td>0</td>
<td>549</td>
<td>0</td>
<td>420</td>
<td>420</td>
<td>95</td>
</tr>
<tr>
<td>Nursing Facility Diversion</td>
<td>For persons with IDD diverted from nursing facility admission</td>
<td>71</td>
<td>150</td>
<td>419</td>
<td>141</td>
<td>179</td>
<td>320</td>
<td>42</td>
</tr>
<tr>
<td>Nursing Facility Transition</td>
<td>For persons with IDD moving from nursing facilities</td>
<td>100</td>
<td>150</td>
<td>492</td>
<td>109</td>
<td>141</td>
<td>250</td>
<td>72</td>
</tr>
<tr>
<td>Child Protective Services Aging Out</td>
<td>For children aging out of foster care</td>
<td>5</td>
<td>110</td>
<td>189</td>
<td>106</td>
<td>31</td>
<td>137</td>
<td>31</td>
</tr>
<tr>
<td>Nursing Facility Transition for Children</td>
<td>For children (age 21 or younger) moving from nursing facilities</td>
<td>2</td>
<td>0</td>
<td>19</td>
<td>0</td>
<td>7</td>
<td>7</td>
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<sup>42</sup> Carry-Over is the number of slots still in the pipeline at the close of a biennium.

<sup>43</sup> Appropriated slots can be released on demand, as long as allocation is available.

<sup>44</sup> Attrition slots require input from HHSC Budget to determine if resources are available and to what capacity for the specified point in time. Data counts in this column include carry-over from the 2016-17 biennium and additional slots made available through attrition where enrollment was completed during the reporting period.
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</thead>
<tbody>
<tr>
<td>Large, Medium and Small ICFs-IID</td>
<td>For persons moving out of an ICF-IID.</td>
<td>36</td>
<td>325</td>
<td>462</td>
<td>267</td>
<td>0</td>
<td>267</td>
<td>58</td>
</tr>
<tr>
<td>HCS Administrative</td>
<td>For persons who’s HCS interest list record was corrected due to an error, which prevented them from receiving a slot when they should have.</td>
<td>1</td>
<td>0</td>
<td>59</td>
<td>0</td>
<td>30</td>
<td>30</td>
<td>12</td>
</tr>
<tr>
<td>Totals</td>
<td></td>
<td>225</td>
<td>735</td>
<td>2,189</td>
<td>623</td>
<td>808</td>
<td>1,431</td>
<td>317</td>
</tr>
</tbody>
</table>
## HCS Interest List Reduction by Biennium

<table>
<thead>
<tr>
<th>HCS Interest List - Biennium</th>
<th>Appropriated Slots</th>
<th>Total Released</th>
<th>Total Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014-2015</td>
<td>1,154</td>
<td>5,885</td>
<td>3,698</td>
</tr>
<tr>
<td>2016-2017&lt;sup&gt;45&lt;/sup&gt;</td>
<td>2,134</td>
<td>1,793</td>
<td>1,079</td>
</tr>
<tr>
<td>2018-2019&lt;sup&gt;46&lt;/sup&gt;</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2020-2021</td>
<td>1,320</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### Recommendations

1. Increase funding for Promoting Independence initiatives for children including waivers to support children currently in nursing homes and other institutional settings to move from facilities and to divert children from admission.
2. Fully fund 10 percent interest list reduction per year.
3. Fully fund sufficient Promoting Independence related transition and diversion

<sup>45</sup> During fiscal year 2014-2015, HCS slots were overfilled in response to feedback DADS received about not filling slots quickly enough. The impacts of over-releasing names from the interest list resulted in exceeding the end-of the year target and impacted the total enrolled for fiscal year 2016-2017. *Waiver Enrollment Report (March 2017).*

<sup>46</sup> HHSC did not receive appropriations for HCS interest list reduction during fiscal year 2018-2019.
waivers for children and adults to timely meet the demand and ensure Texas Promoting Independence plan is comprehensive and effectively working.

4. Provide outreach and training on how to access waivers, including the various attrition waiver slots, to the IDD population (individuals and families) and those implementing the processes for accessing attrition slots. As LTSS services are carved into managed care over the next decade eliminate the LTSS interest list for SSI recipients who qualify for IDD waiver program.

5. Implement no interest list policy for eligible MDCP SSI recipients in STAR Kids and STAR Health managed care programs.

6. Continue the “bridge to the appropriate waiver” policy. When an individual comes to the top of the interest list and is found to be ineligible based on disability or medical necessity, the individual’s name is moved to the appropriate waiver(s) interest list consistent with their disability or medical necessity criteria at the same date that the individual got on the waiver interest list for which they have been determined ineligible. MCOs, LIDDAs, service coordinators and case managers should inform individuals of the policy and assist with the process to get onto the appropriate interest list(s).

7. Implement a comprehensive Interest List study and, while implementing the Interest List Study, continue to provide robust funding for waiver slots for Promoting Independence and Interest Lists.

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

**Background**

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

**Recommendations**

1. Address barriers for individuals with high needs that result in difficulty accessing or maintaining stability in home and community-based programs and services. For example, ensure that provider payments are
both justified and sufficient and that billing is allowed for critical services such as nursing and supervision.

2. Establish clear expectations and ensure compliance for providers who delay or deny services to high needs individuals by providing technical assistance and resources for successful services, and by tracking delays and denials.

3. Continue to expand the behavior, medical, and psychiatric regional teams to serve all waiver programs.

4. For new HCS waiver enrollments, accept the initial proposed LON from the LIDDA for the first 12 months unless the LON is appealed due to not sufficiently reflecting the individuals’ higher LON.

5. Enhance capacity of crisis respite and long-term stabilization across all waiver programs.

6. Ensure access to protective supervision across all waiver programs.

7. Create due process rights so individuals and their representatives, not just providers, have the right to appeal a level of need determination.

8. Implement a one-year presumption of LON 6 or LON 9 for individuals enrolling from all institutional settings or aging out from CCP skilled nursing, not limited to SSLC transitions, and maintain, at a minimum, the LON of an individual transitioning from another waiver or other program for a year.

9. Modify LON 9 to address the need for 1:1 staff beyond aggressive behavior supports and supervision to include any behavior, or medical or physical need, that is life threatening or puts a person at risk of physical harm and requires the same high level of supervision and intervention.

10. Create high needs services that support advanced direct service professional training, supervision and compensation when supporting individuals with high medical, behavioral, physical or psychiatric needs.

11. Create an-add on level or “bump” in Community First Choice services and payment for individuals with more complex needs.

12. Add higher level of services with higher total cost allowance for individuals with the most complex needs in Medicaid and streamline access to General Revenue funds for those who exceed the cost cap for individual waiver.
Create Housing Transition Specialist

Background

There is a lack of affordable housing options and no assistance for individuals with IDD to help them find the best housing solution. Assistance to find appropriate housing can be funded as a Medicaid waiver benefit. Funding for Housing Navigator to assist consumers and families, case managers, service coordinators and low-income individuals with intellectual and developmental disabilities transition and provide housing related services.

The Housing Navigator will educate a potential housing applicant on community living options, property availability, and the application process. The Housing Navigator assists prospective applicant to apply for housing. The Housing Navigator maintains relationship with landlords and property managers, will assist with application process and monitoring of application process ensuring all documents are submitted to prospective landlord. The Housing Navigator works as a member of person centered practices team to communicate changes in housing application progression and to insure awareness and coordination necessary for supports and services and will assist with creative problem solving to resolve landlord/tenant issues, referral to other community resources as need is identified. The Housing Navigator assists prospective and placed applicants to understand lease and tenant responsibilities, training on how to be a good neighbor, and to insure the tenant understands how and when to communicate with a landlord. The Housing Navigator works with other community housing services and resources such as TDHCA and PRA 811, Centers for Independent Living, ADRC Housing Specialist, apartment locator services, etc. to identify available properties.

Recommendations

1. Create Housing Navigator to assist people with IDD transition to the most integrated, appropriate housing for the individual.
2. Request appropriation and legislative approval to fund a Medicaid waiver benefit of Housing Navigator and assistance.
3. Address barriers for individuals with high needs that result in difficulty accessing housing.
4. Explore opportunities to establish funding for security deposits and basic furniture/household items for those without resources.

Navigation Across the Entire IDD Service System

Background

Individuals with IDD in Texas migrate across multiple services and service delivery systems over the course of their lifetimes depending on their age, availability of services and changing needs and preferences. There is no strategic plan nor sufficient data to best evaluate when and why these migrations occur. The SRAC recommends reviewing the broader IDD system, across community and institutional services, in order to anticipate, plan and implement a more flexible and sensible system of supports and services whether in managed care or fee for service. The February 2019 Foundational IDD Strategic Plan is a start to better understanding the needs, services, gaps in services and timely availability of services and an opportunity to more strategically use data that has historically been fragmented and not part of a strategic, actionable plan.

Recommendations

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

The Health and Human Services Commission shall coordinate and consult with the SRAC to identify and obtain data needed to fully evaluate migration/transition of individuals with IDD across systems, including the reasons and number of transitions, and provide recommendations on the delivery of services to facilitate timely access to the services most appropriate to individual needs, including:

1. Providing comprehensive data at least quarterly to the SRAC and the public regarding the demand for waivers, enrollment, interest lists, and institutional
census, admission and discharge of individuals with IDD including State Supported Living Centers (SSLCs), Intermediate Care Facilities (ICFs), General Residential Operations (GROs) and Nursing Facilities (NFs).

2. Improving Interest List data and tracking across programs serving individuals with IDD including Star Plus, including the number of individuals on the interest list who are receiving institutional services by institutional type and waiver interest list.

3. Providing choice of the most appropriate waiver when an individual in an SSLC or other institutional setting is transitioning to the community and would qualify for the Deaf Blind Multiple Disabilities (DBMD) or Home and Community Based Services (HCS) waiver.

4. Participating in the development of the IDD Strategic Plan and encouraging broad stakeholder input.

5. Contributing to the development, implementation and recommendations of the STAR Plus IDD Pilot for individuals with IDD and similar functional needs and the Pilot Workgroup.

6. Implementing a well-coordinated transition and referral process to prevent breaks in services when an individual is moving between or leaving a Medicaid medical assistance waiver program or moving between service delivery systems due to a change in the individual's disability status or needs, aging out of a current delivery system, moving between geographic areas within the state or transitioning from an institution to the community;

7. Fully assessing an individual with IDD at the time the individual applies for assistance to determine all appropriate services for the Individual under the Medicaid medical assistance program, including both waiver and non-waiver services;

8. Improving procedures for obtaining authorization for IDD Medicaid waiver services and other non-waiver services under the Medicaid medical assistance program, including procedures for appealing denials of service that take into account physical, intellectual, behavioral and sensory barriers and providing feedback on development of the new Independent Review Organization, including outreach and education;

9. Continuing use of waivers under Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n(c)) most appropriate to the IDD population to provide the state with the flexibility to provide services outside the scope, amount, or duration of non-waiver services available under the Medicaid state plan medical assistance program;

10. Developing policies that ensure that a child or youth receiving Medicaid services
has access to the most appropriate, comprehensive waiver service as adults, based on that persons needs and preferences, when person ages and loses eligibility for Medicaid State Plan or Medicaid waiver services for children;
11. Establishing the family support necessary to maintain an individual's living arrangement with a family for children and, if desired, for adults with IDD;
12. Ensuring that eligibility requirements, assessments for service needs, and other components of service delivery are comprehensive, accurate, and designed to be fair and equitable for all families, including families with parents who work outside the home, parents who volunteer and parents who are not employed;
13. Providing for a broad array of integrated community service options and a reasonable choice of service providers, consistent with home and community based service settings requirements, including improving use and flexibility of consumer directed services options and training for self-advocates to direct their own services when desired.
14. Evaluating the quality and effectiveness of services for individuals with IDD; including individuals with high support needs and including whether access to crisis services prevented or could have prevented the need to migrate to a more restrictive setting or a different Medicaid waiver.
15. Monitoring the implementation and impact of managed care, new policies and initiatives required by the 86th Texas Legislature.
16. Identify state agency staff to assist individuals to understand, maintain, and manage their benefits.

**Improve the Medicaid Managed Care Problem Resolution Process**

**Background**

Since the transition of the acute care services for certain eligible individuals with IDD to managed care on September 1, 2014, there has been lack of clarity regarding how and to which entity individuals, their legally authorized representatives or the providers of their long term services and supports are to obtain resolutions to problems encountered; i.e. MCOs, HHSC’s Managed Care Compliance and Operations (MCCO) unit, formerly known as Health Plan Management, or HHSC Ombudsman office. While HHSC has made movement to standardize the appeals process and to encourage appeals be reviewed by a managed care organization for resolution before escalating to a state fair hearing, the process is cumbersome and time consuming to a final determination.
One of the primary issues lies with appeals coming in through multiple entry points. Whether a complaint comes through an MCO or through MCCO or the HHSC Ombudsman, multiple points of entry impacts clear visibility for tracking and trending of systemic issues. Additionally, complaints are not tracked by specific subpopulations within Medicaid, which impacts the ability of either an MCO or HHSC to identify and remedy systemic problems related to specific programs or to objectively consider root cause for issues affected by regulatory, statute, or program policy and that may benefit from review and revision.

Though efforts to obtain resolution to the issue have been ongoing (both via the IDD SRAC and the 2015 Executive Commissioner’s Commitment to Improving Member and Provider Experience in Medicaid Managed Care initiative), as evidenced in the 2017 Implementation of Acute Care Services and the Long Term Services and Supports System Redesign for Individuals with Intellectual or Developmental Disability Report (statutorily required to be submitted to the Legislature on an annual basis) and reports from stakeholders, to date the aforementioned concerns remain. [The report indicated that over a two-year period (FYs 2015 and 2016), very few complaints were filed by either providers, persons with IDD or the Legally Authorized Representative (43 filed with HHSC; 113 filed with the MCOs). In fact, the MCCO expressed concern about the low statistics.]

As reported in the 2018 Implementation of Acute Care Services and the Long Term Services and Supports System Redesign for Individuals with Intellectual or Developmental Disability Report, in FY 2017, there were 105 complaints received by MCOs related to acute care services from individuals in an IDD waiver or ICF/IID receiving services in STAR+PLUS, STAR Kids and STAR Health. The report further states that in FY 2017 the Managed Care Compliance & Operations team received a total of four complaints from STAR+PLUS, STAR Kids and STAR Health members with IDD, noting “this was a significant decrease from previous years.” [See recommendation #1.]

**Current Activities**

In 2017, the IDD SRAC worked with HHSC to redesign the HHSC website page to make it easier for an individual to understand how to file a complaint. To date, this work has not been fully implemented and the site has not been updated with the recommended changes. In 2018 Interim Legislative hearings, HHSC stated agency staff are working to improve the complaint process to allow HHSC to use
complaint data to identify risks, increase program transparency and inform areas for improvement. The improvement initiatives HHSC offers do not holistically examine root cause for administrative and systemic concerns with the complaint or problem resolution process. Improvements are needed to simplify the appeal process and to make it more understandable for those served by Medicaid programs.

Though the Statewide Medicaid Managed Care Advisory Committee (SMMCA) is reviewing the Medicaid Managed Care Complaint process, to date there has been no communication between the IDD SRAC and SMMCA related to their respective efforts.

**Recommendations**

1. Require MCOs to educate its members and acute care and LTSS providers (including IDD LTSS providers who serve individuals receiving only acute care services from an MCO) on the Complaint Resolution Process annually. [Though data included in the 2018 Implementation of Acute Care Services and the Long Term Services and Supports System Redesign for Individuals with Intellectual or Developmental Disability Report reflects a decrease in complaints filed, anecdotal reports from individuals, family members and LTSS providers suggest that if the complaint process for all affected stakeholders was streamlined and more consumer-friendly, these numbers may increase. Many affected stakeholders report they do not know whom to contact when an issue surfaces. Many also report that even if they do know how to report a complaint they either experience challenges in being able to report their complaint to the appropriate person(s) within a MCO, they are never called back or the outcome of the complaint is typically deemed unsubstantiated. As the result, many stakeholders report they no longer attempt to access the process.]

2. Require MCOs to share Appeal information with members, involved others, or their Legally Authorized Representative in writing and verbally and to assist them to file an appeal.

3. Although HHSC states changes are underway to the process, HHSC should re-issue the current process for submitting a complaint to those who receive HHSC communications, encouraging persons to share with others
as appropriate. [Many stakeholders still do not subscribe to the communications or even know they can. Many also still have no access to a computer, and many do not feel comfortable asking the MCO how to submit a complaint or even filing one for fear of some form of retaliation. The last time HHSC disseminated the process was in 2015.]

4. HHSC should review federal and state statutes including regulation by TDI to more clearly align with federal and state regulators in definition and action. This includes HHSC more clearly defining an inquiry and a complaint, and providing clear policy and direction on how each may be clearly identified and resolved. To support HHSC’s recent proclamation before the House Human Services Committee and the joint hearing of the House Appropriations Article II subcommittee and General Investigating and Ethics Committee that there is ‘no wrong door,’ HHSC should clearly align agency departments so that a complaint coming into HHSC enters in a streamlined and coordinated single point of entry. No less than quarterly, HHSC should examine complaints for root causality and develop action(s) and/or policy change to resolve recidivism.

5. The current HHSC webpage should be updated to more clearly reflect specific or classification of complaints and to whom a complaint is filed, which includes a clear but simple explanation for a defined complaint and the entity to which a complaint may be reported. It would be beneficial if the page also included a button or tab that clicked to a form/section that collected a complaint and when entered into the system could be sent directly to the correct entity without a member, provider or other person being responsible for choosing the entity to which the complaint is submitted. This offers persons who access the HHSC complaint email box the option to either send their complaint via email or use a form similar to the Ombudsman on-line form.

6. A standardized point of entry for filing a complaint regardless of the entity to which a stakeholder (an individual who receives services from a MCO or their LAR, acute care providers and LTSS providers) files a complaint (the MCO, MCO unit or Ombudsman office), the information collected (in particular about the person and general nature of the complaint) should be uniform across the entities. In other words, to assist in identifying trends across complaints and populations, each entity should collect data on the general nature of the complaint, the type services one is receiving, etc. [In the recent past HHSC has stated that when the LAR of an
individual calls to register a complaint, it is noted during the intake that the individual is with STAR Kids. The same practice should apply when a complaint is filed by a person with IDD who, at this time, is only receiving their acute care services through STAR+PLUS or by a person on behalf of a person with IDD.

7. Improvements to the process need to support that a LTSS provider serving an individual with IDD is able to report a complaint on behalf of the individual. At the time of the transition of the acute care services for persons with IDD to managed care, stakeholders (specifically LTSS providers) were informed they could communicate with MCOs and HHSC about any concerns with the services individuals were experiencing, including filing a complaint on behalf of the individuals. This ‘agreement’ has not been widely upheld.

8. The complaint resolution process must clearly outline the process and date for expected resolution. Today for a complaint filed with an MCO, the entity receives an acknowledgement letter within 5 days of receipt with an expectation that any MCO complaint is resolved within 30 days. To accomplish this, HHSC should review current internal processes and the managed care contract to reflect a more streamlined and consistent resolution process no matter the point of entry.

9. When a determination is reported back to the person who filed the complaint, clear explanation to validate or substantiate an appeal decision should accompany the determination as well as what recourse a person has if they disagree.

10. Consideration should be given to moving the complaint investigation function to an independent and conflict-free entity.

11. Ensure communication between the IDD SRAC and SMMCAC regarding their respective efforts on improving the complaint process, including a process for each committee to review and provide input on the efforts.

Increase Community First Choice Utilization and Improve Coordination

Background

As an early step in the IDD System Redesign, on June 1, 2015, Texas became one of the first states in the nation to implement Community First Choice (CFC). CFC
was implemented as a Medicaid State Plan benefit, available for children and adults with Medicaid who meet an institutional level of care and have a functional need for services. The main services available in the CFC service array are personal assistance services (PAS), which involves assistance with tasks of daily living, such as bathing, dressing, and eating; and habilitation (HAB), which involves assisting a person to learn, develop and maintain skills for everyday life activities.

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

Unfortunately, the full promise of CFC has not been realized. The uptake rate for CFC (the number of people offered the service who accept) has remained lower than anticipated (according to “CFC Closures FY17” report, presented by HHSC to System Adequacy subcommittee at June 26, 2018 meeting). Stakeholders, including LIDDA’s, who serve as the front door to CFC services for individuals with IDD, and MCOs, who are responsible for overseeing the delivery of CFC services for many populations, report challenges related to outreach, coordination and data collection. Notably, LIDDA’s found through their outreach efforts that many people offered CFC were not interested because the services offered did not meet the individual’s needs. Individuals and families noted that the in-home assistance and habilitation available through CFC would be more beneficial when coupled with transportation and respite.

The 84th Texas Legislature (2015) responded to the low uptake rate and stakeholders’ call for a package of services more responsive to the needs of individuals with IDD by appropriating approximately $30 million to add respite and transportation services to the CFC service array. Due to complications, these funds were never utilized for their intended purpose and the CFC service array remains unchanged.
Stakeholders note other significant difficulties with CFC implementation. Some additional factors include:

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

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

**Recommendations**

1. Increase awareness of CFC through a concerted, statewide outreach effort.
   a. HHSC should create a brochure and website content that describes CFC in a meaningful, accessible way, to include eligibility requirements for the benefit and information on whom to contact to request services.
   b. MCOs should ensure their members are aware of CFC and are routinely screened for eligibility and interest in the benefit.
2. Enhance the CFC service array.
   a. HHSC should work with the Legislature, as appropriate, to revisit the possibility of adding transportation and respite services to the CFC service array.
3. Set sustainable CFC rates that allow for hiring and retention of direct service workers with experience in habilitation.
4. HHSC needs to develop a strong reporting mechanism from the date of request or determination for the need of assessment for CFC services until the date the services are rendered or denied. HHSC needs to include in
the reporting reasons why members may decide to decline the benefit. Also needed to include in the report is the timeframes between the MCOs and the LIDDAs.

5. Assure proper funding to LIDDAs to provide services.

6. HHSC need strong oversight and possibly more training for MCOs and LIDDAs on the benefit, when to provide, and reporting requirements.
   a. HHSC should ensure rates for CFC services across all programs, including rates paid by MCOs, are sustainable and set to attract and retain direct service workers with experience in habilitation. Rates set for direct service workers who support individuals with IDD must take into account the lifelong needs of individuals with IDD and the distinct skills and abilities required to teach individuals to perform tasks independently.

7. HHSC needs to develop a strong reporting mechanism from the date of request or determination for the need of assessment for CFC services until the date the services are rendered or denied. HHSC needs to include in the reporting reasons why members may decide to decline the benefit. Also needed to include in the report is the timeframes between the MCOs and the LIDDAs.

8. Assure proper funding to LIDDAs to provide services.

9. HHSC need strong oversight and possibly more training for MCOs and LIDDAs on the benefit, when to provide, and reporting requirements.

10. Use data-driven decision-making to commit to continuous improvement in CFC.
   a. HHSC should work in concert with the MCOs to allow for identification and tracking of CFC utilization data for specific populations (i.e. individuals with IDD).
   b. Once gathered and reviewed, utilization data should be used to address network inadequacy.

11. HHSC should work with MCOs and Local IDD Authorities to identify and address issues related to eligibility determination and the authorization processes that may slow down or impede enrollment and that ultimately may negatively affect the ability of an individual to timely access necessary Medicaid benefits and services.
Improvement Opportunities Based on Lessons Learned & Root Causes from STAR Kids Carve-in

Background

On November 1, 2016, the Texas Health and Human Services Commission implemented STAR Kids, a Medicaid Managed Care delivery model for children and young adults under the age of 21 who qualify for Supplemental Security Income due to disability, are on a Home and Community-Based Services (HCBS) waiver, or receive Medicaid under Medicaid Buy-In for Children. The inclusion of children’s acute care Medicaid services as well as the Medically Dependent Children Program (MDCP) waiver services into Managed Care, has not been without issues. Families of children with medically complex conditions and providers report issues that prevent children from receiving timely access to medically necessary services. The 86th legislative session resulted in a number of Medicaid Managed Care improvements. The IDD SRAC will continue to monitor the improvements in STAR Kids and the recommendations of the STAR Kids Managed Care Advisory Committee and the Policy Council for Children and Families as they inform the work of SRAC to create a system for children and adults with IDD. The following are some of the key issues and being addressed.

Screening and Assessment Instrument Improvements

The STAR Kids Screening and Assessment Instrument has resulted in a significant increase in the denial of MDCP waiver services for children who have previously met medical necessity. It is unclear whether the tool or the referral triggers are resulting in CFC assessments for all populations including children with IDD or mental health conditions. Families, health care providers and others have reported that the tool is too long, children who have no change in their conditions are being assessed too frequently, and the assessments are not always accurate.

SB 1207 and SB 1096 from the 86th Texas Legislature require:

- HHSC in consultation with the collaboration with the STAR Kids Advisory Committee to:
  - Reduce the amount of time needed to complete the assessment.
  - Improve training and consistency in completion of the assessment across different Medicaid managed care organizations.
  - To the extent feasible and allowed by federal law, streamline the
reassessment of children who have not had a significant change in function that may affect medical necessity.

- The STAR Kids advisory committee or a successor committee to explore feasibility of adopting a private duty nursing assessment and provide recommendations to HHSC on adopting a tool that would streamline the documentation for prior authorization of private duty nursing.
- Care coordinators with managed care organizations to provide results of MDCP assessments with parents for review.
- HHSC to provide parents who disagree with results of assessment to request to dispute the results with the MCO through a peer-to-peer review with the treating physician of choice.

**Prior Authorizations Consistent Across Plans**

The Policy Council for Children and Families and the STAR Kids Advisory Committee have expressed concern about the lack of certainty and clarity in the prior authorization processes in STAR Kids as well as burdensome requests for information from Managed Care Organizations. Prior to the roll out of STAR Kids, policies and prior authorization processes were set by the state. Now families are working with multiple MCOs who each have their own set of authorization requirements and review processes, some of which are onerous to providers and families and which cause delays in authorization for needed services. While SB 1207 and SB 1096 of the 86th Texas Legislature did not require a standardized documentation requirement for prior authorizations across MCOs and did not ease all of the administrative burdens on providers, the legislation requires:

- MCOs to comply with strong prior authorization determination time frames for individuals who are hospitalized. HHSC to conduct a utilization review on a sample of cases for children in STAR Kids to ensure all imposed clinical prior authorizations are based on publicly available clinical criteria and are not being used to negatively impact a recipient’s access to care.
- MCO to provide for continued access to a drug prescribed to a child enrolled in STAR Kids regardless of whether the drug is on the vendor drug formulary
- MCO may not use a protocol that requires a child to use a prescription drug or sequence of prescription drugs other than the drug recommended by the child’s physician
- HHSC to require by rule that MCOs maintain easily searchable and accessible information about
o Prior authorization timelines
o Catalogue of coverage criteria and prior authorization requirements including list of documentation necessary to obtain authorization
o Process for provider or recipient to submit prior authorization requests
o Assurance that the process is not arduous or overly burdensome to the provider or recipient.

- HHSC or MCOs to provide clear and specific list and description of documentation necessary to make a final authorization determination along with timeline for determination and information for the provider on how to contact the decision maker.
- Annual review of prior authorization requirements including soliciting input from providers

Medical Necessity Determinations

Families and physicians in STAR Kids have voiced their concern about medical necessity determinations being made by the Managed Care Organizations that are contrary to the determinations made by the child’s physician. SB 1207 and SB 1096 require:

- HHSC to contract with an independent external medical reviewer to conduct external medical reviews of denials when requested by the child’s parent. The review must be done by a third-party objective, unbiased clinical staff person with education and practice in the same or similar practice area as the procedure for which an independent determination of medical necessity is sought.

Obtaining Durable Medical Equipment and Supplies Must be Consistent and Efficient

Some MCOs in STAR Kids utilize a preferred vendor for their member’s durable medical equipment and medical supply needs. While HHSC has provided clarification that children in STAR Kids must be able to opt out of a preferred provider arrangement if it does not meet their needs, DME providers are having trouble operating under the new Medicaid Managed Care system due to:

- An increase of up to 25% in administrative costs and burdens for providers in submitting prior authorization and submitting claims;
• A significant decrease of between 12 to 14% for equipment and supplies including enteral formulas; and
• Prior authorization processes that are not consistent across MCOs. There are 10 MCOs in STAR Kids each with their own prior authorization process.

**Strengthen Provider Protections — Timely Payments, Reasonable Rates, and Significant Traditional Providers**

Families and providers have reported significant delays in claims payments to providers, leading some providers to dissolve contracts with MCOs and a smaller network of providers for families to choose from. This is true in both rural and urban areas of the state, but particularly troubling in rural areas where there are fewer providers. Providers have also voiced their concern about delays in payments due to minor administrative errors that did not affect the amount billed, but that substantially delayed the payment due to forced resubmittals.

Families and providers have also reported significant reductions in payment rates. Providers must receive rates that are sufficient and that do not create an access to care issue. Examples of rate reductions that have created access to care issues were cited earlier under DME and therapy.

When STAR Kids rolled out in November 2016, HHSC required MCOs in contract to offer contracts for a period of three years to Significant Traditional Providers. These providers include durable medical equipment providers, home health agencies, therapy providers, waiver providers and other providers who had a history of paid Medicaid claims. This protection will expire in October 2019.

**Reduce Administrative Burdens**

Physicians, therapists, home health agencies, DME companies and others all have reported an increase of up to 25% in their administrative costs due to paperwork requirements of the Managed Care Organizations. Providers are leaving STAR Kids due to increased paperwork.

**Improve Transparency for Members**

SB 1207 and SB 1096 of the 86th Texas Legislature call for improved transparency for families such as:

• Postmarked notices of the right to a fair hearing at least 10 business days
before the termination, suspension, reduction of a service or eligibility.

- A process at HHSC to address situation in which individual does not receive adequate notice.
- Clear and easy-to-understand notices to families and providers citing medical basis for decision.
- Education for families about rights, appeal and fair hearing process, and description of the role of an external medical review.
- Thorough, detailed clinical explanation of the prior authorization decision for the provider and family.
- Requirement that families be provided the annual MDCP assessment to review for accuracy.
- HHSC to operate a Medicaid escalation help line for individuals on MDCP or the Deaf Blind Multiple Disabilities waiver to access assistance to navigate and resolve issues with STAR Kids.

**Develop New Alternative Models of Care for Children with Highest Level of Medical Complexity**

The STAR Kids Advisory Committee is developing recommendations about a new model of service delivery for children with medically complex conditions. There is widespread perception by parents, providers and health plans alike that the current system has not worked as envisioned for a subset of medically complex STAR Kids members. The proposed model would pay providers a higher fee for long physician visits, delegate service coordination to dedicated pediatric practices and create a process that removes some of the administratively burdensome and redundant letters of medical necessity and prior authorization. HB 4533 of the 86 Texas Legislature requires HHSC in collaboration with the STAR Kids Advisory Committee to determine feasibility of providing Medicaid benefits to children enrolled in STAR Kids under an accountable care organization model or an alternative model developed by or in collaboration with the Centers for Medicare and Medicaid Services Innovation Center.

**Provide Service Coordination at the Provider and Community Level**

HHSC allows STAR Kids MCOs to contract out Service Coordination to external groups such as pediatric practices, community organizations, parent groups, etc. To date, it appears that MCOs have not chosen this option and are instead providing service coordination in house. The Policy Council for Children and
Families, as well as other groups, continues to encourage service coordination at the provider and community level rather than the payer level. The newly passed federal ACE Kids Act provides an avenue for improved access to patient centered health homes.

**Improve Eligibility for the Medically Dependent Children Program**

The number of MDCP denials based on the new STAR Kids Screening and Assessment Instrument is significantly higher than the denials for the four fiscal years preceding STAR Kids. SB 1207 from the 86th Texas Legislature requires:

- Children who lose eligibility for MDCP based on a denial of medical necessity to be placed on another waiver interest list based on the date they were originally placed on the MDCP waiting list.

**Improve the Tracking and Trending of Data**

The STAR Kids Advisory Committee has had difficulty getting timely access to data to make improvement recommendations. Any new product roll-out should be accompanied by the active and timely collection and examination of data. It is imperative that data be provided on a regular basis instead of waiting for nine months or more for the data to be finalized.
Appendix B: National Center on Advancing Person Centered Practices and Systems

Texas Technical Assistance Plan

Technical Assistance Plan: Texas

Primary Contacts and Lead Agencies

Primary contact: Mary Bishop, Person Centered Practices Team Lead
(secondary contacts Jennie Costilow and Anntoinete Morgan)

Texas NCAPPS Team:
Anntionete Morgan, HHSC Person Centered Practices Specialist
Jennie Costilow, HHSC Manager in Medicaid and CHIP/Policy and Program Development
Phyllis Matthews, HHSC Person Centered Practices Senior Policy Analyst and Kittie Farmer, HHSC Person Centered Support Specialist

47 The NCAPPS Texas Technical Assistance Plan is under development and adjusted ongoing as the plan develops. Texas NCAPPS Technical Assistance Plan included in this report includes revisions from August 6, 2019.
Jay Smith, Project Manager, HHSC Office of Disability Prevention for Children
Mike Downey, Vice President of Mental Health Services, and Keena Pace, The Harris Center
Jamie White, Director of IDD Services, Gulf Coast Center, Gulf Coast Center
Dr. George Bithos, The Office of Independent Ombudsman for State Supported Living Centers
Jonas Schwartz, Texas Workforce Commission - Vocational Rehabilitation Division
Noah Abdenour, Director of Peer Services and Wendy Latham, Training Specialist, HHSC Peer Services Unit

Carrie Bradford and Mary Cloud, HHSC Office of Acquired Brain Injury
Jennifer Chancellor-Hurd, HHSC Manager, Long Term Services and Supports (LTSS) Policy Unit Medicaid and CHIP Services
Novella (Nova) Evans, HHSC Senior Policy Analyst Office of Mental Health Coordination,

Wes Yeager, HHSC Director, Office of Aging and Disability Resource Centers Access and Eligibility Services/Community Access
Holly Riley, HHSC, Manager, Aging Services Coordination
Lauren Cox, HHSC Blind Children’s Program
Michelle Dionne-Vahalik, HHSC Director Office of the Quality Monitoring Program & Initiatives Medicaid & Chip Services

Norine Gill, private provider and lived experience as a sibling and care giver
Laurie Pryor, HHSC Manager, and Karissa Sanchez, HHSC Policy Specialist, Office of Independent Living Services Program, Rehabilitative and Independence Services, Health, Developmental and Independence Services, Medical and Social Services

Christine Medeiros, HHSC Program Manager and Gabi Simpson, Program Supervisor, Comprehensive Rehabilitation Services, Office of Independence Services
Rehabilitative & Independence Services, Health, Developmental & Independence Services
Maria Alonso-Sanchez, Executive Director, Border Region Behavioral Health
Stanley Williams, Director of Strategic Initiatives, Community Healthcore
Dena Stoner, HHSC Director I, Medical and Behavioral Health Services

**TA Staff**
Statement of Need and Expected Outcomes

Because Texas has a large and geographically dispersed population in urban and rural areas with diverse cultures and needs and a wide span of vocal stakeholder groups, HHSC has identified a need to align policy and practice across the state for all populations across the lifespan. To achieve this aim, HHSC will form and launch a steering committee, composed of agency leadership and key stakeholders to include program participants, to define and prioritize goals and action steps for achieving a person-centered system. This entity will support HHSC’s efforts to ensure a comprehensive continuum of care that reflects person-centered thinking, planning, and practice. The formation of this group will be a primary focus of Year One of the technical assistance.

A Promoting Independence Work Group (originally the Promoting Independence Advisory Council) will serve as a starting point for the Steering Committee. Originally formed in statute as an Olmstead-related Commission, the group’s mission is to ensure there are services and supports for community living in Texas.

HHSC is also interested in creating a person-centered planning framework and accompanying tools, guidance, rules, policies, and procedure, including adaptations use with all HHSC populations. One starting point is a planning tool, My Life Plan, designed to support person-centered planning and practice. The My Life Plan tool was developed through a process of stakeholder engagement and is based on principles of person-centered thinking. The tool has not yet been implemented in HHSC service settings and has been shared with the TA team. Additional work is needed to create a comprehensive person-centered planning framework. This may include vetting the My Life Plan tool with collaborators from other disciplines, and selecting additional tools as needed. Guidelines will need to be developed to adjust the framework for use in specific contexts of with specific populations. Successfully implementing the framework will also involve increasing staff competencies to use the tools in an appropriate manner in multiple contexts. HHSC hopes to further develop the framework and create a strategy for its implementation across programs and services. Successful implementation would involve creating instructions and guidance for administering tools as well as updating policies, rules, documents, forms, contracts, branding guides, and the HHSC website, among other materials. HHSC would like to explore
transitioning the framework into an electronic record that would link functional, behavioral, and other assessments and service planning documents electronically.

In addition to establishing a consistent person-centered planning process, the Steering Committee (with support from NCAPPS TA if appropriate), will consider the following areas enhancing person-centered thinking, planning, and practice in Texas:

- Enhancing person-centered competencies among each agency’s advisory committees and community members who are not part of the health and human services system but who interact with HHSC service users, such as first responders: fire departments, sheriffs and police, and paramedics. This may include training and support to improve the quality of crisis response, promoting the use of psychiatric advance directives, and other activities
- Incorporating person-centered principles into work with Child Protective Services and Adult Protective Services through trainings and revisions of rules, policy, and procedure to support person-centered thinking, planning and practice (representatives from these groups will also be included on the steering committee.
- Promoting the growth of peer support workforce in the state, including behavioral health peer support as well as other peer support models for persons with brain injury, intellectual and developmental disability, and others with long-term service and support needs
- Ensuring initiatives related to person-centered thinking, planning, and practice are aligned with Employment First policies and initiatives
- Partnering with the state’s Employment First efforts to ensure person-centered principles are incorporated into initiatives promoting employment for people with disabilities.
- Develop quality metrics, utilization review practices, and other alternative payment models using a person-centered perspective

**Period of Performance**

- Year one: April 1, 2019 to September 30, 2019 (draft objectives for future years are included in gray)

**Goals and Objectives**

**Goal 1:** By March 31, 2020, HHSC will establish a person-centered steering committee and strategic plan for ensuring person-centered thinking, planning, and practice throughout the HHSC system.
**Domain** (indicate all that apply: Practice, Payment, Policy): Policy, Participant Engagement

**Participant Engagement Strategies:** People with lived experience (service users, families, and advocates) will be key members of the steering committee, and their engagement and representation will be thought through during the development of a Participant Engagement Plan in the first objective.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Milestone</th>
<th>TA Description (include TA activities and projected hours)</th>
<th>Additional Resources to be Leveraged</th>
<th>Responsible Entity</th>
<th>Completion Date</th>
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<tbody>
<tr>
<td>1.1 The Texas Team will create a participant engagement plan, with particular consideration given to ensuring meaningful representation of people with lived experience who represent HHSC service user populations on the Steering Committee, and mechanisms for gathering feedback from the community on the strategic plan</td>
<td>-Participant Engagement Plan</td>
<td>Suggestion of strategies and supplying resources for ensuring participant engagement on the steering committee and engaging with the community Review of draft plan to ensure broadest possible representation TA Hours: 10</td>
<td>Robust stakeholder engagement networks within Texas</td>
<td>Mary Bishop &amp; Jennie Costilow</td>
<td>8/31/19</td>
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<tr>
<td>1.2 Identify and secure engagement with all relevant stakeholders, including service users and families</td>
<td>-Informational materials introducing the initiative -Committee Roster</td>
<td>Assist with development of informational materials for recruitment TA Hours: 2</td>
<td>The Promoting Independence Work Group will serve as the core/starting point for this</td>
<td>Mary Bishop &amp; Beren Dutra</td>
<td>9/30/19</td>
</tr>
<tr>
<td>Objective</td>
<td>Milestone</td>
<td>TA Description (include TA activities and projected hours)</td>
<td>Additional Resources to be Leveraged</td>
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<tr>
<td>1.3 Create a draft steering committee charter that includes group aims,</td>
<td>-Draft Committee Charter</td>
<td>Provide example charters Review draft charter before it is</td>
<td>Mary Bishop, Jennie Costilow, &amp;</td>
<td>6/30/19 <strong>COMPLETE</strong></td>
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<td>roles and expectations of members, and definitions of key terms</td>
<td></td>
<td>is shared with the steering committee TA Hours: 5</td>
<td>Phyllis Matthews</td>
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<td>1.4 Hold a kickoff meeting of the person-centered steering committee to</td>
<td>-Kickoff meeting completed -Finalized Committee Charter</td>
<td>Support agenda development Attend meeting to introduce the</td>
<td>Meeting is scheduled for 6/28/19</td>
<td>Mary Bishop, Beren Dutra, and Jennie Costilow</td>
<td>6/30/19 <strong>COMPLETE</strong></td>
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<td>finalize the charter and NCAPPS TA goals</td>
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<td>and answer questions Attend and co-facilitate meeting</td>
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<td>TA Hours: 26</td>
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<td>1.5 Hold a second meeting of the person-centered steering committee</td>
<td>-Second meeting -Draft strategic plan outcomes and objectives</td>
<td>Attend meeting (via videoconference) TA Hours: 3</td>
<td>Mary Bishop, Beren Dutra, and Jennie Costilow</td>
<td>9/30/19</td>
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<td>focused on developing parameters, outcomes, and objectives for the</td>
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<td>strategic plan</td>
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<td>1.6 With guidance and oversight from the person-centered steering</td>
<td>Draft Strategic Plan shared with person-centered</td>
<td>Support draft development Review draft TA Hours: TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>11/30/19</td>
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<td>committee,</td>
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<td>Objective</td>
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<td>draft a two-year strategic plan for ensuring person-centered thinking, planning, and practice throughout the HHSC system</td>
<td>steering committee</td>
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<td>1.7 Share the Strategic Plan at the Texas and Southwest Friends Gathering</td>
<td>Draft Strategic Plan shared with Gathering attendees</td>
<td>TBD</td>
<td>November 6-8, 2019</td>
<td>Mary Bishop</td>
<td>11/30/19</td>
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<tr>
<td>1.8 Create a crosswalk of the draft strategic plan with the Employment First Policy to ensure alignment, and revise the strategic plan if needed.</td>
<td>Crosswalk of strategic plan and Employment First policy Revised strategic plan to align with Employment First policy</td>
<td>Complete crosswalk OR facilitate/review crosswalk and revisions TA Hours: TBD</td>
<td>TBD</td>
<td>Texas Workforce Commission, Texas Education Agency</td>
<td>TBD</td>
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<tr>
<td>1.9 Hold a third meeting of the steering committee to create a public-facing draft of the strategic plan</td>
<td>-Third meeting -Revised strategic plan suitable for public posting</td>
<td>Attend meeting (via telephone or in person) Review strategic plan revision TA Hours: TBD</td>
<td>TBD</td>
<td>Mary Bishop, Jennie Costilow, &amp; Beren Dutra</td>
<td>12/31/19</td>
</tr>
<tr>
<td>1.10 Hold a public webinar to share the strategic plan with stakeholders (service users)</td>
<td>-public webinar</td>
<td>TBD</td>
<td>TBD</td>
<td>Mary Bishop, Jennie Costilow, and Beren Dutra</td>
<td>TBD</td>
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<tr>
<td>Objective</td>
<td>Milestone</td>
<td>TA Description (include TA activities and projected hours)</td>
<td>Additional Resources to be Leveraged</td>
<td>Responsible Entity</td>
<td>Completion Date</td>
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<td>and families, HHSC Support Services, advocates, and other interested stakeholders</td>
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<tr>
<td>1.11 Post the strategic plan for public comment, and revise the plan based on community feedback</td>
<td>-Finalized Strategic Plan</td>
<td>Review public feedback Review final strategic plan TA Hours: TBD</td>
<td>Stakeholders will be able to provide comments through the use of the Texas Register as required in the statute for rule changes</td>
<td>Mary Bishop, Jennie Costilow, and planning committee</td>
<td>3/31/20</td>
</tr>
</tbody>
</table>

**Goal 2:** By September 30, 2022, HHSC will create a person-centered planning framework and accompanying tools, guidance, rules, policies, and procedure, including adaptations use with all HHSC populations.

**Domain** (*indicate all that apply: Practice, Payment, Policy*): Practice, Policy

**Participant Engagement Strategies:** The person-centered steering committee, which will include representation of people with lived experience, will be instrumental in this goal. In addition, specific objectives are focused on ensuring relevance to diverse service user and family populations throughout the state.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Milestone</th>
<th>TA Description (include TA activities and projected hours)</th>
<th>Additional Resources to be Leveraged</th>
<th>Responsible Entity</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Conduct an environmental scan of current person-centered</td>
<td>Texas environmental scan</td>
<td>Support HHSC staff completing the scan</td>
<td>Some members of the Team</td>
<td>Mary Bishop &amp; Gary</td>
<td>9/30/19</td>
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<tr>
<td>Objective</td>
<td>Milestone</td>
<td>TA Description</td>
<td>Additional Resources to be Leveraged</td>
<td>Responsible Entity</td>
<td>Completion Date</td>
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<tr>
<td>planning tools, guidance, rules, policies, and procedures within the HHSC system</td>
<td>TA Hours: 10</td>
<td>completed a similar scan in the past (pre-HHSC) and as part of compliance activities for the settings rule</td>
<td></td>
<td>Rutenberg (or designee)</td>
<td></td>
</tr>
<tr>
<td>2.2 Working with an environmental scan of cross-agency/ cross-population person-centered planning tools, policies, and procedures used nationally, identify those most relevant for Texas</td>
<td>National environmental scan</td>
<td>Complete scan</td>
<td></td>
<td>Suzanne Crisp, Subject Matter Expert</td>
<td>9/30/19</td>
</tr>
<tr>
<td>2.3 Engage with members of the person-centered steering committee to review the current My Life Plan tool to identify applications and needed adaptations for all HHSC populations and services</td>
<td>Review of My Life Plan tool</td>
<td>TBD</td>
<td></td>
<td>TBD</td>
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<tr>
<td></td>
<td>List of applications and needed adaptations for HHSC populations and services</td>
<td>TBD</td>
<td></td>
<td>TBD</td>
<td>TBD</td>
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<tr>
<td>Objective</td>
<td>Milestone</td>
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<td>2.4 Create draft person-centered planning framework that includes tools, guidance, rules, policies, and procedure.</td>
<td>-Draft framework</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
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<tr>
<td>2.4 In partnership with organizations representing cultural and linguistic groups throughout the state of Texas, review the person-centered planning framework to identify cultural and linguistic responsiveness and needed adaptations</td>
<td>-List of adaptations to framework</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
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<tr>
<td>2.5 In partnership with the Texas Workforce Commission and Texas Education Agency, review the person-centered planning framework to ensure consideration of employment domains and tools to facilitate identification and development of</td>
<td>-List of adaptations to framework</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
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<tr>
<td>Objective</td>
<td>Milestone</td>
<td>TA Description <em>(include TA activities and projected hours)</em></td>
<td>Additional Resources to be Leveraged</td>
<td>Responsible Entity</td>
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<td>competitive, integrated employment goals</td>
<td>2.6 Create guidance for incorporating use of psychiatric advance directives into the person-centered planning framework</td>
<td>-List of adaptations to framework</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
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<tr>
<td></td>
<td>2.7 Review the person-centered planning framework to identify adaptations needed to implement the tool in the context of an electronic health record</td>
<td>-List of applications and needed adaptations for implementation in an electronic health record</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
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<tr>
<td></td>
<td>2.8 Revise the person-centered planning framework and accompanying policy and procedure based on the environmental scans and reviews</td>
<td>-Revised framework</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
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<td></td>
<td>2.9 Field test the person-centered planning framework in a range of settings and with a range of populations reflective of the HHSC system</td>
<td>-Results of field testing</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
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<tr>
<td>Objective</td>
<td>Milestone</td>
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<tr>
<td>2.10 Revise the person-centered planning framework based on the results of the field testing</td>
<td>-Revised framework</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
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<tr>
<td>2.11 Post the person-centered planning framework for public comment</td>
<td>-Public posting</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
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<tr>
<td>2.12 Hold at least three informational webinars to introduce the person-centered planning framework and invite public feedback</td>
<td>-Informational webinars</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
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<tr>
<td></td>
<td>-Public feedback</td>
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<tr>
<td>2.13 Revise the person-centered planning framework based on the public comment</td>
<td>-Finalized framework</td>
<td>TBD</td>
<td>TBD</td>
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</tbody>
</table>

**Additional Details and Background Information**

**Detail about Technical Assistance Approach**

Describe any relevant detail about the planned TA approach. For example, note plans/rationale for site visit, partnerships to explore, and role of other stakeholders

The NCAPPS TA Lead and Subject Matter Expert (Bevin Croft and Suzanne Crisp) will meet with the Texas Team on a monthly basis. Suzanne Crisp will conduct a site visit to TX timed with the first convening of the person-
centered steering committee on June 28, 2019. Bevin and Suzanne will attend the second meeting via videoconference.

**Anticipated Resources for Public Sharing**

*Indicate products (including technical resources, presentations, policies and protocols, or programmatic tools) that might be shared or posted as resources on the NCAPPS website*

Person-centered steering committee charter

Strategic plan for person-centered steering committee

National scan of person-centered planning tools, policies, and procedures

**Specific Plans for Stakeholder Engagement**

*Detail specific plans for stakeholder engagement in the technical assistance process itself*

Texas HHSC relies heavily on stakeholder involvement for all policy and program development, as evidenced by its robust network of stakeholders who are active through formal advisory committees and councils, and less formal work groups and other venues. All these activities incorporate individuals who receive services, families, professional advocates, associations, providers, managed care organizations, and other important groups. Members of these groups will be engaged in the TA process. More detail about specific stakeholder engagement activities are detailed for each goal.

**Additional Texas Health and Human Services Confirmed Collaborative Entities Include**

**State Agencies/Departments:**
- State Supported Living Centers - Clair Benitez Clair.Benitez@hhsc.state.tx.us
• Quality Assurance - Grace Burghart, Quality Analyst V on behalf of Frank Genco, Manager
Frank.Genco@hhsc.state.tx.us

Advocacy Groups:
• Texas Advocates (Person–Centered Thinking, People Planning Together) - Annessa Lewis, Executive Director 512-522-6591 annessa.lewis@texasadvocates.org
• The Time is Now - Shelley Dumas, tfin.dspc@gmail.com
• HHSC Promoting Independence Workgroup- Natosha Petsch HHSC PI Workgroup Liaison Natosha.Petsch@hhsc.state.tx.us
• ADAPT of Texas - Bob Kafka, Organizer bob.adapt@sbcglobal.net
• Texas Association of Home Care and Hospice – Sarah Mills, Sarah@tahch.org

University Centers for Excellence in Developmental Disabilities
• University of Texas Center for Disability Studies - Amy Sharp, Ph. D. 512-232-0745 sharpamy@utexas.edu
• TX A&M University - Meagan Orsag, Ph.D. Associate Director 979-845-4612 meaganorsag@tamu.edu

Texas Council for Developmental Disabilities - Scott Daigle scott.daigle@tcdd.texas.gov

Texas Council of Community Centers - Isabel Casas, Director of IDD Services icasas@txcouncil.com

Coastal Bend Center for Independent Living – Judy Telge, Director of Development judyt@cbcil.org

Texas Community Centers
• The Texas Council for Community Centers represents all of the Community Centers – Erin Lawler elawler@txcouncil.com
• Hill Country MHDD Centers - Ross Robinson, E. D. RRobinson@hillcountry.org
• Metrocare Services-IDD Provider Services - Carrie Parks carrie.parks@metrocareservices.org
• MHMR Authority of Brazos County - Bill Kelley bkelley@mhmrabv.org
• MHMR Services for Concho Valley - Greg Rowe growe@MHMRCV.ORG
• Texoma Community Center - Daniel Thompson dthompson@texomacc.org
• Integral Care - David Evans, E. D. David.Evans@integralcare.org
• Betty Hardwick Center - Jenny Goode jgoode@bettyhardwick.org
• Behavioral Health Center of Nueces County – Mike Davis, E. D. mdavis@bhcnc.org
• Community Healthcare Collaborators:
  o Greg County Sheriff Department
  o Longview Fire Department
  o City of Longview
  o Episcopal Health Foundation
  o Highway 80 Mission
  o United Healthcare
  o Longview Regional Medical Center
  o Christus Health
  o Cornerstone Quarters
  o Optum
  o Hogg Foundation of Mental Health
  o Special Health Resources

National Collaborators
• National Council of Certified Dementia Practitioners (recognized by CMS and are listed on the CMS crosswalk page) - Sandra Stimson sandra@nccdp.org
• The Center for Applied Research in Dementia - Cameron Camp, Ph. D. Director of Research and Development Cameron@cen4ard.com

Anticipated Collaborations
• Medicaid Managed Care Organizations - Plan of engagement: Educating the point of contact for each contracted Managed Care organization (MCO) about person-centered coaching. Following the education about Person-centered coaching, the point of contact would be asked to identify employees that would be a well-suited as a person-centered coach. Those people would then be invited to a Person-Centered Coaching training. The person(s) identified as the coach as well as other identified point of contact within the MCO would be active on technical assistance collaborative interactions.
• Tribes - Plan of engagement: Continuing communication with Tribal Liaison and providing training opportunities for person-centered practices trainings offered throughout the State. The tribes will be asked to identify someone within their tribe that would be a well-suited as a person-centered
These people would then be invited to a Person-Centered Coaching training. The person(s) identified as the coach as well as other identified point of contact within the tribe would be invited to be active on technical assistance collaborative interactions.

- Additional collaborative efforts will include Nursing Facilities, Private Providers, State Supported Living Centers, Community Centers, and State employees to include Department of Family and Protective Services. These efforts will include continuation of person-centered thinking training, and person-centered coaching. Person-Centered Plan Facilitation Training will be provided to Certified Person-Centered Thinking Trainers so they can become certified to train other state collaborators. There will also be a collaboration with the Texas Advocates to provide People Planning Together Training. The institute on Person-Centered Practices will be providing the training for self-advocates to become Certified People Planning Together trainers.

**Relevant Background Information**

*Note background work that has already been accomplished, relevant policy or programmatic contexts, and previously provided technical assistance that this request builds on*

The goal for the technical assistance is to systematize the progress that is currently being realized through collaborative efforts to become a person-centered system. Texas has made great strides toward a person-centered system since 2014 by instituting person-centered thinking training requirements for all case managers and service coordinators in home and community-based programs and managed care organizations; requiring person-centered planning through contracts and program requirements; creating an online introductory course for service providers, families, and others; training many agency, provider, and contractor staff in person-centered thinking; training all ombudsmen at state supported living centers; training staff at many nursing facilities across Texas; working to incorporate person-centered practices in the child protective services adoption staff; developing capacity by achieving 19 state employees as certified trainers, two coaching trainers and two with mentor trainer status; and developing a person-centered planning tool. Texas HHSC has collaborated over the years with its University Centers for Excellence in Developmental Disabilities, Texas A&M University and The University of Texas at Austin, collectively known as the Institute for Person-Centered Practices, on assessments for Community First Choice and STAR Kids Medicaid managed care program; the state plan amendment for Community First Choice; and person-centered trainings using standards based on The Learning Community for Person Centered Practices (TLCPCP). Texas offers providers or contractors to submit their own person-centered trainings that must meet the minimum standards based on TLCPCP. Approved trainings can be found on HHSC’s
Person Centered Planning Website: https://hhs.texas.gov/services/disability/person-centered-planning/waiver-program-providers/person-centered-planning-pcp-training-providers.

**Community of Practice:** The State of Texas has an established Community of Practice (COP) that focuses on enhancing person-centered thinking throughout the state. This group meets once per year and was started through the Learning Community; it is not an HHSC group, but Mary Bishop is a leader in that group. The Texas COP and technical assistance co-applicants (members of the NCAPPS TA Team) met most recently in May 2019, with a focus on dynamics and support for change agents. Group members identified action steps to advance this work. The group hopes to create connections and secure buy-in and collaboration across diverse groups and agencies. The COP will support the work described in this NCAPPS TA Plan. The COP is led by a planning committee that includes TLCPCP Certified Trainers from both University Centers for Excellence in Developmental Disabilities (UCEDD), all of whom are parents with lived life experience along with Mary Bishop representing Texas HHSC. This was the third annual Texas Community of Practice meeting.

**Music and Memory:** National Council of Certified Dementia Practitioners (NCCDP) and The Center for Applied Research in Dementia - Cameron Camp, Ph. D. Director of Research Development Cameron@cen4ard.com has been partnering with the HHSC Quality Monitoring Program (QMP) to bring Alzheimer’s disease and dementia care training to staff in nursing homes and other settings with the goal to improve the quality of care of people receiving supports. The curriculum is maintained for all QMP staff trainers. Music & Memory (M&M) provides people a way to operationalize abstract concepts of PC thinking as the program is rooted in the discovery of individual musical preferences and ensuring those choices are honored. The therapeutic process of going beyond music genre or a favorite artist to drill down to specific songs for one’s playlists results in stimulated memory and engagement. QMP has seen success in both the NFs and SSLCs as the process of determining favorite songs causes staff to connect with people they support that results in trust and empathy. Management in both settings reports using the “Henry video” as part of new employee orientation as well as an interview tool to determine an interviewee's level of empathy. The person-centered techniques of M&M are a great weapon against the inappropriate use of anti-psychotics (AP) because M&M builds deeper relationships between staff and people they support.

**Trauma – Informed Care:** Over the past few years Texas has made significant investments in building awareness about trauma-informed care (TIC) and implementing TIC practices. HHSC has brought Karyn Harvey down on multiple occasions to provide trainings across the state on TIC for individuals with IDD. Additionally HHSC developed 2 different web-based training modules on TIC for individuals with IDD for direct services
workers and physicians. In 2018 HHSC partnered with SAFE Alliance, a non-profit organization whose mission is to stop abuse for everyone by serving the survivors of child abuse, sexual assault, trafficking, and domestic violence, to provide Road to Recovery trainings around the State. Finally, Texas’ 13 State Supported Living Centers have all adopted Ukeru, which is a trauma-informed restraint-free crisis management technique based in the concepts of comfort vs. control.

Through a Substance Abuse and Mental Health Services Administration grant, legacy Texas Department of State Health Services developed The Texas Children Recovering From Trauma (TCRFT) initiative, which aimed to transform children mental health services in Texas into TIC services and foster resilience and recovery. The TCRFT initiative implemented trauma-informed best practices in the community mental health service delivery system for children and adolescents; including trauma screenings, assessments and trauma-focused evidence-based practices (EBPs). Texas wrapped up the four-year initiative with a four-day Trauma-Informed Care Summit in August 2016. The Summit consisted of two days of preconference workshops, including a training in TF-CBT and the Core Competencies for Childhood Trauma.

Most recently Texas has taken on a Trauma-informed Care transformation initiative, the mission of which is to develop a coordinated statewide approach for building a person-centered, trauma-informed behavioral health system and providing quality supports, services, and care to Texans. The trauma transformation initiative includes a cross-agency workgroup whose focus is on building and strengthening a coordinated trauma-informed behavioral health system across Texas. Parallel to the cross-systems effort, HHSC has established a Trauma Transformation Workgroup to focus on internal policies and organizational framework. The objective is to build trauma-informed culture through awareness of trauma and its impacts not only on clients and services, but on the broader organization, agency environments, and with a focus on staff wellness.

The Statewide Behavioral Health Coordinating Council (2016):
Required Council state agencies include: The Office of the Governor (OOG); Texas Veterans Commission (TVC); Health and Human Services Commission (HHSC); Department of Aging and Disability Services (DADS); Department of Family and Protective Services (DFPS); Department of State Health Services (DSHS); Texas Civil Commitment Office (TCCO); The University of Texas Health Science Center at Houston (UTHSC–Houston); The University of Texas Health Science Center at Tyler (UTHSC–Tyler); Department of Criminal Justice (TDCJ); Texas Juvenile Justice Department (TJJD); Texas Military Department (TMD); Health Professions Council has one seat representing the Texas Medical Board, Texas Board of Pharmacy, Texas Board of Dental Examiners, Texas Board of Nursing, Texas Optometry Board, and Texas Board of Veterinary Medical Examiners
Voluntary Council state agencies include: Texas Education Agency (TEA); Texas Commission on Jail Standards (TCJS); Texas Workforce Commission; Texas Department of Housing and Community Affairs (TDHCA). Texas is also a part of the Building Bridges and System of Care Initiatives.