

**Annual Report on Implementation of Acute
and Long-Term Services and Supports
System Redesign for Individuals with
Intellectual and Developmental Disabilities**

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Executive Summary

House Bill (H.B.) 3523, 84th Texas Legislature, Regular Session, 2015, outlined in Texas Government Code Chapter 533, builds on requirements that were outlined in Senate Bill (S.B.) 7, 83rd Texas Legislature, Regular Session, 2013 (Texas Government Code Chapter 534). S.B. 7 also built on previous legislative efforts to improve quality and outcomes in the Texas Medicaid program with an emphasis on improving the long-term services and supports (LTSS) system for individuals with intellectual and developmental disabilities (IDD).

To prepare for the increased need for LTSS, S.B. 7 redesigned the Medicaid LTSS system for individuals with IDD as well as for low-income seniors and individuals with physical disabilities.

S.B. 7 also established the IDD System Redesign Advisory Committee (SRAC) to work in consultation with the Health and Human Services Commission (HHSC) and the Department of Aging and Disability Services (DADS) to implement the S.B. 7 provisions affecting individuals with IDD.

The system redesign to date has focused on the delivery of acute care Medicaid benefits through the STAR+PLUS Medicaid managed care program (STAR+PLUS) to certain individuals who have IDD, and monitoring the provision of those benefits.

On September 1, 2014, individuals with IDD in an IDD waiver (Community Living Assistance and Support Services (CLASS), Home and Community-based Services (HCS), Texas Home Living (TxHmL), Deaf Blind with Multiple Disabilities (DBMD)) or in a community-based Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF-IID), transitioned from Medicaid fee-for-service (FFS) into managed care for acute care services. Individuals with both Medicare and Medicaid (dual eligible individuals) were excluded and children under the age of 21 were voluntary. On average, there are 38,439 individuals on a monthly basis in an IDD waiver or community based ICF-IID. In August 2015, there were 15,667 individuals enrolled in STAR+PLUS for acute care services who lived in a community-based ICF-IID or who received services through an IDD waiver. Of the 15,667 individuals with IDD enrolled in STAR+PLUS, 325 were children under the age of 21 and 15,341 were adults (21 years of age or older).

S.B. 7 directed HHSC to implement the most cost-effective option for the delivery of basic attendant and habilitation services to individuals with disabilities and to maximize federal funding. Community First Choice (CFC) is a federal option that allows states to provide home and community-based attendant services and supports to Medicaid recipients with disabilities. In October 2014 HHSC submitted the required State Plan Amendment (SPA) describing Texas' plans for implementation of the benefit to the federal Centers for Medicare & Medicaid Services (CMS). HHSC received approval from CMS to implement CFC on June 1, 2015.

CFC is a benefit that provides Texas with an additional six percent federal match to provide community-based LTSS to Medicaid recipients who also require an institutional level of care (LOC). Prior to implementation of CFC, habilitation services were available only in the ICF-IID program and IDD waiver programs, and most of the waiver programs have lengthy interest lists. The benefits available within CFC include personal assistance services, habilitation services, emergency response services and support management. During this last legislative session, H.B.

3523 clarified that providers participating in HCS, TxHmL, CLASS and DBMD contracting with DADS could deliver CFC services to individuals in these waiver programs and that DADS would have regulatory oversight authority over these providers for CFC services.

S.B. 7 directed DADS to develop and implement a comprehensive assessment instrument and a resource allocation process for individuals with IDD, as needed, to ensure each individual with IDD receives the type, intensity and range of services both appropriate and available, based on the functional needs of that individual. The new assessment process more effectively considers individuals' needs and available supports and ensures individuals receive the precise scope, amount and duration of services they require. A subcommittee of the IDD SRAC was created to provide input into the selection and evaluation of the assessment tool(s). In April 2015, DADS, with consideration of stakeholder input, decided to pilot the international Resident Assessment Instrument (interRAI) Intellectual Disability (ID) assessment.

DADS currently is working with HHSC to publish a request for proposal (RFP) to solicit vendors to assist the state in implementing an IDD assessment pilot. Pilot activities will begin during the current biennium. DADS will also work with a vendor to analyze the results of the IDD assessment pilot and this analysis will inform future assessment rollout activities.

S.B. 7 directs HHSC to adopt rules allowing for additional housing supports for individuals with disabilities, including individuals with IDD. HHSC and DADS continue to work with partner agencies to increase options for community-based housing that permit individuals to select the most integrated and least restrictive setting appropriate to the individual's needs and preferences. A subcommittee of the IDD SRAC has been created to explore and recommend additional housing supports for the IDD community.

S.B. 7 directs HHSC and DADS to develop and implement pilot program(s) to test one or more service delivery models involving a managed care strategy based on capitation to deliver Medicaid LTSS to individuals with IDD. H.B. 3523 requires the pilot(s) be implemented by September 1, 2017, and expanded the qualified entities for delivery of the pilot to include managed care organizations (MCOs), in addition to private service providers. The pilot(s) must be designed to increase access to LTSS, improve quality of acute care services and LTSS, and promote efficiency and the best use of funding. In April 2015, HHSC conducted a survey to obtain feedback from the IDD SRAC on the development and structure of the pilot program. Additionally, HHSC developed and posted a request for information (RFI) that was released on July 20, 2015. Responses were received by August 20, 2015, and HHSC is currently reviewing the responses to identify next steps for implementation of the pilot.

Subject to the availability of federal funding, S.B. 7 directs DADS to develop and implement specialized training for providers, family members, caregivers, and first responders providing direct services and supports to individuals with IDD and behavioral health needs who are at risk of institutionalization. A number of projects relating to behavioral health intervention have been approved for funding through HHSC's 1115 Healthcare Transformation Waiver and are in various stages of implementation. Additionally, Money Follows the Person Demonstration (MFPD) grant funds are supporting the development of an online web-based training system designed for direct service workers across long-term services in community-based settings, focused on the behavioral health needs of individuals with IDD who have challenging behaviors.

MFPD funds will also support the creation of eight local medical, behavioral and psychiatric teams and enhanced community coordination.

This report does not include any specific recommendations from the state for the Legislature. However, at the end of the report, HHSC has provided recommendations received from the IDD SRAC. The current statute clearly defines the next steps in the redesign process and HHSC and DADS continue to move forward with implementation of the projects described in this report.

Introduction

Background

The goals of the system redesign outlined in S.B. 7 and Texas Government Code 534.051 are to design and implement an acute care services and LTSS system for individuals with IDD:

- 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.
- 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. Also educate individuals on how to apply for the programs and services.
- Improve the assessment of individuals' needs and available supports, including the assessment of individuals' functional needs.
- Promote person-centered planning (PCP), self-direction, self-determination, community inclusion, and customized, integrated, competitive employment.
- Promote individualized budgeting based on an assessment of an individual's needs and PCP;
- Promote integrated service coordination of acute care services and LTSS.
- Improve acute care and LTSS outcomes, including reducing unnecessary institutionalization and potentially preventable events.
- Promote high-quality care.
- Provide fair hearing and appeals processes in accordance with applicable federal law.
- Ensure the availability of a local safety net provider and local safety net services.
- Promote independent service coordination and independent ombudsmen services.
- 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.

S.B. 7 directed HHSC to report annually to the Legislature on implementation of the Medicaid acute care services and LTSS delivery system for individuals with IDD. H.B 3523 further expanded the reporting requirements. Implementation activities began in September 2013 and the full redesign will roll out gradually through 2021.

The delivery system components addressed in S.B. 7 include:

- Requiring all individuals with disabilities who are eligible for Medicaid acute care services to receive those services in a coordinated manner through a managed care plan.
- Providing basic attendant and habilitation services to eligible individuals with disabilities who are currently waiting for services.

- Implementing a new functional assessment instrument that will more accurately assess the needs of individuals with IDD.
- Establishing behavioral supports to help individuals with IDD avoid institutionalization;
- Establishing a long-term plan for piloting and delivering services for individuals with IDD through managed care.
- Allowing for the development of additional housing supports for individuals with disabilities.

S.B. 7 also established the IDD SRAC, to work in consultation with HHSC and DADS to implement the provisions affecting individuals with IDD. Although some of the requirements below were previously required of HHSC, H.B. 3523 expanded the role of the IDD SRAC to consult and collaborate with HHSC and DADS on the following:

- Identifying private service providers or MCOs to implement the pilot program.
- Evaluating proposals submitted by private service providers and MCOs to determine if the private service providers and MCOs have the ability to provide LTSS to individuals that will receive services through the pilot program.
- Analyzing information provided during the operation of the pilot for purposes of making recommendations about future systems or programs.
- Preparing and submitting a report to the Legislature.
- Reviewing and evaluating the progress and outcomes of each pilot program implemented as part of the annual report that must be submitted to the Legislature.
- Development of the transition plan for transitioning the provision of Medicaid benefits between a Medicaid waiver program or an ICF-IID program and a pilot program to protect continuity of care.
- Analyzing the outcomes of providing acute care Medicaid benefits to individuals with IDD under the pilot.
- Developing a process to receive and evaluate input from interested statewide stakeholders on the transition of TxHmL into managed care.
- Ensuring there is a comprehensive plan for transitioning the provision of TxHmL to managed care.
- Analyzing the outcomes of the transition of the LTSS under TxHmL to a managed care program delivery model.

The advisory committee consists of 26 members representing various communities of interest (see Appendix A). The committee met for its initial meeting in January 2014 to discuss the Legislature's intent and establish committee goals. Since the initial meeting, the committee continues to meet on a quarterly basis. Since January 2014 the IDD SRAC, among many other things, adopted Principles of Quality that were developed by the Quality subcommittee, recommended that letters be sent out to individuals in managed care notifying them of their service coordinator information, completed a survey providing feedback on the development of the IDD managed care pilot, made recommendations related to housing, and provided feedback on the various assessment tools presented to the committee. The committee's recommendation for the MCOs to send out letters with the service coordinator information resulted in all five STAR+PLUS MCOs sending out letters to their members with the service coordinator contact information.

The IDD SRAC has established five subcommittees.

- Housing
- Assessment
- Transition to managed care

- Day habilitation and employment services
- Quality

The housing subcommittee continues to focus on supporting the development of affordable, accessible and integrated housing for individuals with IDD. The housing subcommittee created recommendations and submitted a letter to the Texas Department of Housing and Community Affairs (TDHCA) with the recommendations. The TDHCA letter with recommendations is in Appendix B. The housing recommendations from the full IDD SRAC are included in Appendix C.

The assessment subcommittee continues to focus on the goal of implementing a new functional assessment instrument that will more accurately assess the needs of individuals with IDD. This subcommittee has continued to provide DADS and HHSC with feedback on the assessment tools being considered and feedback on the design and outcome of the IDD assessment pilot.

The transition to managed care subcommittee continues to focus on the various transition activities outlined in S.B.7, make recommendations, and identify areas for system improvements. The transition to managed care subcommittee created recommendations that were adopted by the full IDD SRAC for regional healthcare collaborations in Appendix I, network access in Appendix J, and education and outreach in Appendix K.

The quality subcommittee continues to address planning, development and implementation of a quality strategy for acute care services and LTSS provided under the Medicaid program and makes recommendations to the full committee for ongoing quality and system improvements. The quality subcommittee has created the Principles of Quality that the full committee adopted. The Principles of Quality are in Appendix D.

The formation of the day habilitation and employment services subcommittee was a recommendation of the full committee during the April 2015 meeting. CMS issued new Home and Community-based Services (HCBS) rules that became effective March 17, 2014. The new rules require states to ensure all locations in which HCBS services are provided in a setting that is integrated and supports access to the greater community, among many other requirements. Individuals served in the IDD waivers receive day habilitation services through their waiver providers.¹ It is common for waiver providers to subcontract with independent day habilitation providers to deliver day habilitation services. In certain instances, these services are offered in a setting that may not meet the HCBS settings requirements. States are required by CMS to ensure all HCBS settings are in compliance with the federal guidelines by March 17, 2019.

The day habilitation and employment services subcommittee held its initial meeting on October 28, 2015, and plans to provide input on newly proposed policies and initiatives and review existing policies as the state works to ensure compliance with the HCBS settings requirements and comply with S.B. 1226, 83rd Legislature, Regular Session, 2013, the Employment First legislation.

H.B. 3523 allows the IDD SRAC to establish additional work groups for purposes of studying and making recommendations on issues the committee considers appropriate.

¹ CLASS does not offer day habilitation as a service but provides prevocational services. Individuals in CLASS often receive their prevocational services at a day habilitation program.

Implementation Activities

Delivery of Acute Care Medicaid Services Through Managed Care

On September 1, 2014, individuals with IDD enrolled in HCS, TxHmL, CLASS, DBMD and community-based ICF-IIDs transitioned from traditional Medicaid FFS into managed care Medicaid provided through the STAR+PLUS program. Individuals enrolled in STAR+PLUS have a service coordinator employed by the MCO to assist in the appropriate and timely provision of acute care services. Every member received an MCO service coordinator. The number of required visits and level of service coordination for each individual varies by acuity and the member's or their legally authorized representative's (LAR's) personal preference.

Individuals served in state supported living centers (SSLC) and individuals who receive Medicare Part B benefits in addition to Medicaid (known as full dual eligibles), were excluded from this carve-in. Children and young adults age 20 and younger enrolled in these programs who do not receive Medicare Part B benefits can elect to enroll in STAR+PLUS or remain in traditional Medicaid.

Current Status

Individuals with IDD that transitioned into managed care continue to receive their LTSS services from their waiver or ICF-IID provider, (to include the addition of CFC services implemented on June 1, 2015) and their acute care through the STAR+PLUS program. In addition to the MCO service coordinator, these individuals also have an LTSS case manager, service coordinator or qualified intellectual and developmental disability professional (QIDP) depending on the program from which the individual receives services, who assists the individual with developing and implementing the LTSS service plan and monitoring the LTSS service delivery. As part of the transition, MCO service coordinators and LTSS case managers, service coordinators and QIDPs were encouraged to work together to coordinate acute care and LTSS services. DADS issued an information letter in July 2014 outlining the role of the MCO service coordinator and outlining requirements that the DADS LTSS providers must coordinate service delivery with the MCO service coordinators including encouraging participation in the LTSS service planning meetings, based on the individual/LARs recommendations about who should be invited to the meetings. Ongoing communication continues to be encouraged by HHSC (at trainings, presentations, workgroup meetings, and stakeholder meetings and forums) to ensure coordination of the individual's LTSS and acute care services.

In the spring of 2015, approximately six months after the transition into managed care, all five STAR+PLUS MCOs sent out reminder letters to their members to provide the members with information about their MCO service coordinator as a result of the IDD SRAC recommendations. HHSC currently has a service coordination workgroup evaluating what is working well in the area of service coordination, areas in need of improvement, as well as how service coordination can be improved.

Education and Outreach

In the fall of 2013, HHSC created an IDD Managed Care Improvement Workgroup to discuss the MCO and LTSS providers' responsibilities, identify stakeholders' educational needs, review training materials and make suggestions to promote a smooth transition for individuals with IDD into STAR+PLUS. The workgroup is composed of representatives from advocacy agencies, LTSS provider agencies, local intellectual and developmental disability authorities (LIDDAs) and other agencies that provide service coordination/case management, MCOs, the managed care enrollment broker (MAXIMUS), DADS and HHSC. The workgroup provided valuable review and feedback on a number of operational issues and continues to meet on a quarterly basis to address issues and challenges as it relates to the carve-in and system redesign activities. HHSC has implemented a number of the recommendations and feedback that was received from the workgroup.

Other opportunities for ongoing stakeholder involvement include the bi-monthly DADS IDD System Improvement Workgroup meetings, quarterly Promoting Independence Advisory Committee (PIAC) meetings, quarterly IDD SRAC meetings, and the monthly IDD transition to managed care subcommittee meetings.

At the end of September 2014, and through the middle of December 2014, HHSC leadership held 12 listening sessions across the state to gather feedback from stakeholders, advocates, acute care providers, individuals served, their LARs and family members, and the public to discuss their experiences with the transition. During the listening sessions, concerns were expressed about network adequacy, particularly related to a lack of psychiatrists and hospitals not contracting with MCOs. MCOs continue to offer the opportunity for providers to complete single case agreements with the MCO to deliver services to individuals.

HHSC's Executive Commissioner hosted a stakeholder meeting at the beginning of November 2015 to discuss improvements to the managed care system with the following areas of focus: member experience, provider directories, member assistance, the credentialing process, and service coordination improvement.

Network Adequacy

To address network adequacy concerns specifically related to lack of psychiatrists, HHSC met with the Federation of Texas Psychiatry, MCOs, DADS, Texas Medical Association and Texas Health Plan Association to discuss potential solutions. One common concern expressed was related to a lack of IDD specific training for medical providers. The MCOs also talked about what they are doing to ensure an adequate network and strategies they are using to obtain providers. Some of the strategies the MCOs discussed include increasing telemedicine services and agreements with providers, negotiating rates strategically, and reaching out by phone and in person to out of network psychiatrist to offer contracts. HHSC provided the MCOs with a list of psychiatrists who are contracted with Medicaid but not contracted to provide services in managed care so the MCOs could reach out to these psychiatrists to see if they would be interested in providing services within the networks.

During the transition into managed care, MCOs also worked closely with physicians and set up single case agreements or closed panels for physicians to contract with the MCOs to serve specific members instead of contracting with the MCOs to provide services to the entire network. Additionally, the MCO service coordinators are required to assist their members with locating providers. HHSC continues to provide education to individuals and their LARs around the service coordinators' role in locating providers.

S.B. 760, 84th Legislature, Regular Session, 2015, requires MCO monitoring of provider networks to ensure MCOs provide members sufficient access to Medicaid providers and services. The bill requires:

- HHSC must develop, collect and report data regarding network adequacy.
- MCOs must assign initial and subsequent primary care physician (PCP) providers.
- STAR+PLUS members must receive paper directories unless they opt-out of receiving them.
- HHSC must identify provider types that qualify for expedited credentialing and include requirements in managed care contracts.
- HHSC must develop methodology to collect data on open panels and appointment wait times.

To address the requirements outlined in S.B. 760, HHSC created a broad implementation plan and anticipates new requirements will be incorporated into the appropriate managed care contracts, handbooks and manuals for a September 2016 effective date. Additionally, HHSC is in the process of soliciting stakeholder input and has a stakeholder meeting scheduled for November 30, 2015.

Challenges

The following IDD acute care carve-in challenges were identified.

- Across the health and human services enterprise, certain IT systems do not interface. As a result, some dually eligible (Medicaid and Medicare) individuals received enrollment letters in error, some individuals did not initially receive an enrollment packet (when they should have), and some information was sent to individuals at the wrong address. As the state identified these errors, the state worked to resolve the issues by sending corrected letters, and implemented manual processes.
- The IDD community has expressed concern about access to specialists (particularly psychiatrists, gastroenterologists, and podiatrists) and primary care physicians in managed care and has indicated that certain Medicaid providers are declining to participate in managed care. Network access to specialists continues to be a challenge to Texas Medicaid and is not limited to managed care. HHSC and the MCOs continue to work with stakeholders to address their concerns around network access. HHSC will also be addressing S.B. 760 requirements around network adequacy and access.
- Coordination between MCO service coordinators and LTSS service coordinators, case managers, or QIDPs. HHSC and DADS continue to encourage the MCO service coordinators and LTSS service coordinators, case managers or QIDPs to maintain open communication to assist individuals with coordinating their services. The IDD managed care workgroup has helped facilitate better communication between agencies. Additionally, although not related

to the carve-in, the MCOs and Texas Council started meeting regularly in September 2014, which has resulted in better and more open communication between the MCOs and LIDDAs.

- Coordination of individuals leaving an SSLC to transition into the community from FFS Medicaid to managed care Medicaid. When an individual has complex medical needs, the coordination of Medicaid as they transition into the community has proven to be a challenge with ensuring coordination of care. HHSC is aware of this challenge and is working with stakeholders and advocates addressing the challenge and creating a seamless transition into the community.

Successes

Some of the successes from the IDD acute care carve-in are outlined below:

- The collaboration and communication that occurred prior to implementation and continues to occur between the stakeholders, MCOs, LIDDAs, and providers. The IDD managed care workgroup created an opportunity for the IDD stakeholders, MCOs, LIDDAs, and providers to all work collaboratively.
- The transition went smoothly and was implemented on time. Based on experience from previous rollouts, HHSC made improvements to project implementation. This combined with extensive support and feedback from stakeholders made for a smooth and timely transition.
- There was a higher choice rate of individuals and LARs selecting an MCO compared to other rollouts. Statewide, 54 percent of individuals with IDD that were included in the acute care carve-in selected an MCO. In the rural service area, 63 percent of individuals with IDD selected an MCO. This is attributed to extensive education and outreach to stakeholders and support from providers and advocates.
- Individuals enrolled in managed care now have access to additional services. In STAR+PLUS, individuals have a service coordinator for their acute care needs. This allows for additional coordination between the LTSS service coordinator, case manager or QIDP and the MCO service coordinator. As part of the carve-in, individuals with IDD were given a service coordinator. Additionally, individuals have access to value added services². Individuals also have the opportunity to receive additional services that the MCOs may authorize on a case by case basis that are above and beyond the Medicaid benefits. Some examples provided by the STAR+PLUS MCOs of services offered to individuals with IDD included diabetic shoes and supplies, and incontinence supplies (i.e., wipes, and diapers).
- Individuals have the opportunity to choose between the STAR+PLUS waiver and an IDD waiver depending on which waiver best meets their needs (if they meet both Medical Necessity (MN) and ICF-IID LOC criteria). HHSC and DADS continue to work with the LIDDAs and MCOs to ensure that individuals know their options and are able to make an informed choice about the services and benefits available in each program.

² Value added services are services offered by the MCOs that are above and beyond the Medicaid benefits. Examples of value added services include a 24 hour nurse line, additional dental and vision benefits beyond the Medicaid benefits offered, and pest control services. Not all MCOs offer the same value added services.

Fair Hearing Data

Since the acute care carve-in on September 1, 2014, the five STAR+PLUS plans reported the following fair hearing data specific to acute care services for the IDD members from September 1, 2014, through July 31, 2015.

Total number of acute care fair hearings for IDD members	Types of fair hearings with reason.	Total number of fair hearings upheld by MCO.	Total number of fair hearings overturned.	Total number of fair hearings withdrawn.	Pending
14	-Pharmacy denials; -Denial for durable medical equipment, -Denial of pain management; -Denial for out of network provider; -Denial for MN due to loss of waiver benefits; -Denial for MN for speech and hearing therapy; -Denial of dental benefits; and, -Denial for MN for physical therapy.	5	2	5	2

Complaint Data

HHSCs Health Plan Management (HPM) tracks complaints received from members, LARs or family members, provider agencies and other interested entities. Individuals are encouraged initially to contact the MCO directly to resolve the complaint, prior to contacting HPM for assistance. Individuals also may contact the Ombudsman's office. HHSC continues educate individuals and providers on the complaint process. Over the last year, HPM tracked less than 35 complaints for individuals with IDD that were carved-in to managed care. This number is based

on complaints that were submitted to HPM by an individual, LAR or family member, provider, advocate, stakeholder or state employee. Any complaints received outside of this process are not reflected in the total.

HPM has tracked the following types of complaints related to the IDD acute care carve-in,

- Access to care
- Benefits issues (denials, communication about benefits provided, updating provider)
- Coordination of benefits
- Member enrollment issues-dual eligible individual's not eligible for STAR+PLUS
- Member requested disenrollment
- Denial of claims
- Recoupment of claims
- In network specialty care/provider access

Community First Choice (CFC)

In 2013 the Legislature required HHSC to implement basic attendant and habilitation services for individuals with disabilities maximizing federal funding for the delivery of these services.

HHSC responded by creating the CFC benefit utilizing the 1915(k) Medicaid state plan option that allows states to provide home and community-based attendant services and supports to Medicaid recipients with disabilities. The 1915(k) SPA was approved by CMS on April 2, 2015. The state receives a six percent increased federal match for CFC services, which in turn is used to fund services for individuals who do not have access to LTSS.

Individuals may be eligible for CFC services if they:

- Are eligible for Medicaid;
- Meet an institutional LOC; and,
- Have functional needs that could be addressed by CFC services.

CFC services include:

- Personal assistance services;
- Habilitation services;
- Emergency response services; and
- Support management.

CFC services are provided in home or community-based settings and not in nursing facilities, hospitals providing long-term services, institutions for mental disease, ICF-IIDs, or a setting with the characteristics of an institution. CFC services are not time or age limited and continue as long as eligible individuals reside in their own home or family home settings and needs are present.

CFC services are provided by LTSS providers and state plan service providers determined to be qualified by the state of Texas in a program already approved by CMS.

S.B. 7 directed DADS to contract with LIDDAs to provide IDD service coordination, provide assessments to MCOs, assist in the development of the plan of care, and coordinate with MCOs and DADS regarding recommended plans of care for CFC services. S.B. 7 (Texas Government Code 534.152) outlines that LIDDAs that provide service coordination are restricted from providing attendant or habilitation services. LIDDAs provide LOC determinations for individuals that might meet an ICF-IID LOC and functional needs assessments for potentially-eligible individuals. The CFC Provider Summary Tool in Appendix E outlines which entity handles the assessments (eligibility and functional needs) for CFC as well as other functions such as approvals, etc.

Federal legislation requires states to consult and collaborate with a Development and Implementation (D&I) Council as the SPA for CFC is drafted and implemented. The D&I Council must be composed of a majority of individuals with disabilities, elderly individuals, and their representatives. HHSC designated the PIAC members as the CFC Development and Implementation (D&I) Council. CFC is a standing item on PIAC meeting agendas.

The CFC benefit implemented on June 1, 2015.

Current Status:

MCOs are working together with the LIDDAs to outreach and provide CFC services to STAR+PLUS members who have IDD or are on one of the following IDD waiver interest lists.

- HCS
- CLASS
- TxHmL
- DBMD

STAR+PLUS and STAR Health MCOs are also offering CFC services to new members of any age who ask for or are identified as potentially benefiting from CFC services, and they are offering CFC services to existing members in STAR+PLUS and STAR Health at the member's next reassessment contact.

MCOs are required to contract with the significant traditional providers (STPs) for a minimum of three years. The STPs based on S.B. 7, include CLASS direct services agencies, and certified HCS, and TxHmL providers who delivered CFC type services. HHSC has also extended the STP provisions to DBMD providers. HHSC monitored a weekly network report for each MCO effective January 23, 2105, through October 2, 2015. Based on HHSCs standards, all MCOs have an adequate network to provide services to the CFC population, so the weekly MCO network reports ended effective October 2, 2015. Although the network is considered adequate, the MCOs continue outreach efforts to STPs (that haven't contracted with an MCO) through various means (i.e., phone calls, face-to-face visits to the address on file, sending additional letters, and requesting updated contact information from DADS for providers with incorrect addresses). Ongoing monitoring of the network continues through the complaint process.

The CFC benefit for children in the FFS delivery system is managed in a way that parallels that used for personal care services (PCS). The Department of State Health Services (DSHS), through their regional case management staff, provides a front door for new individuals and current PCS individuals requesting CFC. When an individual requests CFC services, the DSHS case manager refers the individual to an appropriate entity for LOC assessment the state's subcontracted entity, AxisPoint, for nursing facility (NF) LOC, LIDDAs for ICF-IID LOC, or the local mental health authorities (LMHAs) for an Institution for Mental Disease (IMD) LOC. Once the LOC is established, the DSHS case manager performs a functional assessment to determine the individual's needs and preferences related to CFC services. Once DSHS obtains authorization from the Texas Medicaid Healthcare Partnership (TMHP), CFC services are delivered by the appropriate service provider with the DSHS case manager available for ongoing case management and annual reassessment.

Individuals who, prior to June 1, were served by both PCS and a DADS IDD waiver, will receive their CFC services through their waiver program, as described below, rather than through DSHS.

CFC was implemented in the four IDD waiver programs:

- HCS,
- TxHmL,
- CLASS, and
- DBMD Program.

All four of the IDD waivers include habilitation as a benefit in the waivers. Since habilitation is now a CFC service, available as a state plan benefit, individuals receiving these services as a waiver service started transitioning to receive these services as CFC on June 1, 2015. Since transportation was a component of the waiver habilitation and is not part of the CFC benefit, transportation will be provided as a waiver service. Based on billing information through May 2015 approximately 11,728 individuals enrolled in the IDD waivers are receiving CFC.

To maintain the existing structure and leverage the individuals' existing waiver provider for CFC services, HHSC in collaboration with DADS, submitted a 1915 (b) (4) waiver application to CMS. CMS approved the application. This waiver requires individuals in the four IDD waivers to continue to receive their CFC services through their comprehensive waiver provider or through the consumer directed services option (for CFC personal assistance services and habilitation services). By leveraging existing provider structures, LOC determinations (that are valid for both CFC and the waiver) and developing service plans continues to be handled through the existing waiver structure.

H.B. 3523, (Texas Government Code, §534.152 [g]) authorizes DADS to contract with providers participating in the HCS, TxHmL, CLASS, and DBMD Programs for the delivery of basic attendant and habilitation services through CFC and gives DADS regulatory and oversight authority over those providers.

Education and Outreach

HHSC, DADS, and DSHS staff provided training and information in a wide variety of forums in the year leading up to the implementation of CFC. These sessions gave stakeholders a chance to provide input and gain valuable information about the CFC benefit. More importantly, these meetings provided state staff an opportunity to hear the concerns of providers, individuals, parents, LARs, and other stakeholders about the rollout of CFC. The meetings varied in scope and included provider training, program presentations, parent outreach, and internal workgroups. A summary of the training and educational outreach efforts are in Appendix F.

In addition to the in-person meetings, HHSC and DADS both maintain CFC websites. These sites include information on eligibility, benefits and services, provider information, and contact information for questions. DSHS and DADS have created brochures to educate individuals about the CFC benefit, as well as information letters to help providers navigate the new world of CFC. These documents were distributed to stakeholders and are posted on the websites.

Person-centered Planning (PCP)

New HCBS federal rules applying to all home and community based services, including CFC, require the services to be provided through a person-centered framework. Texas proposed, and CMS approved, a person-centered planning process and required components of the person-centered service plan. Details on the process and plan requirements are in the SPA and the CFC rules, and the state developed a functional assessment that incorporates person-centered planning principles.

A person-centered plan identifies the strengths, preferences, needs (clinical and support) and goals of an individual, and balances what is important *to* a person with what is important *for* the person. Person-centered planning touches on non-clinical areas such as relationships, community participation, employment, finances, wellness, and education.

HHSC requires all individuals who are responsible for facilitating a person-centered service plan for CFC services to obtain HHSC-approved training in person-centered thinking within two years of CFC implementation (by June 1, 2017) or within two years of hire if the hire date is after June 1, 2015.

HHSC and DADS have established a cross-agency work group which is working to identify opportunities to offer the training around the state in different formats and venues to ensure everyone who needs it has access to it. This work group will also establish ways to ensure quality person-centered service planning is being delivered consistently across the system of home and community-based services. Once the training requirements are fully implemented, the state will look toward infusing person-centered practices through all levels of home and community-based service delivery.

Challenges

- Operating under an aggressive timeline for implementing the CFC benefits. However, even with the aggressive timeline, the initiative was successfully implemented shortly after the initial target date for implementation.
- Implementing several concurrent initiatives while implementing CFC.
- Educating stakeholders and individuals about the intricacies of CFC. A great deal of education was required and is still ongoing to ensure individuals understand the services available to them and the means by which they will receive the services. The state worked closely with stakeholders, provider groups, advisory committees, the LIDDAs, MCOs and many other organizations and individuals with an interest in CFC to provide clarification on the benefit. All of these groups were instrumental in partnering with the state to provide education about this new benefit. Appendix F outlines the education and outreach efforts by the state.
- Ensuring individuals who qualify for CFC have timely access to the new entitlement benefits, which are available to anyone that qualifies. CFC will provide services to a large number of people in Texas that were not receiving LTSS benefits prior to implementation. Most of these individuals will require outreach by the LIDDAs. The LIDDAs have competing and limited resources to dedicate to processing this amount of outreach.

Successes

- Providing services to individuals who did not have access to LTSS prior to CFC, some of whom have been waiting on an interest for many years.
- Timely approval of the SPA and close collaboration with our federal partners CMS to implement this new benefit. Texas is one of five states to offer CFC services.
- Ability to use an existing provider base and infrastructure, since all of the services offered through CFC were already available in Texas through various avenues. For example, habilitation is an integral service offered through all of the IDD waivers, so in implementing CFC, the state was able to use that same provider base to deliver this service. The state was also able to leverage existing assessment tools to assess for LOC eligibility and leveraged components of existing assessment tools to create the functional needs assessment.
- Fostering closer collaboration between multiple entities (i.e., HHS internal agencies, LIDDAs, MCOs, providers and stakeholders) that do not always get the opportunity to work together.

IDD Comprehensive Assessment

S.B. 7 directs DADS to develop and implement a comprehensive assessment instrument and a resource allocation process for individuals with IDD, as needed, to ensure that each individual with IDD receives the type, intensity and range of services that are both appropriate and available, based on the functional needs of that individual. Concerns have been expressed about the current assessment, the Inventory for Client and Agency Planning (ICAP). The ICAP focuses on deficits and does not directly assess strengths, resulting in inferences being made to determine supports needed. Additionally, while the ICAP collects information about community supports, it does not collect information about the availability of natural supports (e.g., unpaid caregivers,

such as family members, friends and neighbors). Another concern noted with the ICAP is the associated resource allocation does not adequately tie resources to an individual's identified need.

A new assessment process should more effectively consider individuals' needs and available supports and ensure individuals receive the precise scope, amount and duration of services they require without receiving services they do not need.

Current Status

DADS staff completed an initial analysis of nationally recognized comprehensive assessment instruments for individuals with IDD and, through an online survey, solicited stakeholder input on elements that should be included within a comprehensive assessment.

Staff also interviewed individuals with health and human services agencies in several states about their assessment instrument(s), how the instrument is tied to resource allocation, and the state's experience in piloting and implementing a new assessment process. Information from the agency's review of other states' assessment instruments and survey results were shared with the PIAC and the IDD SRAC.

In August 2014 DADS posted an RFI to solicit information from vendors about assessment instruments or inter-related groups of assessment instruments for populations including individuals with IDD. Responses to the RFI were received from the American Association on Intellectual and Developmental Disabilities (AAIDD), interRAI Research Collaborative, Momentum Healthcare and Deloitte Consulting LLP. Of these four responses, only two met the specifications of the RFI. The responsive submissions were from AAIDD for the Supports Intensity Scale (SIS), which is a single assessment for individuals with IDD and from the interRAI, which includes an IDD assessment as a subset of an inter-related group of assessment instruments.

Based on the research completed, the interRAI ID assessment instrument meets the specifications set forth in S.B. 7 and is responsive to feedback received from external stakeholders. The interRAI suite of assessments has the capability to accommodate the ongoing system reform as it contains multiple assessment instruments across intellectual disability (ID) and non-ID populations such as adult ID, acute care, adult mental health, home care, long-term care facilities, palliative care and the child and youth ID and mental health assessment tools slated for release in 2015. The final determination to pilot the interRAI ID assessment was made in April 2015. In July 2015 some stakeholders requested the scope of the pilot be expanded to include other interRAI instruments in addition to the interRAI ID assessment. In order to complete a direct comparison of the current assessment instruments with another instrument developed specifically for individuals with IDD, the pilot will encompass only the interRAI ID. Other assessments included in the suite may be considered following the completion of the pilot and the external evaluation of the pilot.

DADS is currently working with HHSC to publish a request for proposal (RFP) to solicit vendors to assist the state in implementing the pilot. Pilot activities will begin during the current biennium. DADS will also work with a vendor to analyze the results of the pilot and this analysis will inform future assessment rollout activities.

Flexible Low-cost Housing

S.B. 7 directs HHSC to adopt rules allowing for additional housing supports for individuals with disabilities, including individuals with IDD. These additional housing supports include community housing options that comprise a continuum of integration that permits individuals to select the most integrated and least restrictive setting appropriate to the individual's needs and preferences,

- Provider-owned and non-provider owned residential settings,
- Assistance with living more independently,
- Rental properties with onsite supports.

S.B. 7 directs DADS, TDHCA, the Department of Agriculture (TDA), the Texas State Affordable Housing Corporation (TSAHC) and the IDD SRAC to coordinate with public housing entities to expand opportunities for accessible, affordable, and integrated housing to meet the complex needs of individuals with disabilities.

In June 2015 CMS issued an informational bulletin on Medicaid coverage of housing-related activities for persons with disabilities. Texas offers many of the housing related support service options outlined in the bulletin and is reviewing the additional options in the bulletin.

Current Status

HHSC and DADS continue to work with partner agencies to increase options for community-based housing that permit individuals to select the most integrated and least restrictive setting appropriate to the individual's needs and preferences.

One example of this cross-agency collaboration involves the Section 811 Project Rental Assistance (PRA) program that provides project-based rental assistance for extremely low-income persons with disabilities linked with long term services. The program is made possible through a partnership between TDHCA, HHSC and eligible multifamily properties funded by TDHCA. TDHCA was awarded \$12,342,000.00 from the Housing and Urban Development (HUD's) Fiscal Year 2012 Section 811 Project Rental Assistance Demonstration Program and \$12,000,000 from HUD's Fiscal Year 2013 Section 811 Project Rental Assistance Program. The Section 811 PRA program creates the opportunity for persons with disabilities to live as independently as possible through the coordination of voluntary services and providing a choice of subsidized, integrated rental housing options. The Texas health and human services system will provide service coordination and supportive services to eligible participants and TDHCA will manage the funds and the wait list for the rental properties.

Eligible populations include:

- Individuals with IDD and other disabilities who are exiting institutions and eligible for Medicaid waiver services;
- Individuals with mental illness who are eligible for services through DSHS; and,
- Youth with disabilities aging out of foster care.

TDHCA placed two points in its 2015 Qualified Allocation Plan (QAP) for those who submitted an application for low income housing tax credits and agreed to participate in the Section 811 PRA Program. A total of 15 properties (150 units), a combination of existing and new properties, received awards. It is anticipated the first 50 to 60 units will be ready for lease later this fall and the remainder sometime in 2017. TDHCA plans to publish a notice of funding announcement before the end of the year to attract additional interested owners. The 2016 draft QAP, currently open for public comment, continues tax credit incentives for participants in the Section 811 PRA.

Recommendations for changes to the draft 2016 QAP focused on incentivizing development of affordable, integrated housing for individuals with IDD were submitted by the IDD SRAC to TDHCA on September 10, 2015. During their September meeting, the housing subcommittee heard from representatives of an organization that develops low income housing and a housing project finance corporation about other possible ways to encourage the housing community to respond to the unmet and growing need for housing options. The subcommittee plans to submit additional comments on the draft 2016 QAP as well as continue to participate in other opportunities for public input related to the on-going implementation of Section 811 PRA.

IDD Managed Care Pilots

S.B. 7 directs HHSC and DADS to develop and implement a pilot program to test one or more service delivery models involving a managed care strategy based on capitation to deliver Medicaid LTSS to individuals with IDD. H.B. 3523 delayed implementation of the pilot by one year. Originally, S.B. 7 required the pilot to be implemented by September 1, 2016. H.B. 3523 requires the pilot to be implemented by September 1, 2017.

S.B. 7 and H.B. 3523 (specifically section 534.104 of the Texas Government Code) requires the pilot to be designed to:

- Increase access to LTSS;
- Improve quality of acute care services and LTSS;
- Promote meaningful outcomes by using person-centered planning, individualized budgeting, and self-determination, and promote community inclusion;
- Promote integrated service coordination of acute care services and LTSS;
- Promote efficiency and the best use of funding;
- Promote the placement of an individual in housing that is the least restrictive setting appropriate to the individual's needs;
- Promote employment assistance and customized, integrated, and competitive employment;
- Provide fair hearing and appeals processes in accordance with applicable federal law; and
- Promote sufficient flexibility to achieve these goals.

Current Status

In April 2015 HHSC issued a survey to the IDD SRAC to allow for the committee members to provide feedback on the development and structure of the pilot. On July 20, 2015, HHSC issued an RFI. HHSC requested RFI responses by August 20, 2015. HHSC is currently reviewing the RFI responses and will be identifying next steps.

Serving Individuals with Significant Needs in the Community

There is a clearly recognized need to develop stronger capacity within the community-based long-term services system to support individuals with IDD who have high medical needs (HMN) and want to live in the community. DADS is working in concert with a HMN workgroup to improve overall system capacity to serve individuals with high medical needs. The initiative consists of two primary efforts focused initially on individuals leaving an SSLC.

Part one of the initiative focuses on creating opportunities for individuals with high medical needs to move into small ICF-IIDs. Part two of the initiative is exploring expanded service capacity within the HCS waiver program to meet the needs of these individuals.

Current Status

DADS worked with HHSC to develop and pilot an “add on rate” for ICF-IID providers based on an individual’s assessed high medical needs. Initial plans to pilot the initiative with individuals transitioning from the Austin SSLC and four ICF-IID providers in the Austin area have not resulted in the enrollment of any individuals to date. In July 2015 DADS expanded potential referrals to include individuals transitioning from any of the SSLCs. Future plans are to expand the offer of the ICF-IID “add on rate” to providers of services to eligible individuals who are leaving a nursing facility and seeking ICF-IID services.

The HCS initiative for individuals with HMN continues to progress. A workgroup with participation of stakeholders has developed recommendations for changes to the HCS waiver to enhance services for individuals with HMN. Stakeholders are requesting changes be available to all HCS recipients, not just those leaving institutional settings.

DADS’ fiscal year 2016 through 2017 appropriations includes \$5.9 million general revenue/\$13.8 million all funds to support this initiative. These funds will support the ICF-IID “add on rate” over the biennium and the HCS waiver enhanced services beginning in the second year of the biennium.

The proposed services and rates to be developed for the waiver initiative will determine the number of individuals to be served.

Behavioral Supports for Individuals with Intellectual and Developmental Disabilities

Subject to the availability of federal funding, S.B. 7 directs DADS to develop and implement specialized training for providers, family members, caregivers, and first responders providing direct services and supports to individuals with IDD and behavioral health needs that are at risk of institutionalization. In addition, S.B. 7 directs DADS to establish one or more behavioral health intervention teams to provide services and supports to those same persons.

Many individuals with physical disabilities and/or IDD and individuals who are aging have co-occurring behavioral health needs. In fact, nearly two-thirds of the SSLC population has a dual diagnosis (mental illness or substance abuse co-occurring with IDD), as do almost 90 percent of

individuals admitted to SSLCs in the past two years. In addition, nearly one-fourth of individuals across all DADS waiver programs have a dual diagnosis. The percentage of individuals with co-occurring behavioral health needs in certain waiver programs is even higher, such as in the HCS waiver, with 36 percent of HCS enrollees having a dual diagnosis. The additional challenge of a behavioral health diagnosis can further limit these individuals' ability to become fully integrated in the community.

Current Status

Medical, Behavioral, and Psychiatric Supports Regional Teams and Enhanced Service Coordination

In March 2015 HHSC and DADS received approval from CMS for a three year grant to support a new initiative under the Texas MFPD to enhance services for individuals with IDD relocating from an institution by strengthening the infrastructure to enhance (1) medical, behavioral and psychiatric supports, and (2) enhance community coordination. This new funding makes available an array of safety net services and supports that will assist LIDDAs and program providers in ensuring successful relocation of individuals into community settings. The LIDDA will be crucial to these coordination and community preparedness activities and are responsible for establishing eight regional medical, behavioral, and psychiatric support teams. The goals of the teams are to provide the following support services to the 39 local authorities and service providers across all 254 Texas counties:

- Quarterly webinars, videos and other educational activities focused on increasing the expertise of IDD local authorities and providers in supporting targeted individuals.
- Technical assistance pertaining to specific disorders and diseases, with examples of best practices for individuals with significant challenges.
- Case-specific support to service planning teams needing assistance to provide effective care for an individual. Assistance may include addressing any unique regional and cultural issues and challenges, and reporting to DADS about any gaps in medical, psychiatric and behavioral resources.

In June 2015 DADS contracted with eight LIDDAs to serve as administrators of funds within an appropriate region, and to address the distinct issues and challenges within the coverage area. The majority of teams are currently in the implementation phase and a few have begun providing technical assistance functions. Additionally, standardized reporting processes will support the identification of systemic issues and potential solutions to be implemented at the regional or statewide level. The eight LIDDA regional teams will continue to provide these consultative services through the end of fiscal year 2017 with ongoing federal funding through the MFPD funds. On-going evaluation of outcomes associated with the activity of the teams will help support future requests for funds to sustain these efforts. Appendix G provides a list of the established regional teams, and Appendix H illustrates the coverage area for each region.

Efforts are underway at DADS for implementing the new enhanced service coordination services for individuals who have chosen to relocate from an institutional setting into the community. Intensive service coordination services will be provided through the LIDDAs, which will be

responsible for facilitating continuity of services, service and care planning, and coordination of services and supports for individuals being relocated from institutional settings with complex behavioral and/or medical needs. Enhanced service coordination will provide a single point of accountability for ensuring that necessary medical and/or behavioral services are accessed, coordinated, and delivered in a strength-based, individualized, person-centered manner and that additional supports and services are integrated in a holistic approach.

Crisis Respite and Behavioral Intervention Teams

The 84th Texas Legislature provided funding to support individuals with IDD and significant behavioral and psychiatric challenges, many of whom transitioned or were diverted from institutional settings. These individuals often exhibit significant needs requiring additional support beyond the array of services typically provided within community programs. The development of behavior intervention services and crisis respite programs across the state will provide assistance to individuals with IDD in crisis, allowing them access to temporary stabilization resources while looking for long term supports to meet their needs.

DADS is in the initial stages of conducting a gap analysis to determine areas of the state lacking behavior intervention and crisis respite services including mobile crisis response units, 24-hour crisis hotlines, accessible community behavior support services, on-call programs, respite support services, and psychiatric emergency services. These activities will be coordinated with local crisis support service efforts occurring through the Department of State Health Services. Next steps will be consistent with the goals identified in the HHSC Behavioral Health Statewide Plan.

Results of the analysis will guide allocation of funds to those areas of the state lacking services. Implementation is targeted for March 2016 and will include an evaluation component to inform future requests of funds for sustainability.

Improve Access

Promote Person-Centered Planning, Self-Direction

Ongoing efforts to promote person-centered thinking (PCT) principles are occurring throughout the service delivery system. During the past year, DADS, in conjunction with the Institute for Person-Centered Practices, provided six PCT workshops around Texas for LIDDAs and program provider staff. PCT is the fundamental first step in providing the basic knowledge of PCP and facilitating the use of the tools to support others. PCP is a process that empowers individuals and their LAR to direct the development of a plan of supports and services that meet their personal outcomes by identifying supports and services, including natural supports. PCP focuses on individuals directing their service provision, meeting the goals and outcomes that are important to the individuals, including the people and supports chosen by the individuals and accommodating the individuals' style of interaction and preferences regarding time and setting.

Consumer direction of certain services is available in all of the DADS IDD waivers for those who live in their own homes. Individuals residing in HCS residential settings or DBMD assisted living settings do not have access to consumer directed services. Since DADS expanded consumer direction beyond services typically included in the residential rate, DADS continues to explore

the feasibility of offering certain limited consumer directed services, such as employment services, to waiver participants regardless of living arrangement.

Inform about Community Options and all Options

To comply with H.B. 2276, 83rd Legislature, Regular Session, DADS created a pamphlet that describes the residential options for individuals titled, “*Residential Options for Individuals with an Intellectual Disability or Related Condition.*” The pamphlet showcases the types of services available in SSLCs, a community ICF-IID, and an HCS group home or host home/companion care setting. DADS is required to ensure each person inquiring about residential services receives information relating to whether appropriate residential services are available in each program or service for which the person may be eligible. DADS delegates this responsibility through contracts with LIDDAs. The LIDDAs are responsible for providing the pamphlet and an oral explanation to every individual and LAR who inquires about IDD residential services.

DADS provides funding to expand efforts to inform individuals and their families of community options through contracts with LIDDAs and other providers. For individuals residing in SSLCs and NFs, LIDDAs perform Community Living Options and Information Process (CLOIP) annually. For individuals residing in an NF, LIDDAs and contracted relocation specialist provide outreach activities for residents who have indicated an interest in relocating into community living arrangements. A DADS workgroup is in the process of revising the CLOIP information brochures.

In July 2015 the Interagency Task Force for Children with Special Needs launched a new website created by parents for parents of children with disabilities and special health care needs. The site offers comprehensive, relevant and reliable information for families, professionals, advocates and anyone who works with children who have disabilities and their families. The website is available at the following link: navigatelifetexas.org.

DADS continues to work with stakeholders in refining and implementing effective materials and outreach efforts for ensuring all individuals are informed about appropriate community and service options.

Quality Improvement

DADS Community Services and Program Operations section is undertaking training responsibilities for LIDDA functions related to the HCS and TxHmL programs. The training will include development of a statewide uniform curriculum with the goals of improving the number and speed of individual transitions from institutions to the community as well as helping to strengthen local oversight of Medicaid services and service coordination. Additionally, DADS is currently in the process of hiring six training staff to provide preadmission screening and resident review (PASRR) related training for service coordinators throughout the state.

Employment Assistance and Customized, Integrated, and Competitive Employment

Employment First Task Force – S.B. 1226, 83rd Legislature, Regular Session, 2013, establishes employment as the first and preferred option for working-age Texans with disabilities, and also establishes the interagency task force to promote competitive employment of individuals with

disabilities and the expectation that individuals with disabilities are able to meet the same employment standards, responsibilities, and expectations as other working-age adults [Texas Government Code Section 531.02448(a)]. The task force continues to meet at least quarterly to promote competitive employment for individuals with disabilities. During the coming year, the task force will focus on designing an education and outreach process targeted at working-age individuals with disabilities, including young adults with disabilities, the families of those individuals, services providers, and state agencies that provide employment and other services and supports to individuals with disabilities.

Money Follows the Person Employment Pilot - Consistent with Employment First, DADS is administering a five-year employment pilot designed to help individuals with disabilities achieve meaningful, competitive employment in an integrated community setting. DADS selected two LIDDAs (Bluebonnet Trails Mental Health Developmental Disabilities [MHDD]) Center and Hill Country MHDD Center) and one private HCS provider (Thomas & Lewin Associates) to participate in the pilot. These providers are implementing systems change, including “Employment First” policies and practices that improve employment outcomes for individuals with disabilities.

For the purpose of this project, Employment First means that integrated, competitive employment is the primary goal for individuals receiving public services regardless of type or level of disability. All working age adults and youth with disabilities can work in jobs fully integrated within the general workforce, working side by side with co-workers without disabilities to the same extent as workers without disabilities, earning minimum wage or higher. Employment services will be the first service option considered in the course of service planning and all efforts will be made to encourage and assist individuals in obtaining the support needed to succeed in competitive, integrated employment before other day services are pursued.

Employment should be competitive and integrated. Competitive employment means the individual earns minimum wage or higher, or the prevailing wage paid to individuals without disabilities performing the same or similar work, whichever is higher. Integrated employment means individualized employment at a work site where the individual routinely interacts with people without disabilities (excluding the individual’s work site supervisor or service providers), and does not include group work. Competitive, integrated employment can also include self-employment.

Participating providers are transforming their organizations from relying on day program services to community-based, integrated employment. The State Supported Leadership Network conducted site visits with the three providers and provided guidance in the development of provider work plans. An evaluation of the pilot activities will be conducted by the Texas Center for Disability Studies at the University of Texas to determine successful approaches to improving employment outcomes through organizational change activities. Evaluation activities will begin in the summer of 2016 and will conclude in the early fall of 2016.

IDD S.B. 7 Fiscal Assumptions and Implementation Status

Below is a comparison of the S.B. 7 fiscal assumptions and information about how each initiative was implemented.

Item	S.B. 7 Assumption	As Implemented
STAR+PLUS IDD Acute/Prescriptions (RX) ³	September 1, 2014, implementation. Net reduction in cost of one percent, after recognition of additional administrative costs, risk margin and premium tax.	September 1, 2014, implementation. Five percent savings for acute and drug costs for individuals coming from FFS, prior to administrative costs, risk margin and premium tax. No additional savings assumed for individuals coming from STAR.
Community First Choice	September 1, 2014, implementation. New habilitation services available to individuals that meet an institutional LOC.	June 1, 2015, implementation. New habilitation services available to individuals that meet an institutional LOC. Individuals in STAR+PLUS waiver must be SSI level of income.

Average Monthly CFC Caseload Projections

	<u>FY 16</u>	<u>FY 17</u>
CFC provided through DADS Programs	13,300	13,300
HCBS Population in STAR+PLUS	38,800	40,100
Newly served population: IDD Interest List via STAR+PLUS (not part of S+P IDD population)	10,100	10,400
Total Assumed Population*	48,900	50,500

* Does not currently include PCS children who aren't in a DADS waiver.

³ Analyses and actual managed care rates for IDD clients were based on historical Medicaid claims data for clients in DADS CLASS, HCS, DBMD, TXHML, and ICF programs. Because this expansion is relatively new and data takes time to complete, further analysis of any actual fiscal impact (savings of costs) is not available at this time.

CFC Related GR Expenditures

	<u>FY 2016</u>	<u>FY 2017</u>
Savings from +6% enhanced match on existing eligible expenditures	(56,800,000)	(60,600,000)
Costs of Habilitation rate increases	26,000,000	28,500,000
New services for currently unserved IDD IL Adults in STAR+PLUS	<u>91,300,000</u>	<u>98,800,000</u>
Net GR Impact	60,500,000	66,700,000

Current services that gain the 6 percent enhanced match rate represent attendant care services for individuals meeting NF or ICF-IID LOC in the following programs: HCS, CLASS, DBMD, TXHML all at DADS; STAR+PLUS HCBS for qualifying supplemental security income (SSI) individuals, Personal Care Services for children at HHSC. Increases over existing costs for current populations assume the following:

- CFC rate increases in STAR+PLUS HCBS reflect attendant/habilitation cost blended between HCBS and other community care (OCC). Prior CFC estimates assumed HCBS specific rating. The blended rates shifts costs previously shown for IDD clients in OCC to the HCBS group, but result in no additional net costs.
- The currently unserved, adult SSI IDD population in STAR+PLUS on an IDD interest list is assumed at 9,900 members per month. This caseload is assumed to grow each year at the same rate as our overall Medicaid disability-related adult caseload.
- Habilitation costs at HHSC for this newly served adult IDD interest list population are assumed at the blended CFC rate, plus an average enhancement of \$1.33 per unit of service. Individuals are assumed to use 109 hours of habilitation services per month, based on utilization in IDD programs at DADS and an assumption of 25 hours per week/per person. These costs receive the CFC enhanced Federal Medical Assistance Percentages (FMAP).

Recommendations On Implementation of and Improvements to the System Redesign

The IDD SRAC has made recommendations in the areas of housing, quality, and the transition to managed care. The Housing recommendations are in Appendix C. The Principles of Quality adopted by the IDD SRAC Quality subcommittee are in Appendix D. The Transition to Managed Care subcommittee recommendations adopted by the IDD SRAC are Regional Healthcare Collaboration recommendations (Appendix I), Network Access recommendations (Appendix J), and Education and Outreach recommendations (Appendix K).

Future areas of focus for consideration by the IDD SRAC will include meaningful outcomes for Medicaid recipients using person-centered planning (PCP), individualized budgeting and self-determination (including inclusion in the community).

HHSC and DADS will continue to work closely with the IDD SRAC to consult and collaborate on the initiatives outlined in S.B. 7 and H.B. 3523. Additionally, HHSC and DADS will continue to work with stakeholders, providers, individuals and any other interested stakeholders. HHSC plans to continue the IDD Managed Care Improvement Workgroup referenced in the report, to assist in identifying issues, resolutions and ongoing improvements to the managed care program for persons with IDD.

Appendix A
IDD SRAC Membership

Mr. Mickey Atkins	Austin	LTSS provider, Medicaid non-managed care
Mr. Clay Boatright, Chairman	Plano	Family member of an individual with IDD who receives waiver/ICF-IID services
Ms. Lynne Brooks	San Antonio	LTSS provider, Medicaid non-managed care
Mr. Ricky Broussard	Alvin	Individual with IDD and recipient of services under the waiver programs
Ms. Kay C. Carlson	Houston	Family member of an individual with IDD who receives waiver/ICF-IID services
Mr. John P. Delaney	Terrell	Representative of community mental health and ID centers
Ms. Susan Garnett	Fort Worth	Representative of community mental health and ID centers
Ms. Debbie Gill	Dallas	Family member of an individual with IDD who receives waiver/ICF-IID services
Ms. Jillana Holt-Reuter	San Marcos	Advocate of individuals with IDD who receive waiver or ICF-IID services
Ms. Katy Hull	Henderson	Individual with IDD and recipient of services under the waiver programs
Mr. Gary Hidalgo	Beaumont	Representative of aging and disability resource centers
Mr. Gerard Jimenez	Austin	Family member of an individual with IDD who receives waiver/ICF-IID services
Ms. Jean Langendorf	Austin	Advocate of individuals with IDD who receive Medicaid or ICF-IID services
Ms. Linda Levine	Bee Cave	Family member of an individual with IDD
Ms. Amy Litzinger	Austin	Individual with IDD and recipient of services under waiver programs
Ms. Janet Marino	McKinney	Representative of an MCO that contracts with the state to provide IDD services
Mr. Frank McCamant	Austin	Advocate of individuals with IDD who receive waiver/ICF-IID services
Ms. Susan Murphree	Austin	Advocate of individuals with IDD who receive waiver/ICF-IID services
Ms. Susan Payne	College Station	Family member of an individual with IDD who receives waiver/ICF-IID services
Ms. Mary Stephney Quinby	Rosenberg	Advocate of individuals with IDD who receive waiver or ICF-IID services
Ms. Leah Rummel	Austin	Representative of MCO that contracts with the state to provide IDD services
Ms. Carole Smith	Austin	LTSS provider, Medicaid non-managed care
Mr. David Southern	Granbury	Private ICF-IDD provider
Dr. Carl Tapia	Houston	Pediatrician with Texas Children's Health Plan
Ms. Cheri Wood	Tyler	Family member of an individual with IDD who receives waiver/ICF-IID services
Ms. Ivy Zwicker	San Antonio	Private ICF-IDD provider

Appendix B
IDD SRAC
Housing Subcommittee Housing Recommendations Letter

September 10, 2015

Mrs. Kathryn Saar
Tax Credit Program Manager
Texas Department of Housing and Community Affairs
221 East 11th Street
Austin, Texas 78701-2410

Re: Recommendations for 2016 Qualified Allocation Plan to support development of housing for individuals with intellectual and development disabilities

Dear Mrs. Saar:

I am writing on behalf of the Intellectual and Developmental Disability Redesign Advisory Committee. Created through S.B. 7 in the 83rd Texas Legislature, the committee works in consultation with the Health and Human Services Commission and the Department of Aging and Disability Services to implement the S.B. 7 provisions affecting individuals with IDD.

Part of the effort includes allowing for the development of additional housing supports for individuals with disabilities. The U. S. Department of Housing and Urban Development Report to Congress found that there are substantial unmet needs for affordable rental housing. According to the report, "the unmet need for decent, safe, and affordable rental housing continues to outpace the ability of federal, state and local governments to supply housing assistance."

We know the number of children and young adults needing services is huge; however it is difficult to identify actual numbers at this time. For a point of reference, however, the Texas Education Agency's report on persons with disabilities lists thirteen disability categories. For the purposes of this letter, only three are being considered: Intellectual Disabilities, Multiple Disabilities, and Traumatic Brain Injury. In these three categories alone, those currently attending high school and those who will soon be aging out (students age nineteen to twenty-two) total 16,895.

Residential housing options are a critical need for these Texans. The need to stimulate interest among builders and developers is both great and urgent, thus the Committee requests the following:

- Integrated housing units development and set aside for Tenant populations with IDD or multiple disabilities receive four (4) points;
- Housing units proposed by developers that have formal agreements for social services for qualified tenants attached to the application receive three (3) points; and
- An on-site service coordinator at the development should be awarded one (1) point. In determining tenant eligibility for these units, a person of any age having intellectual and developmental disabilities may qualify as an eligible household.

We appreciate your consideration of this request. Please let me know of any questions, concerns, or if you would like to discuss it in more detail.

Sincerely,

Clay Boatright
Chairman
Texas IDD System Redesign Advisory Committee

Appendix C

IDD SRAC Housing Subcommittee Proposed Recommendations and Benefits

Possible examples of benefits are in italics.

1. INCREASE TARGETING in all current housing programs for individuals with IDD at the Supplemental Security Income (SSI) level:

- administered/funded through the Texas Department of Housing and Community Affairs (TDHCA);
 - ✓ *Belle is able to receive Tenant-Based Rental Assistance (TBRA) set-aside for people with IDD through a local TDHCA HOME Investment Partnerships Program administrator to move into an apartment she can afford. Belle will be able to receive \$606 a month from the program to apply towards her rent of \$686. Belle must meet requirements such as have income less than 50% of the area median income, have a disability, find an apartment that will pass the housing quality standards and a landlord who will accept the housing subsidy.*
 - ✓ *Christopher Robin's family home in rural Texas is very old and in need of repair but the family does not have a lot of money to do the repairs. The family qualifies (have an income that is 80% area median income or below, have all the necessary ownership documentation and the needed repairs can be met by the funds available) for the Homeowner Rehabilitation Assistance (HRA) program that has been established with a 'set aside' for households with a member with a developmental disability and the home is repaired and brought up to housing quality standards*
 - ✓ *Jasmine receives down payment assistance to purchase her first home through a local housing organization funded through TDHCA's HOME program that manages funds to assist individuals with disabilities to become first time homebuyers. She qualifies for this funding because her income is less than 80% area median income, she has good credit, qualifies for a mortgage loan, and the home she selected meets quality standards.*
 - ✓ *Woody now needs to use a wheelchair and faces many barriers to accessing parts of his house. He applies for assistance from a local housing provider who administers the Amy Young Barrier Removal Program with funding from TDHCA. His home meets housing quality standards, his income is less than 80% area median family income and funds are still available to make the needed home modifications to increase accessibility and eliminate hazardous conditions in their home.*
- administered/funded through the Texas Department of Agriculture (TDA) Community Development Block Grant (CDBG) to address the housing needs of low-income persons with intellectual and developmental disabilities in rural communities with options to include assistance for the development/modifications of housing that includes 1 – 4 units.
 - ✓ *The city of Marble Falls, in partnership with Habitat for Humanity of the Highland Lakes, receives a CDBG grant from TDA to rehabilitate four duplexes and a four-plex to provide accessible and affordable housing in Marble Falls for individuals with Intellectual and Developmental Disability (IDD). Alice, Aurora, Sofia, Mulan, Johnny, Madeline, Maurice, Melody, Merlin, Oliver, Penny and Peter all move into their own apartment that they can afford.*

2. RAISE AWARENESS of the Project Access Program to move individuals with intellectual and developmental disabilities out of institutions and establish a set-aside for TDHCA's Tenant-Based Rental Assistance (TBRA) Program that will immediately serve those on the Project Access waitlist.

- ✓ *Ariel has lived in a state supported living center for many years. She wants to move out into the community. She needs financial assistance to pay rent at the apartment community she*

has located and is on the TDHCA Project Access Voucher waitlist. Her services are all in place to assist her and an apartment has just come open – because a local non-profit is administering a TDHCA TBRA program, she can get the rental assistance now to move into the apartment. The rental assistance includes \$606 towards her rent of \$686 that will help her until the permanent Project Access Voucher becomes available to provide the rental assistance. In addition to the TBRA assistance, funding may also be available for utility deposits and transition funds (through her Medicaid waiver program) that can be used to purchase furniture and household items.

3. ADD RESOURCES to support the financing of integrated, accessible, and affordable housing and services to meet the needs of underserved disability groups and older adults by:

A. Funding from other sources, e.g. grants;

- ✓ *Jack wants to live independently in his own home. His family is supportive of this idea and he has relatives who would like to financially make this happen for Jack. With one-time grant funds available for down payment and closing costs assistance and the contributions from his family, Jack can purchase a condo that he can afford to cover his housing expenses with his SSI income and income from a roommate. He checked into the down payment assistance programs that the City of Houston and Easter Seals Greater Houston offer. He found the house he wanted in Montgomery County so he was assisted by Easter Seals.*

B. Funding for Housing Transition Specialists to assist case managers and service coordinators as low-income people with intellectual and developmental disabilities transition to different housing locations;

- ✓ *Jill has been receiving services at home and is getting ready to graduate. She wants to move out of her family home but does not know where she wants to live or in what her options are for housing. She calls her case manager who sets up a meeting with Jill and the new Housing Transition Specialist to talk about what options are available in her city. The Housing Transition Specialist will review available options with Jill in her area, work through those options to help Jill find the best housing solution. This option must be funded as a Medicaid waiver benefit and will need appropriation and legislative approval.*

C. Expanding Relocation Contractor services for people with Behavioral Health challenges;

- ✓ *Dick has been receiving services from the state mental health facility and is ready to be discharged. His family is no longer able to have him live at home with them so Dick needs an affordable place to live. Dick has never lived away from home and needs assistance. The local 'relocation specialist' helps him find a place to live in the community by showing him various housing options to transition to life in the community.*

D. Funding to replicate the current Texas Department of State Health Services housing voucher program for individuals experiencing mental illness for persons with IDD.

- ✓ *Jane has lived in a group home and has worked at a sheltered workshop managed by her provider. A new mail processing center is opening up across town and she has been offered a competitive wage paying position there due to the skills she has acquired. There is also a new apartment community opening next to her new company where she would like to move but she will not have enough income to pay the rent amount. The local IDD authority has state IDD funds that can be used to pay a part of her rent so she is able to move. With replication of the funding, a total of 3,400 individuals with IDD would receive rental assistance.*

- E. Continue to make funds available through the Texas Department of Housing and Community Affairs for home modifications for accessibility and implement outreach for individuals with intellectual and developmental disabilities.
 - ✓ *Dora can no longer walk and now uses a wheelchair. Her home has barriers to accessing parts of her house and she needs home modification assistance. She applies for assistance from her local Habitat for Humanity who administers a barrier removal program with funding from TDHCA. Program beneficiaries must include a Person with a Disability, must have a household income that does not exceed 80% of the Area Median Family Income, and may be tenants or homeowners of manufactured or stick built homes.*

4. DEVELOP FINANCE AND CAPACITY BUILDING STRATEGIES to encourage the development of housing opportunities in mid-sized cities and rural areas of the state including:

- A. Replicating the Housing and Services Partnership Academy⁴ to include specific emphasis on the housing needs of individuals with intellectual and developmental disabilities;
- B. Expanding the Capacity Building Initiative for Community Living to encourage set-asides for individuals with intellectual and development disabilities;
 - ✓ *Public Housing Authorities (PHAs) across Texas have obtained approval on their PHA Plan from the U.S. Department of Housing and Urban Development to set aside units and vouchers for people with IDD*
 - ✓
- C. Educating property managers about people with intellectual and developmental disabilities;
 - ✓ *A statewide disability advocacy organization has partnered with the Texas Apartment Association (TAA) to include education about people with IDD in the TAA property manager training*
- D. Increasing points in the Qualified Allocation Plan (QAP) for developers who develop projects in rural and mid-sized cities that better serve individuals with intellectual and developmental disabilities;
 - ✓ *Developers have responded by creating single family housing and multifamily housing options in rural and mid-sized cities. The list of properties developed is available for families to access on the Texas Department of Housing and Community Affairs website.*
- E. Re-establishing TDHCA’s Rural Housing Expansion Program with a focus to develop housing opportunities for individuals with intellectual and developmental disabilities; and
 - ✓ *TDHCA has re-established its Rural Housing Expansion Program to focus on housing for people with IDD.*
- F. Reviewing support services within HCBS waivers and developing service options to support integrated housing.

5. ADOPT A SERIES OF INCENTIVES within TDHCA’s Low-Income Housing Tax Credit Program to encourage the development of a pipeline of integrated, affordable, and accessible housing opportunities for individuals with intellectual and developmental disabilities by:

⁴ The initiative is a partnership at the federal level that brings together housing and human services agencies on state and local levels who have implemented a number of strategies to address the housing and services needs of people with disabilities and older adults.

6.
 - A. Encouraging people with IDD and advocates to participate in the Qualified Allocation Plan (QAP) process;
 - ✓ *Elsa is a member of the S.B.7 IDD SRAC Housing Subcommittee and has participated in developing recommendations on how to improve the Qualified Allocation Plan to better develop housing for individuals with IDD. She works with the TDHCA representative on the Housing Subcommittee to make sure the subcommittee's input is provided to the staff involved in developing the QAP.*
 - B. Create incentives to develop housing for individuals with intellectual and developmental disabilities. Reviewing the possibilities of creating points in the QAP for developers
 - ✓ *Anna is a member of the S.B.7 IDD SRAC Housing Subcommittee and has participated in developing recommendations to include scoring points in the QAP to incentivize the development of more housing for individuals with IDD. Developers have responded by creating single family housing and multifamily housing options.*
7. **CONTINUE COORDINATING state agency expansion of housing and services initiatives.**
8. **ENCOURAGE HOUSING SUBSIDIES and other initiatives that increase the affordability of housing for individuals with intellectual and developmental disabilities and support efforts to prevent discrimination due to source of income.**

Appendix D
Quality Principles for IDD System Redesign
Adopted April 2015

1. Adequate planning to allow time in advance of implementing new, expanded or reconfigured programs to allow for thoughtful planning and design, incorporation of stakeholder input and implementation of safeguards to ensure a smooth transition to Medicaid managed long term supports and services (MLTSS).
2. Stakeholder engagement with a structure for outreach and engaging stakeholders regularly in development and implementation of new, expanded or reconfigured MLTSS programs, including the State's and its contractors ongoing education of stakeholders prior to, during, and after implementation.
3. Enhanced provision of home and community-based services consistent with the Americans with Disabilities Act (ADA) and the Supreme Court's Olmstead v. L.C. decision that offers the greatest opportunities for active community and workforce participation.
4. Alignment of Payment Structures and Goals that hold providers accountable through performance-based incentives and/or penalties and that support the goals of the program.
5. Support for People Receiving Services by offering conflict-free education, enrollment/disenrollment assistance, and advocacy in a manner that is accessible, ongoing, meaningful, and consumer-friendly.
6. Person-centered Processes that are required and monitored as to the implementation and use of person-centered needs assessment, service planning, and service coordination policies and protocols that encourage self-determination and provide opportunities for self-direction of services.
7. Comprehensive, integrated service package that ensures participants receive services and supports in the amount, duration, scope, and manner as identified through the person-centered assessment and service planning process.
8. Qualified Providers must be identified and a network of qualified providers must be maintained including the incorporation of existing qualified providers as MCO network providers to the extent possible.
9. Participant protection system that ensures health and welfare, includes a statement of participant rights and responsibilities; requires a critical incident management system with safeguards to prevent abuse, neglect and exploitation; and implements fair hearing protections including the continuation of services during an appeal and assistance to participants in understanding their fair hearing rights.
10. Quality strategies that include development and implementation of a comprehensive quality strategy that is transparent, integrated across programs and services, and appropriately tailored to address the needs of the MLTSS populations served.

*Adapted from the Centers for Medicare and Medicaid Services (CMS), May 20, 2013, *Guidance to States using 1115 Demonstrations or 1915 (b) Waivers for Managed Long Term Services and Supports*

Programs. Phases for evaluating and aligning principles with services provided by Mickey Atkins, Quality Subcommittee member.

Phase Breakdown of Principles

When measuring quality of services, four distinct phases can be identified. Following is a brief description of each phase and the above stated principles that pertain to each phase.

- A. Planning Phase – Individuals are identified to receive services; program options are explored; plans developed to enter HCBS system
- Adequate planning
 - Stakeholder engagement
 - Support for People Receiving Services
 - Person-centered Processes
 - Comprehensive, integrated service package
 - Qualified Providers
 - Participant protection system
 - Quality strategies
- B. Processing Phase – Individuals and interested parties review options; choose provider; and begin transitioning process into HCBS system
- Stakeholder engagement
 - Enhanced provision of home and community-based services
 - Alignment of Payment Structures and Goals
 - Support for People Receiving Services
 - Person-centered Processes
 - Comprehensive, integrated service package
 - Participant protection system
 - Quality strategies
- C. Active Phase – Individuals are receiving services from selected provider
- Stakeholder engagement
 - Enhanced provision of home and community-based services
 - Alignment of Payment Structures and Goals
 - Support for People Receiving Services
 - Person-centered Processes
 - Comprehensive, integrated service package
 - Participant protection system
 - Quality strategies
- D. Evaluation Phase – Individuals have been receiving services for a predetermined period of time
- Stakeholder engagement
 - Support for People Receiving Services
 - Person-centered Processes
 - Comprehensive, integrated service package
 - Participant protection system
 - Quality strategies

Appendix E

Community First Choice Provider Summary Tool

This summary tool includes information on action and responsible parties for CFC services overseen by HHSC through STAR+PLUS and STAR Health, DADS waivers, managed care organizations, and fee-for-service. More information on managed care plans can be found here: <http://www.hhsc.state.tx.us/medicaid/managed-care/plans.shtml>

Contact Information

Amerigroup	1-713-218-5100	Ext. 55446
Cigna HealthSpring	1-877-653-0331	
Molina	1-866-449-6849	
Superior	1-866-615-9399	Ext. 22534
United Healthcare	1-888-787-4107	
HHSC Mailbox	<u>MCD_CFC@hhsc.state.tx.us</u>	
DADS Mailbox	<u>CFCpolicy@dads.state.tx.us</u>	

STAR + PLUS Nursing Facility and Hospital Level of Care

<p><i>Applies to individuals in STAR+PLUS and STAR+PLUS Home and Community Based Services (HCBS) Waiver, including those receiving STAR+PLUS services and participating in the Dual Demonstration. Individuals in the STAR+ PLUS HCBS Waiver, whose eligibility is "Medical Assistance Only", are not eligible for CFC.</i></p>	DADS		DSHS		TMHP		Managed Care Organization		Local Authority		Local Mental Health Authority	
	^ 21	v 21	^ 21	v 21	^ 21	v 21	^ 21	v 21	^ 21	v 21	^ 21	v 21
Level of Care Determination - <i>Medical Necessity Level of Care Assessment</i>							●	●				
Approves LOC					●	●						
Functional Assessment - <i>CFC Assessment (H6516 with the 2060B for individuals 21 and over) or PCAF CFC addendum (for individuals under 21)</i>							●	●				
Authorization of Services							●	●				
Service Coordination							●	●				

STAR + PLUS ICF/IID Level of Care

<p><i>Applies to individuals in STAR+PLUS, including those receiving STAR+PLUS services and participating in the Dual Demonstration.</i></p> <p><i>Excludes individuals enrolled in STAR+ PLUS for acute care services only who are receiving LTSS through a DADS 1915(c) Waiver (CLASS, TxHmL, HCS, DBMD).</i></p> <p><i>Service coordination for adults in this population will be provided by both the MCO and the Local Authority.</i></p>	DADS		DSHS		TMHP		Managed Care Organization		Local Authority		Local Mental Health Authority	
	< 21	≥ 21	< 21	≥ 21	< 21	≥ 21	< 21	≥ 21	< 21	≥ 21	< 21	≥ 21
Level of Care Determination – Intellectual Disability/Related Condition Assessment										●	●	
Approves LOC	●	●										
Functional Assessment - CFC Assessment (H6516 with the 2060B for individuals 21 and over) or PCAF CFC addendum (for individuals under 21)								●			●	
Authorization of Services								●	●			
Service Coordination								●	●		●	

STAR + PLUS IMD Level of Care

<p><i>Applies to individuals in STAR+PLUS who are under 21 or older than 64, including those receiving STAR+PLUS services and participating in the Dual Demonstration..</i></p> <p><i>Excludes individuals enrolled in STAR+ PLUS for acute care services only who are receiving LTSS through a DADS 1915(c) Waiver (CLASS, TxHmL, HCS, DBMD).</i></p>	DADS		DSHS		TMHP		Managed Care Organization		Local Authority		Local Mental Health Authority	
	< 21	≥ 21	< 21	≥ 21	< 21	≥ 21	< 21	≥ 21	< 21	≥ 21	< 21	≥ 21
	<p>Level of Care Determination - <i>Child and Adolescent Needs and Strengths Assessment (CANS)/Adult Needs and Strengths Assessment (ANSA)</i></p>											●
<p>Confirms LOC</p>							●	●				
<p>Functional Assessment - <i>CFC Assessment (H6516 with the 2060B for individuals 21 and over) or PCAF CFC addendum (for individuals under 21)</i></p>							●	●				
<p>Authorization of Services</p>							●	●				
<p>Service Coordination</p>							●	●				

STAR Health

Nursing Facility and Hospital Level of Care

Applies individuals enrolled in STAR Health. STAR Health is a statewide, comprehensive healthcare system for individuals in DFPS conservatorship or programs related to DFPS conservatorship.

Young adults who have signed an extended placement agreement with DFPS remain in STAR Health until age 22.

	DADS		DSHS		TMHP		Managed Care Organization		Local Authority		Local Mental Health Authority	
	< 21	≥ 21	< 21	≥ 21	< 21	≥ 21	< 21	≥ 21	< 21	≥ 21	< 21	≥ 21
Level of Care Determination - Medical Necessity Level of Care Assessment							●	●				
Approves LOC					●	●						
Functional Assessment - CFC Assessment (H6516 with the 2060B for individuals 21 and over) or PCAF CFC addendum (for individuals under 21)							●	●				
Authorization of Services							●	●				
Service Coordination							●	●				

STAR Health ICF/IID Level of Care

<p><i>Applies to individuals in STAR Health. STAR Health is a statewide, comprehensive healthcare system for individuals in DFPS conservatorship or programs related to DFPS conservatorship.</i></p> <p><i>Young adults who have signed an extended placement agreement with DFPS remain in STAR Health until age 22.</i></p>	DADS		DSHS		TMHP		Managed Care Organization		Local Authority		Local Mental Health Authority	
	< 21	≥ 21	< 21	≥ 21	< 21	≥ 21	< 21	≥ 21	< 21	≥ 21	< 21	≥ 21
	<p>Level of Care Determination - Intellectual Disability/Related Condition Assessment</p>									●	●	
<p>Approves LOC</p>	●	●										
<p>Functional Assessment - CFC Assessment (H6516 with the 2060B for individuals 21 and over) or PCAF CFC addendum (for individuals under 21)</p>							●	●				
<p>Authorization of Services</p>							●	●				
<p>Service Coordination</p>							●	●				

STAR Health IMD Level of Care

<i>Applies to individuals under 21 year of age enrolled in STAR Health. STAR Health is a statewide, comprehensive healthcare system for individuals in DFPS conservatorship or programs related to DFPS conservatorship.</i>	DADS		DSHS		TMHP		Managed Care Organization		Local Authority		Local Mental Health Authority		MNLOC Contractor	
	^ 21	v 21	^ 21	v 21	^ 21	v 21	^ 21	v 21	^ 21	v 21	^ 21	v 21	^ 21	v 21
Level of Care Determination - <i>Child and Adolescent Needs and Strengths Assessment (CANS)</i>											●			
Confirms LOC							●							
Functional Assessment - <i>PCAF CFC addendum</i>							●							
Authorization of Services							●							
Service Coordination							●							

Traditional Fee-For-Service (FFS) Medicaid Nursing Facility and Hospital Level of Care

Applies to children in FFS (Traditional Medicaid) and the STAR program who will receive CFC services through the FFS program, including those enrolled in the MDCP waiver.

	DADS		DSHS		TMHP		Managed Care Organization		Local Authority		Local Mental Health Authority		MNLOC Contractor		
	^ 21	∇ 21	^ 21	∇ 21	^ 21	∇ 21	^ 21	∇ 21	^ 21	∇ 21	^ 21	∇ 21	^ 21	∇ 21	
Level of Care Determination - <i>Medical Necessity Level of Care Assessment</i>														●	
Approves LOC					●										
Functional Assessment - <i>PCAF CFC addendum</i>			●												
Authorization of Services					●										
Service Coordination			●												

Traditional FFS Medicaid ICF/IID Level of Care

<i>Applies to children in FFS (Traditional Medicaid) and the STAR program who will receive CFC services through the FFS program.</i>	DADS		DSHS		TMHP		Managed Care Organization		Local Authority		Local Mental Health Authority		MNLOC Contractor	
	^ 21	v 21	^ 21	v 21	^ 21	v 21	^ 21	v 21	^ 21	v 21	^ 21	v 21	^ 21	v 21
Level of Care Determination - <i>Intellectual Disability/Related Condition Assessment</i>										●				
Approves LOC	●													
Functional Assessment - <i>PCAF CFC addendum</i>			●											
Authorization of Services					●									
Service Coordination			●											

Traditional FFS Medicaid IMD Level of Care

<i>Applies to children in FFS (Traditional Medicaid) and the STAR program who will receive CFC services through the FFS program, including those enrolled in the YES Waiver.</i>	DADS		DSHS		TMHP		Managed Care Organization		Local Authority		Local Mental Health Authority		MNLOC Contractor	
	^ 21	v 21	^ 21	v 21	^ 21	v 21	^ 21	v 21	^ 21	v 21	^ 21	v 21	^ 21	v 21
Level of Care Determination - <i>Child and Adolescent Needs and Strengths Assessment (CANS)</i>											●			
Confirms LOC			●											
Functional Assessment - <i>PCAF CFC addendum</i>			●											
Authorization of Services					●									
Service Coordination			●											

Appendix F
CFC Outreach/Education

HHSC and DADS conducted 12 CFC Roadshows that included training for providers throughout Texas (see table below for locations).

Date	Location
January 6, 2015	Weslaco – Knapp Medical Center
January 8, 2015	Laredo – UTSA Health Science Center
January 12, 2015	Ft. Worth – Catholic Charities
January 13, 2015	Dallas – Dallas Public Library
January 16, 2015	Austin – JJ Pickle Center
January 20, 2015	Houston – Houston Food Bank
January 22, 2015	Waco – Workforce Solutions Heart of Texas
January 29, 2015	San Antonio – Alamo Area Council of Governments
February 3, 2015	Lubbock – Teaching and Mentoring Communities
February 4, 2015	Abilene – Hendrick Medical Center
February 10, 2015	El Paso – Providence East Medical Center
February 12, 2015	Longview – Community Connections

Additionally, HHSC, DADS and DSHS conducted provider trainings for provider associations, advocacy groups, and organizations that requested additional training. DADS and HHSC have also hosted a series of provider webinars. HHSC and DADS hosted several webinars for state staff. HHSC and DADS staff also participated in advisory committee and workgroup meetings with the Promoting Independence Advisory Committee, the IDD System Redesign Advisory Committee, the Consumer Directed Services Workgroup, and the STAR+PLUS workgroup.

Ongoing meetings with DSHS, DADS, the MCOs and LIDDAs continue to occur. The LIDDAs and MCOs continue to meet every two weeks to work through operational issues.

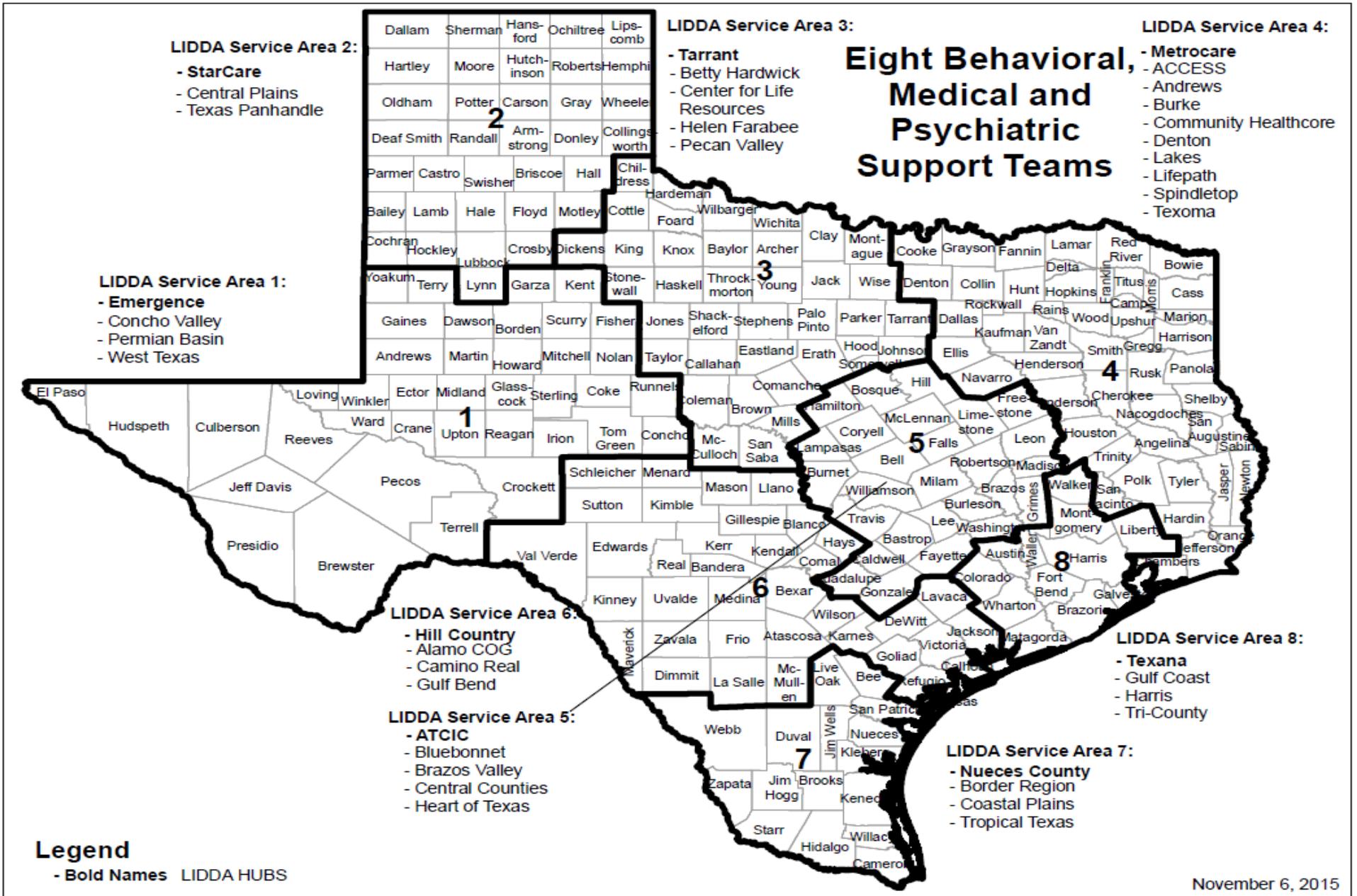
Training was also provided to the Regional Advisory Committee through a train-the-trainer approach.

Appendix G
LIDDA Medical, Behavioral and Psychiatric Regional Teams

Regional Teams require one LIDDA to serve as designated “HUB” which is responsible for administering funds related to the team and to execute certain administrative responsibilities delegated by DADS. Below is an outline of the Regional Teams and service areas.

Region	LIDDA HUB	Covered LIDDA Service Areas
1	Emergence	Concho Valley Emergence Permian Basin West Texas
2	StarCare	Central Plains StarCare Texas Panhandle
3	Tarrant	Betty Hardwick Center for Life Resources Helen Farabee Pecan Valley Tarrant
4	Metrocare	ACCESS Andrews Burke Community Healthcore Metrocare Denton Lakes LifePath Spindletop Texoma
5	ATCIC	ATCIC Bluebonnet Brazos Valley Central Counties Heart of Texas
6	Hill Country	Alamo COG Camino Real Gulf Bend Hill Country
7	Behavioral Health Center of Nueces County	Border Region Coastal Plains Nueces County Tropical Texas
8	Texana	Gulf Coast Harris Texana Tri-County

Appendix H



Appendix I
IDD SRAC
Transition to Managed Care subcommittee
Regional Healthcare Collaboration Recommendations

The Transition to Managed Care subcommittee is recommending that MCOs, LIDDAs and long-term services and supports (LTSS) providers collaborate on a routine basis through regional collaboration meetings. It is important to note, that some areas of the state are already engaging in regional collaborations meetings. Listed below are the recommendations from the subcommittee regarding the regional collaboration meetings and structure for these meetings.

1. Routinely (monthly or bi-monthly), the MCOs and LIDDAs will meet in each region to discuss operational issues (i.e. specific cases, challenges, care coordination, etc.) to quickly resolve systemic issues.
 - a. Consideration will need to be given regarding whether these meetings should be with the LIDDAs and specific MCOs or if all MCOs in the region would be willing to participate in a joint meeting.
2. Periodically through a separate meeting, each region will hold a stakeholder meeting with the MCOs, LIDDAs and providers in the region.
 - a. The existing required MCO Advisory Committees may be leveraged for these meetings.
 - i. Each MCO could add a specific IDD stakeholder advisory committee for these meetings.
 - b. Some LIDDAs host quarterly meeting with Providers. These meetings may be able to be leveraged for these meetings if MCOs are invited to these meetings.
 - c. The frequency of these meetings would need to be determined.
 - d. Existing meetings and future meetings should be broadened to include Deaf Blind with Multiple Disabilities (DBMD) and Community Living Assistance and Support Services (CLASS) providers.
 - e. Host some of these meeting as a webinar.
3. All meetings should be webcast with a conference line available for individuals to call in.
4. In order for these meetings to be effective, decision makers from the MCO and LIDDA need to be present at these meetings so decisions can be made.
5. Regional LIDDA and MCO representatives will have flexibility to determine the meeting structure that works best for them.
6. HHSC with participate in these meetings as needed when issues arise that require HHSCs participation.
7. On a quarterly basis, any issues that are not resolved through the regional healthcare collaboration meetings will be sent to HHSC and the IDD SRAC to discuss and address.
8. These meetings will be structured around the MCOs service delivery areas (SDA).
9. These meetings must have a specific agenda and be contained so issues can be resolved and addressed effectively.

- a. Consideration will need to be given to who will lead and set the agendas for these meetings (i.e. MCO, LIDDA, or provider).
- b. All MCOs and LIDDAs will need to commit to attend these meetings.

Appendix J
IDD SRAC
Transition to Managed Care subcommittee
Education and Outreach Recommendations

The Transition to Managed Care subcommittee recognizes the importance of ensuring individuals with IDD, their LAR and family members receive information about the benefits and services in a way that is easy for the individual, LAR and family members to understand.

Ongoing education and outreach is critical. The committee also recognizes that providing education continues to be an ongoing challenge. Listed below are recommendations from the subcommittee on how the managed care organizations (MCOs), local intellectual and developmental disability authorities (LIDDAs), providers, stakeholder, advocacy groups and the state can improve outreach and education efforts for individuals with IDD.

1. Everyone must recognize that education is an ongoing challenge that requires ongoing efforts.
2. Information must be made available to individuals, their LARs and family members in as many different methods as possible (i.e. brochures, promotional materials such as magnets, letters, flowcharts, video clips/You tube, and workflows, etc.).
3. Consistent messaging is critical. Information provided to individuals/LARs must be consistent with the information given to providers and stakeholders.
4. Literature must be at a reading level that all can understand.
5. Engage self-advocates and family members in the development of educational materials to ensure the materials meet their needs and are understandable.
6. Look at other states to identify strategies other states have used to provide education and outreach to individuals.
 - a. Leverage what has worked well for other states.
7. Host additional listening sessions around the state.
8. Host webinars for individuals with topics that are helpful to individuals and their families (i.e. facts and myths about the IDD acute care carve-in, discuss relevant issues/challenges that are current issues, etc).
 - a. Archive webinar recordings so individuals and providers can access them later.
 - b. Host webinars once every three to four months with various topics of interest to individuals/LARs and family members.
9. Make sure that state resources are equipped to refer individuals to the right place when they call with questions (i.e. 2-1-1 must be able to receive a call and then refer the individual to the appropriate place for assistance).
10. Create a distinct help line with extended hours (i.e. 8 a.m. to 8 p.m.) to address technical questions/issues.

11. MCOs should be encouraged to send quarterly newsletters/communications out to their members and providers with important/critical information.
 - a. Focus on specific topics each quarter
 - b. Providers must have access to the same information so they can help explain the information to the individual if they receive questions about the information.
12. State agencies could send communications to individuals in addition to providers.
13. Provide education and outreach information more frequently and through shorter notifications/communications.
 - a. Re-send updated materials on a regular basis (i.e. quarterly and annually).
14. Train MCO member services staff on how to ask additional questions when members with IDD or their representatives call to assure physician and provider access, better understanding of managed care, and redirecting to other resources in the MCO if needed.
15. Create a distribution list for individuals/LARs and their family members so educational information can go out electronically through text and emails to the individuals on the distribution list (i.e. gov delivery specific for individuals/LARs and family members).

Appendix K
IDD SRAC
Transition to Managed Care subcommittee
Network Access Recommendations

An ongoing challenge that has continued to be expressed through various stakeholder meetings/forums is network adequacy. The Transition to Managed Care subcommittee recognizes this challenge and would like to make the following recommendations to address network adequacy/access.

1. Access to Medicaid Managed Care providers should be an area of focus at the Regional Healthcare Collaboration meetings.
2. A recommendation was made to go to each medical association (specialty) to discuss issues, barriers to contracting and to brainstorm on potential solutions.
3. Look at telemedicine when appropriate.
4. Education for the individual (member), family and friends is critical.
 - Education regarding the role of the MCO service coordinator to help the individual locate a provider.
 - Education regarding the complaint process (i.e. Ombudsman, health plan management)
 - Education about resources available
 - Examine the complaint process to see if the information being collected is beneficial to the individual/LAR.
5. Education campaign through the state, MCOs, provider/medical associations, etc.
 - Each region (based on service delivery area) should have an education campaign
 - Provide education about the access issues and how to work with individuals with IDD to students/educators in medical school residency programs
6. Continued funding for the Delivery System Reform Incentive Payment (DSRIP) projects and Network Access Improvement Program (NAIP) projects.
 - a. Encourage the development of the NAIP educational centers/facilities across the state.
7. In unique circumstances, MCOs can approve doctors that are out-of-network if the individual is unable to find a provider. However, some services require prior authorization so this could be a challenge.