Overview of IDD Service System Redesign (SB 7 - Nelson - 83rd Texas Legislature)

KEY BILL PROVISIONS RELATED TO THE REDESIGN OF THE IDD SERVICE SYSTEM

Bill Directive	Summary of Directive
General Overview	SB 7 (Senator Jane Nelson), passed by the 83rd Texas Legislature on 5/26/13, has been sent to the Governor for his signature. The intent of SB 7 is to improve the delivery and quality of Medicaid acute care services and Medicaid long term services and supports by placing the management and coordination of these services under a managed care service delivery model, such as STAR +PLUS. While SB 7 calls for reform in various Medicaid programs, this document focuses only on changes to the IDD service system that are of importance to persons receiving services in these programs and their families. In reviewing the information please note the following: 1. It is based on our understanding to date. New information and interpretations regarding intent will be shared as received. 2. A glossary of definitions and acronyms is provided on page 7. 3. The IDD system redesign calls for changes in **both** the provision of **one's acute care** (medically-related) services and **one's long term services and supports** (all other services that assist persons to reside in the community): ~ Changes in how one's **acute care services** are delivered are targeted **to occur first** (beginning 9-1-14); ~ Changes in how one's **long term services and supports** are delivered are **to occur later** (see timelines below). **Note:** The above means that your family member will most likely experience a change in how his/her medical services are provided before experiencing a change in how his/her other services are delivered. Depending on decisions HHSC makes as it attempts to 'roll out' these initiatives or changes made by future Legislatures (i.e., the 84th or 85th Texas Legislatures), it is also possible your family member may experience no changes, only a change in his/her acute care services or changes in both his/her acute care and long term services and supports.
Services Affected	Community-based ICF-IID programs and the following IDD waiver programs: HCS, CLASS, TxHmL and DBMD. **Note:** State Supported Living Centers (SSLCs) are exempt.
Timelines	**10-1-13:** Establishment of the IDD Redesign Advisory Committee **9-1-14:** Implementation of the Community First Choice (CFC) Option; i.e., provision of basic attendant and habilitation services to 11,902 persons on the current DADS' HCS, CLASS and DBMD Interest Lists **9-1-14:** Transition of acute care services under STAR +PLUS (possibility exists for this to occur in phases) **9-1-16:** Implementation of the pilots to test capitated managed care strategies **9-1-17:** Transition of TxHmL services and benefits under STAR +PLUS or the managed care model selected by HHSC **9-1-20:** Transition of services and benefits related to ICF-IID and other waivers (HCS, CLASS & DBMD) under STAR +PLUS or the managed care model selected by HHSC

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IDD Advisory Committee	HHSC and DADS are authorized to appoint committee members which include a host of persons and entities integral to the development of the IDD system redesign. Although not inclusive, the committee is to be comprised of persons receiving IDD waiver and community based ICF-IID services as well as providers and/or advocates of these services, Local IDD Authorities, representatives of managed care organizations and physicians. The committee's charge includes advising HHSC and DADS on all aspects of the system design, including the pilots, the CFC Option, the transition of current ICF-IID and IDD waiver services and benefits under a managed care model, a 'new' assessment tool and a process for requesting and receiving residential services, the development of low-cost, flexible housing options and the numerous reports on all of these directives that must be prepared and submitted to the legislature. **Note:** In addition to input from the committee, DADS must also seek statewide stakeholder input on all initiatives.
Transfer of Acute Care Services to STAR +PLUS	Calls for the transfer of acute care (medical and other healthcare related) services from the current process (traditional fee-for-service) to the most cost-effective capitated managed care model. (most likely, the STAR +PLUS managed care model) on 9-1-14. **Note:** Responses vary as to when acute care services will transfer: **S**ome note 9-1-14; **S**ome note 9-1-14 is a 'solid' for all except *dual eligibles* (Medicaid and Medicare) which will not transfer until 9-1-16. **O**thers note it will occur in accordance with the 'transition' dates targeted for each affected program. If correct, in this latter case, as transition of HCS services and benefits is targeted for not later than 9-1-20, transfer of one's acute care services to a managed care arrangement would occur then. Regardless of the date, transfer of acute care services under a managed care model for all will occur - and for many, as early as 9-1-14. Although mandatory participation in a Medicaid capitated managed care program for all persons eligible for acute care benefits is required, the bill also allows HHSC to implement alternative models or arrangements, **including a traditional fee-for-service arrangement,** if the alternative would be more cost-effective or efficient. [See Continuity in Provision of Acute Care Services, page 3.] Requires HHSC to monitor the transfer and provision of these services. **What Does This Mean to You and/or Your Family Member?** Rather than your family member receiving their medical/healthcare needs provided with their 'Medicaid' card, it will be managed by the managed care organization (MCO) that you or your loved one selects for this service. It is possible your family member's current heathcare provider(s) may choose not to contract with the MCOs in your area. In that event, your family member will have to select a healthcare provider who does contract with the MCO you or your family member select. [See Continuity in Provision of Acute Care Services, page 3.] HHSC contracts with MAXIMUS to assist with enrollments in an MCO. It is also possible, under certain circumstances and if HHSC deems such more cost-effective or efficient, your family member may be able to continue to use the traditional fee-for-service system he/she currently uses. **Note:** Initially, rumors were that it may not be feasible for the transfer of acute care services to a managed care model for persons receiving ICF-IID services. During a meeting with agency staff on May 31, 2013, this rumor was dispelled.

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Continuity in the Provision of Acute Care Services	Requires HHSC to develop processes to ensure persons have choice and that their healthcare needs are not compromised when acute care services are placed under STAR +PLUS, referencing processes currently used under STAR +PLUS to assure this. Requires that, upon transition of acute care services to STAR +PLUS, HHSC must monitor the provision of those services. Calls for the House Human Services and Senate Health and Human Services Committees to examine the impact on persons in nursing homes receiving services under STAR +PLUS. [*It is our hope that the charge can be expanded to include the IDD population*.] **What Does This Mean to You and/or Your Family Member?** Inclusion of processes in SB 7 to assure that persons' healthcare needs were not compromised was one of the major issues advocated for by many stakeholders. The reason was based on the experiences of persons currently having their health care needs managed by an MCO and the more recent experiences of persons in the HCS, CLASS, TxHmL and other waivers whose acute care services were transferred under a managed care model last summer. *Example*: As the result of some persons' physicians choosing not to contract with an MCO, some are now receiving care from a physician whose practice is in another city. Although the bill's directives do not include some of the more specific policies and assurances that were advocated for, the current processes have not gone far enough in assuring continuity in the delivery of one's medical needs. The SB 7 directives will thus strengthen any current processes used by HHSC to assure a person's access to and continuity in healthcare treatment.
Pilot Programs	Calls for one or more pilots to test a capitated managed care service model for persons with IDD to begin not later than 9-1-16. Pilots may be for only 24 months; DADS is required to select the region in which the pilot is established . Pilot proposals may be submitted by any private provider; DADS will select the proposal(s) that meets the criteria called for in the bill. Participation is voluntary; i.e., persons in ICF, HCS, CLASS, TxHmL or DBMD services or their LAR **will be able to choose whether or not to participate in a pilot.** Requires that persons served in the pilot must have access to a facilitated, person-centered plan. **What Does This Mean to You and/or Your Family Member?** As we understand, unless your provider submits a pilot proposal (and is selected), this stage of the system redesign will not affect you. Moreover, even if your provider chooses to establish a pilot, you or your family member will have the option to not participate in it.
CFC Option	Established under the Affordable Care Act, this program will provide basic attendant and habilitation services under the STAR + PLUS managed care program and offer voluntary training on how to select, manage, and dismiss CFC attendants beginning 9-1-14. DADS received funds to provide this new service to 11,902 persons on the HCS, CLASS & DBMD Interest Lists (IL). **Notes:** i) Of the 11,902 persons eligible for this service: **8,478** are on the HCS IL; **3,403** on the CLASS IL; and **21** on the DBMD IL. ii) This service will also be available to persons currently enrolled in STAR +PLUS. ***Continued on next page***

Bill Directive	Summary of Directive
CFC Option, *cont'd.*	Defines "Basic attendant services" as assistance with activities of daily living, including instrumental activities of daily living, provided to a person because of a physical, cognitive, or behavioral limitation related to the person's disability or chronic health condition. Defines "Habilitation services" as assistance provided to a person with acquiring, retaining, or improving: skills related to the activities of daily living; and the social and adaptive skills necessary to enable the person to live and fully participate in the community. Specifies that the Local Authority (LA) will serve as the service coordinator, conduct the assessments to determine a person's eligibility for CFC and assist in the development of the person's plan of care. Authorization of the plan will be by the MCO. Allows current HCS, TxHmL & CLASS providers to serve as the provider of this new service. The LA may not be a CFC provider. **What Does This Mean to You and/or Your Family Member?** If your family member currently receives services through the ICF, HCS, CLASS, TxHmL or DBMD program, he/she will not be affected by the CFC implementation. However, if your family member receives services under the Star +PLUS managed care model in the future (as contemplated in SB 7), the CFC service would most likely be available to him/her. If your family member is on the HCS, CLASS or DBMD Interest List, it is possible he/she may be one of the 11.902 persons who will be offered this service.
Transition of TxHmL Services	Calls for the transition of TxHmL long term services and supports/benefits (not later than 9-1-17) under the STAR +PLUS or managed care model selected by HHSC. Requires HHSC to determine whether to: ▪ Continue operation of the TxHmL program for purposes of providing supplemental services and supports not available under the managed care program delivery model selected by HHSC; **or** ▪ Provide all or a portion of the services and supports previously available under the TxHmL program through the managed care program delivery model selected by HHSC. Requires a comprehensive plan for transitioning the Medicaid benefits to protect the continuity of care provided to persons in TxHmL. **What Does This Mean to You and/or Your Family Member?** If your family member currently receives TxHmL services and depending on HHSC's decision noted above, it is possible that in the future your family member will either continue to receive the service as you know it today, **OR** he/she will receive all or some of the TxHmL services under a managed care model. If HHSC determines not to continue the TxHmL program and also determines that it is not cost effective to offer all services currently available through TxHmL in the managed care model, your family member could potentially lose access to one or more of the services he/she currently receives. **Note:** Through the various stakeholder forums held over the last few months, DADS, HHSC and legislative staff have not hinted at any concerns with all TxHmL services being available under the managed care model.

Bill Directive	Summary of Directive
Transition of ICF and Other Waiver Services (HCS, CLASS & DBMD)	Calls for the transition of ICF-IID and IDD waiver services/benefits under STAR +PLUS or the managed care model selected by HHSC not later than 9-1-2020. Requires HHSC to determine whether to: 1. Continue operation of the IDD waiver or ICF-IID programs only for purposes of providing, if applicable: ~ supplemental long-term services and supports not available under the managed care program selected by HHSC; **or** ~ long-term services and supports to waiver program recipients who choose to continue receiving benefits under the waiver program; **OR** 2. Provide all or a portion of the long-term services and supports previously available under the Medicaid waiver programs or ICF-IID program through the managed care program delivery model selected by HHSC. **What Does This Mean to You and/or Your Family Member?** **IF** your family member currently receives services through either the **HCS, CLASS or DBMD** waiver program, depending on HHSC's decision (as noted above), the following possibilities exist: ▪ **Decision #1:** Nothing will change and your family member will continue to receive the service as you know it today, **OR** ▪ **Decision #2:** He/she will have all or only some of the services currently available to them provided through a managed care model. In this case, your family member **will have the option** to choose whether to receive their services through the current waiver in which he/she is enrolled or to receive services (which all or only some may be offered) through the managed care model. **Note:** Under Decision #2, persons choosing to receive their services through a managed care program **may NOT**, at a later time, choose to receive the services under the waiver program. **IF** your family member currently receives services through the **ICF-IID program**, depending on HHSC's decision (as noted above), the following possibilities exist: ▪ **Decision #1:** Nothing will change and your family member will continue to receive the service as you know it today, **OR** ▪ **Decision #2:** He/she will have all or only some of the services currently available to them provided through a managed care model. Unlike persons in waiver services , in this case, your family member **will not be afforded the option** to choose whether to receive their services through the current ICF-IID program in which he/she is enrolled or to receive these services (which all or only some may be offered) through the managed care model.
Provider Qualifications	Before transitioning the provision of Medicaid program benefits under a managed care model, a MCO must demonstrate to the satisfaction of HHSC that its network of providers has experience and expertise in providing services to persons with IDD.

OTHER IDD REDESIGN - RELATED DIRECTIVES

Bill Directive	Summary of Directive
Income Disregards	Requires HHSC to evaluate the need for applying income disregards to persons with IDD receiving benefits under the medical assistance program, including through a Section 1915(c) waiver program and submit to the legislature not later than 1/15/2015. **Note:** A Section 1915 (c) waiver includes HCS, CLASS, TxHmL and DBMD.
Behavioral Supports	Subject to the availability of federal funds, requires the development and implementation of specialized training for providers, family members, caregivers, and first responders providing direct services and supports to persons with IDD and behavioral health needs who are at risk of institutionalization. Directs DADS to establish one or more behavioral health intervention teams to provide services and supports to persons with IDD and behavioral health needs who are at risk of institutionalization. Specification of who must be on the team is included in the bill as well as the type training each must receive.
Comprehensive Assessment and Resource Allocation Process	Requires DADS to develop a comprehensive assessment tool and a resource allocation process to ensure each person receives the type, intensity, and range of services that are appropriate and available, based on a person's functional needs. The assessment will be used in SSLCs, community-based ICF-IIDs and IDD waiver programs (HCS, TxHmL, CLASS and DBMD). Defines "functional need" as the measurement of a person's services and supports needs, including the person's intellectual, psychiatric, medical, and physical support needs. Resource Allocation: DADS must establish a prior authorization process for requests for placing a person in a group home that must ensure that the placement is available only to persons for whom a more independent setting is not appropriate or available. Defines 'group home' as HCS 3 or 4 persons homes .
Low Cost, Flexible Housing	Directs DADS and HHSC to adopt or amend rules related to additional housing options for persons with disabilities including persons with IDD in urban and rural areas. Options that must be included are: (1) a selection of community-based housing options that comprise a continuum of integration, varying from most to least restrictive, that permits individuals to select the most integrated and least restrictive setting appropriate to the individual's needs and preferences; (2) provider-owned & non-provider-owned residential settings; (3) assistance with living more independently; and (4) rental properties with on-site supports. Requires DADS, in concert with TDHCA,TDA and TSAHC to coordinate with federal, state, and local public housing entities to expand opportunities for accessible, affordable, and integrated housing for persons with disabilities including persons with IDD. Requires HHSC and DADS to conduct a study to identify crisis intervention programs currently available to, evaluate the need for appropriate housing for, and develop strategies for serving the needs of persons in this state with Prader-Willi syndrome.

ACRONYMS AND DEFINITIONS

Acronym or Word	Description or Definition
Acute Care Services	Usually refers to physician and/or hospital services of less than three months' duration and includes services such as office visits to a doctor, prescription drugs, behavioral health treatment, emergency room visits, and inpatient hospital services.
Capitation	A method of compensating a provider on a monthly basis for providing or coordinating the provision of a defined set of services and supports that is based on a predetermined payment per services recipient.
CLASS	Community Living Assistance and Support Services waiver program.
DADS	Department of Aging and Disability Services
DBMD	Deaf-Blind with Multiple Disabilities waiver program
Fee-for-Service	Traditional heath care payment system under which physicians and other providers receive payment for each unit of service provided.
HCS	Home and Community-based Services waiver program
HHSC	Texas Health and Human Services Commission
IDD	Intellectual and developmental disabilities
ICF-IID	The Medicaid program serving persons with intellectual and developmental disabilities who receive care in intermediate care facilities.
Income Disregards	The amounts of income, combined with the items which are excluded from consideration as income amounts, deducted in determining one's Medicaid eligibility. Currently federal rules for counting income vary from state to state and also differ based on the category through which an individual is eligible for the program in each state. **Note:** As the result of the Affordable Care Act, starting in 2014 states will no longer be able to maintain their current rules governing disregards and deductions in determining whether someone qualifies for benefits. Instead, there will be a single methodology that will determine how income is counted. This single methodology will standardize and simplify income eligibility across states.
LA	Local intellectual and developmental disability authority
LTSS	Long-Term Services and Supports: Services provided to someone in the home or other community based setting that are necessary to allow the individual to remain in the most integrated setting possible.
Managed Care	A system in which the overall care of a patient is overseen by a single provider or organization as a method of improving quality and controlling costs. The Texas Medicaid managed care system is STAR +PLUS.
MCO	Managed care organization
SC	Service coordination
SSLC	State supported living center
STAR +PLUS	Capitated HMO model for disabled Texas Medicaid clients and dual eligibles (Medicaid and Medicare). Provides both acute care services and long term services and supports.
TDA	Texas Department of Agriculture
TDHCA	Texas Department of Housing and Community Affairs
TSAHC	Texas State Affordable Housing Corporation
TxHmL	Texas Home Living waiver program