Meet Susan. Susan is 35 years old. She has an intellectual disability and a hearing impairment. The intellectual disability limits her conceptual skills, which makes it difficult for her to understand money, time and basic literacy. In addition, she has difficulty with practical skills, requiring support to use the telephone and public transportation. She does not have a driver’s license. However, Susan does not define her life by what she finds difficult, but rather by what she can do. Susan has a part time job at Randall’s, takes good care of her dog and helps her parents cook dinner. She has family and friends and actively participates in her church.

Structuring service delivery—including prevention, acute medical care including primary and specialty care, mental health resources, long-term services and supports, and institutional care—for children and adults with intellectual disabilities requires careful consideration and a focus on both acute needs and life-long planning.

We serve a greater cause. The primary responsibility of Community Centers is to ensure that specialized community-based mental health and intellectual disability services and supports are available to Texans who need them. As new opportunities for improving the system emerge, we remain focused on how to most effectively address the needs of children and adults with intellectual disabilities.

With that responsibility in mind, the Texas Council led an effort through the Healthcare Opportunities Workgroup to consider new possibilities for system design that could more effectively serve Texans with intellectual disabilities.

When determining the key elements of a redesigned system, careful consideration must be given to the impact on individuals, families and communities. The system design must promote access, consumer choice, coordination of services, and quality outcomes—while maintaining local control of important community decisions related to delivery of services for people with intellectual disabilities.
Supporting Individuals and Families

In a time of unprecedented change in the healthcare landscape, it is not surprising that the field of intellectual disability services also faces change. Texas has joined a growing number of states considering an expanded role of Medicaid managed care organizations in an effort to improve cost effectiveness and efficiency of programs for people with intellectual and developmental disabilities.

In 2013, Senate Bill 7 was passed and set forth a vision for the future of Medicaid services for people with intellectual disabilities. The bill directs the incorporation of acute medical care services, including primary and specialty care, and the appropriations bill funds a new attendant/habilitation benefit for people with intellectual disabilities into the Medicaid managed care program by September 2014 (see Appendix A for a list of Medicaid covered acute care services).

The bill also describes a path of options for providing specialized long-term services and supports in the future:

- **Texas Home Living Program (TXHL).** SB 7 contemplates that all or part of the benefits in the Texas Home Living Program will transition into STAR+PLUS or the most appropriate integrated capitated managed care program by September 1, 2017. The Texas Health and Human Services Commission (HHSC) must consider cost-effectiveness and the experience of the STAR+PLUS program in providing basic attendant and habilitation services, along with the experience of the pilot programs authorized by the bill, when determining how to provide the TXHL benefit in the future.

- **Other IDD Waivers, including Home and Community-based Services (HCS).** SB 7 contemplates that all or part of the benefits in the other IDD waivers might transition into STAR+PLUS or the most appropriate integrated capitated managed care program by September 1, 2020. HHSC must consider stakeholder input, cost-effectiveness and the experience of the STAR+PLUS program in providing basic attendant and habilitation services, along with the experience of the pilot programs authorized by the bill, when determining if the programs remains outside of, is partially included or fully included in managed care. In addition, individuals in the waiver services prior to implementation can choose to remain outside of managed care.

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1 In 2010, Rosa’s Law (Pub. L. 111-256) replaced the term "mental retardation" with "intellectual disability" in federal law.
The application of the medical model of managed care, developed for acute care settings, seems incongruent with the current philosophy for intellectual disabilities: person-centered, community-based, long-term services and supports. Before a decision is made on the most appropriate redesign of the current system, we must consider whether necessary adaptations can be made to traditional managed care models in order to ensure people have the supports and services necessary to live successfully in community. We must remain committed to improve, but not lose, a system designed to support person directed planning and individualized services for people with intellectual disabilities and their families.

*Life Long Focus*
Managed care typically achieves savings and improvements by providing administrative controls over the use and cost of services for persons in acute care settings for a specified period of time. For example, in Texas, the greatest savings have been generated in reduced payments to hospitals through more aggressive rate negotiation, reductions in length of stay and prevention of hospitalization. Managing long-term care for persons with intellectual disabilities is quite different.

Managed care organizations and network providers must understand and acknowledge the life-long needs of people with intellectual disabilities. Services must encourage stable and coordinated transitions in both community living and medical care, giving special attention to transitions as individuals age and family circumstances change.

*Stability with Self-Direction*
In addition to a unique life-long focus, the key tenet of services for persons with intellectual disabilities is self-direction. Individuals and their families must have assurance their choices will be respected. The criteria for authorizing services and supports in any future system must be clear, stable and aimed at the critical outcomes defined and expressed by the individual and family. System redesign should expand, not diminish, the choices individuals and families have throughout their lifetime so preferences are honored and opportunities are enhanced.

*Core System Elements*
The Texas Council identified the following core elements required in any new service delivery model for persons with intellectual disabilities, looking at how systems work today and how future systems can be better aligned with the new and dynamic healthcare system.

- Eligibility for Services
- Access to Care
- Service Planning and Resource Allocation
- Coordination of Services and Supports
Eligibility for Services
The home and community-based waiver programs designed for persons with intellectual disabilities have a combination of functional and financial eligibility requirements. By waiving certain regulatory requirements for institutional care, these community-based programs were designed to increase the ability of individuals to live in communities rather than institutions, therefore the financial requirements are equivalent to eligibility for institutional care.

As Senate Bill 7 contemplates eliminating distinct waivers for people with intellectual disabilities and shifting them into managed care, the financial eligibility issue must be addressed. Without distinct waivers, either the financial eligibility for all Medicaid services must be increased or individuals currently in the waivers must be cut from community-based Medicaid program and services unless the 1115 Waiver addresses and maintains current requirements.

As an example, an adult who receives SSDI (as a result of a parent’s death or retirement) greater than the SSI monthly income (74% of the Federal Poverty Level or approximately $8600 per year for an individual) is eligible to receive HCS services as a result of the waiver’s expanded financial eligibility based on institutional level of care. If the state were to limit participation in HCS only to those who have an income at the SSI level these current participants, typically middle-aged dependents of older parents, would lose eligibility for HCS. Decisions on changes to waivers and financial eligibility must be made carefully given the cost to the state or the loss of critical benefits to individuals and families in services.

<table>
<thead>
<tr>
<th>Medicaid Program</th>
<th>Financial Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas Medicaid (including STAR+PLUS)</td>
<td>74% FPL</td>
</tr>
<tr>
<td>Texas Home Living (TXHL)</td>
<td>74% FPL</td>
</tr>
<tr>
<td>Community First Choice Attendant/Habilitation</td>
<td>150% FPL</td>
</tr>
<tr>
<td>Home and Community-based Services (HCS)</td>
<td>220% FPL</td>
</tr>
<tr>
<td>State Supported Living Centers (SSLC) and ICF-IDD</td>
<td>220% FPL</td>
</tr>
</tbody>
</table>

Access to Care
A fundamental component of any health care delivery model is timely access to quality care. For individuals with intellectual disabilities, this includes both medical acute care services and
long-term services and supports. For adults with intellectual disabilities, particularly those with medically complex issues, there is a growing crisis in access to medical acute care services. Some of the more common health conditions among people with intellectual disabilities include motor deficits, epilepsy, allergies, ear infections, gastroesophageal reflux disease (GERD), excessive menstrual pain, sleep disturbances, seizure disorders, mental illness, vision and hearing impairments, oral health problems, and constipation. In addition to medical issues, individuals with intellectual disabilities have significant limitations in intellectual functioning, significant limitations in adaptive behavior and have the onset of the condition before the age of 18.

The life expectancy for individuals with intellectual disabilities has increased significantly over the years, which means many older individuals with medically complex conditions are now in need of adult care and the medical community lags in preparing for this change.

According to the Department of Aging and Disability Services’ (DADS) report, Individuals Who Are Aging with Intellectual and Developmental Disabilities and DADS Services (2012) the older population in the larger IDD programs grew between 2001 and 2010. Program growth over the 10-year period was dominated by expansion of the CLASS and HCS waivers, while the numbers of individuals residing in SSLCs and community ICFs declined due to rebalancing initiatives. Although relatively few individuals over age 60 enrolled in CLASS and HCS but the number of people over 60 in the programs increased more than three-fold in those programs between

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2 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3004690/
2001 and 2010. In SSLCs and community ICFs, the number of individuals over 60 increased despite overall program decrease.

<table>
<thead>
<tr>
<th>Percent Change</th>
<th>CLASS</th>
<th>HCS</th>
<th>SSLC</th>
<th>Community ICF/IID</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 50</td>
<td>185%</td>
<td>410%</td>
<td>-40%</td>
<td>-28%</td>
<td>74%</td>
</tr>
<tr>
<td>51-59</td>
<td>185%</td>
<td>438%</td>
<td>36%</td>
<td>9%</td>
<td>91%</td>
</tr>
<tr>
<td>60+</td>
<td>336%</td>
<td>330%</td>
<td>14%</td>
<td>24%</td>
<td>69%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>186%</td>
<td>407%</td>
<td>-23%</td>
<td>-18%</td>
<td>76%</td>
</tr>
</tbody>
</table>

Increases also show for individuals aged 51 – 59. Thus, the number of individuals with IDD who are aging and served in DADS programs is likely to increase sharply by 2020.

This change in life expectancy, coupled with increased community living, also impacts long-term services and supports. Texas has limited availability of long-term services and supports through waivers by allocating a specified number of slots and maintaining interest lists. As individuals live longer in our communities, the opportunity to access these critical services becomes more limited for other individuals and their families. They wait. Without these services, families fail, crisis services increase, caregivers age and maximizing an individual’s potential falls short.

In the design of a system for individuals with intellectual disabilities, there are three key areas of access that must be addressed to consider the model successful: service availability, provider infrastructure and local crisis response.

**Service Availability**

Based on research and policy documents adopted by the American Association on Intellectual and Developmental Disabilities and The Arc of the US, the following continuum of care—provided in a way that addresses inclusion, quality of life and self-determination—is required to fully address the needs of individuals with intellectual disabilities:

- Prevention
- Early Intervention
- Health, Mental Health, Vision and Dental Care
- Employment
- Housing
Behavioral Supports
Family and Caregiver Supports
Individual Supports
Support Coordination

In addition to the continuum of services, individuals with intellectual disabilities should have choice in how services are managed. For example, waiver services are most often managed directly by service providing agencies, a model consistent with comprehensive, site-based services such as day habilitation and group home residential services. Alternatively, the consumer-directed services (CDS) option allows individual and their representatives to select, hire and manage those who provide the services, and decide when and where services will take place. People using the CDS option for hourly supported home living services may find family, neighbors or friends to work for them (within limits on which relatives may be hired). In order to meet the varying needs of individuals and families, both options for managing services should be available in any service delivery design of the future.

In the existing service delivery model in Texas, long-term care costs to the State are controlled primarily through waiting lists for specialized services and supports for individuals with intellectual disabilities. If HCS and other waiver services are shifted into managed care, the waiting lists for specialized services must be eliminated.

When the Community-based Alternatives (CBA waiver) was incorporated into the STAR+PLUS program, one of the major gains for individuals in need of these services was the elimination of the waiting list for services. The State determined the cost-effectiveness of managed care for the waiver population and services eliminated the need to use waiting list to control costs. Without addressing the waiting list for services for individuals with ID, new service delivery models fall short.

Provider Infrastructure
For people with intellectual disabilities, there is value and importance in existing provider relationships in acute and long-term services and supports. In addition, there is a need for training and education to support and improve the ability of the provider infrastructure to provide needed services and improve quality outcomes.

Acute Care
Acute care services in the Medicaid program include traditional medical care, such as primary and specialty care physicians, therapists and hospitals (see Appendix A for a list of Medicaid covered acute care services). There are two key components for future acute care provider

3 www.ncd.gov/publications/2013/0522013A
infrastructure. The first is preservation of existing expertise in provider networks and value given to longstanding relationships between providers and individuals. Often individuals have long standing relationships with their providers and changes in those relationships can be stressful and disruptive. In addition, given the complex nature of treatment for individuals with intellectual disabilities, there may not be other qualified providers in the individual’s community.

The second key component requires development of new acute care providers with expertise to provide quality services to individuals with intellectual disabilities. With advances in medical care leading to lengthened life-spans, new transitional expertise and access is particularly needed in adult acute care services. This increase in access will only come from a greater availability of training opportunities for all levels of medical providers. This includes increased residency training positions in Transitional Medicine, greater opportunity for Physician Assistants and Advanced Practice Nurses to receive focused training, and training for practicing physicians in communities. In addition to medical providers, families must be educated and informed on how to prepare for health care transition from pediatric to adult care.

**Long-term Services and Supports**

For long-term services and support providers, there is a growing recognition of the need to develop a higher level of expertise for behavioral supports and for supporting individuals with complex medical needs. This expertise is needed both in the provider sector, which is largely private providers, and in the Local Authority’s service coordination role.

In addition, stability of the long-term services and supports provider base is critical given the personal nature of these services. The providers of these services are coming into a person’s home to provide services and provide basic care needs such as dressing and bathing. An individual with intellectual disabilities and the family develop trust and rely on consistency of the provider for these services.

"My daughter Christy is 34 years old and has significant disabilities. Transition from pediatric to adult care for adolescents with medical issues and chronic illness and for adolescents with severe and multiple disabilities can be like a “bridge to nowhere”. Adult health care providers who know how to handle special needs are hard to find, to say the least.”

--Jamie Travis, Texas Council Board Member, Christy’s Mom
As the State contemplates the options for a future design model, significant considerations must be given to the requirements for any system related to provider infrastructure. The future system must:

- Preserve existing provider-individual relationships. This is more difficult in a managed care environment. While HHSC has made provisions for single-case agreements between health plans and providers, the reality is the process is difficult for both parties. As HHSC moves acute care services into managed care and if HHSC were to move IDD services into a managed care model, changes to the single case agreement process must be made to simplify what a provider must do to participate in the MCO network for a single or limited number of individuals. The MCO must create a streamlined process for contracting, credentialing and payment to reduce the administrative burden on the provider. Provider penalties for single-case agreements, such as reduced out-of-network rates and increased prior authorization requirements, should be eliminated.

- Education for providers. Any redesigned system must place emphasis on training the existing acute care provider base to improve knowledge, comfort and attitude toward treating patients with intellectual disabilities. In addition, long-term services and support providers, along with Local Authority service coordinators, should increase training on medical issues for people with intellectual disabilities.

- Meaningful measure of access. When determining if acute and long-term care services are accessible, measures must include if the provider is accepting new patients, if the provider will see an individual with an intellectual disability and length of time to get an appointment. It is inappropriate to assume a contracted provider is available to any patient.

**Local Crisis Response**

Individuals with intellectual disabilities have a high incidence of mental health and behavioral challenges. In the United States, people with intellectual disabilities are four to five times more likely to be diagnosed with the symptoms related to mental illness compared to the general population. This combination of diagnosis often results in referrals to institutional care due to a lack of community-based providers with the expertise to provide needed intervention and support. The capacity of the system to prevent and intervene early in behavioral and other crises must be in place so that people may remain in their homes and communities. Diversion strategies to prevent costly institutional care must be a high priority in any service delivery model.

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4 [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3004690/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3004690/)
The lack of mental health and positive behavioral support services for individuals with intellectual, developmental or autism spectrum disabilities has prompted many Community Centers to develop demonstration projects to address this gap in service. This is a natural fit with the crisis response system that has been developed by Community Centers for individuals in mental health crisis. Several models are available across the state including the nationally recognized START program (Systemic Therapeutic, Assessment, Resource and Treatment model). START provides emergency response 24-7, crisis respite services, clinical assessments and service linkages to providers to increase expertise and service capacity for this population. START does not replace programs such as Home and Community Based waivers, but utilizes trained staff to support the provider network and prevent institutionalization.

Innovations in crisis services should be promoted and expanded in any future service delivery design. Local crisis response is of particular importance in the IDD system when you consider the growing number of people with more extensive needs now receiving services through community-based waiver programs, increased numbers of providers in the system and now the introduction of multiple health plans for acute care. The connection of the individual to a consistent, Local IDD Authority means that when a crisis does occur, the individual is known to the system and one entity is responsible for coordinating responses into a rapid plan of action.

**Service Planning and Resource Allocation**

There has been considerable discussion across states on how to strike the appropriate balance between self-determination, life-long focus and traditional managed care utilization management principles when planning and allocating resources for individual with intellectual disabilities. The needs of the individual are not driven only by IQ but also based on the individual’s life circumstances. Two people with the same diagnosis may have very different needs if one has living parents and one does not. Service planning and resource allocation is more complicated for individuals with IDD compared to a traditional medical model allocating resources for an episode of care. It is easier to plan and allocate for a hip replacement or heart surgery compared to gauging the impact of life events, such as aging parents.

The Person Directed Plan authorizes services on an annual basis. A financial limit is set based on level of need and individuals only use what is necessary.

For example, Michael is a 35 year-old adult with intellectual disabilities living with his parents. The Person Directed Plan includes respite services. In 2012, no respite services were needed or paid for but they remained in the plan for 2013. In 2013, Michael’s parents needed to leave home to be with a dying relative. Respite services were used, without any need for additional authorization at the time the support was needed.
Article 3 of Senate Bill 7 from the 83rd Legislative Session, directs incorporation of a standardized, comprehensive assessment and resource allocation process for all individuals with intellectual disabilities. This assessment, in conjunction with a person directed plan, would serve as the authorization tools for all services. Both the assessment and the service plan should reflect the strengths and goals of the individual and their support networks and ensure that each individual receives the type, intensity, and range of services that are appropriate and available, based on both the unique needs of that individual and their support networks, in order to maintain an appropriate quality of life in the least restrictive environment. As this process is established and modified, it will be important to establish consistency between the assessment, authorization and reauthorization process in order to ensure that individuals receive needed services and supports.

As the system continues to evolve, it is anticipated that an increased emphasis will be placed on outcomes as has occurred in other areas of healthcare. Any comprehensive assessment and resource allocation plan being established should be designed to allow for measurement of outcomes. The measures should be determined in advance and included in models in order to encourage providers of service to strengthen their focus on these areas.

**Coordination of Services and Supports**

Individuals with intellectual disabilities often require support in accessing medical, social, educational, and other services and supports necessary to achieve community participation and an acceptable quality of life. In the current system, Local IDD Service Coordinators support and assist individuals in achieving their personal goals through screening and assessment, service planning and coordination, monitoring and crisis intervention, as necessary. These services are defined by federal and state policy as Targeted Case Management. Services are comprehensive, individualized, and provided at a frequency and intensity necessary to maintain a successful life style.

**Coordination of the Full Array of Services and Supports**

Any fully integrated service system must include a local service coordination component that effectively bridges multiple systems of care to create a manageable system for individuals and families. Improvement to the current system requires working to coordinate and integrate primary and acute medical needs, mental health needs, and long-term services and supports, including community, nursing home and State Supported Living Centers, through personalized,
and independent local IDD service coordination. This is a service based on relationships with individuals, families and communities.

The single point of access and service coordination role of the Local IDD Authority is vitally important in a system that includes more than 400 active private sector HCS providers and five STAR PLUS health plans—collectively serving more than 30,000 people with intellectual and developmental disabilities. In this system, the Local Authority Service Coordination role serves a fundamental public function independent of service delivery, ensuring people with intellectual disabilities are able to freely exercise choice among many providers and health plans, transitioning as necessary over time.

The local IDD service coordination role is person-centered, not program centered, and is provided to individuals with intellectual disabilities regardless of insurance or payer source. The typical caseload is 40 individuals for each LIDDA service coordinator. The face-to-face contacts are required at minimum once per quarter but are often monthly or more frequently if necessary due to crisis or other intensive need. Other contacts, including telephonic, occur with the individual, legally authorized representative, family, providers, non-Medicaid resources and others in the community.

Service Coordination in a Managed Care Environment
In September 2014, acute care services for persons with intellectual disabilities, including primary and specialty medical care, will be included in the State’s Medicaid managed care program. In a managed care environment, the health plans provide service coordinators to authorize and coordinate covered acute care services across managed care network providers. Local IDD Authority service coordinators retain comprehensive responsibilities for person-centered planning and monitoring long-term services and supports, while partnering with health plans to ensure integrated service delivery for people with intellectual disabilities.

There are areas for improvement to better coordinate acute and long-term care systems for people with intellectual disabilities. Formal mechanisms need to be established by the state to permit and facilitate communication and coordination between Local IDD Authorities and health plans on behalf of people with IDD. In addition, this exchange of information and communication must be extended to the individual’s designated representative for both service planning and utilization management decisions. The Local IDD Authority and the individual’s
support network must also have a formal mechanism to discuss enrollment options with the State’s enrollment broker.

The interaction between the Local IDD Authority and health plan provides an opportunity to leverage the expertise and experience of each to enhance coordination of care, create opportunities for innovation and increase efficiency in resolving problems. Although both entities bring a wide-range of experience to the table, the Local IDD Authority can enhance the process through holistic knowledge of the individual and families and on the ground understanding of community resources, while the health plan can provide data management technologies not currently available to the system. This enhanced relationship will assure the full range of services and supports reflect the preferences of the individual, contribute to health and well-being, and minimize risk for higher levels of care.

**New Role for the Local IDD Authority**

In 2013 the state charged Local IDD Authorities with implementing Pre-Admission Screening and Resident Reviews (PASRR) to support people with IDD who are in or at risk of admission to nursing facilities in Texas. Local IDD Authorities also assumed nursing facility service coordination responsibilities as a result of interim settlement negotiations in the *Steward v. Perry* lawsuit.

Federal law and civil rights protections form the foundation of new Local Authority responsibilities. Specialized IDD and mental health services must be provided to people in nursing facilities to assure appropriate levels of care. People must be afforded the choice to live in the most integrated setting and engage in community activities to the full extent practicable.

In supporting people to remain in or return to the community as an alternative to a nursing facility, Local Authority service coordinators conduct focused individual needs assessments, facilitate person-centered service planning and offer education on community living options. Service coordinators obtain expert consultation and have working knowledge regarding medical, nursing, nutritional management and other necessary services.
and supports that must be developed and sustained so that individuals may successfully live and thrive in the community.

**Supporting Health Care Transitions and On-going Care**

In addition to working with individuals, families and managed care organizations, local IDD service coordinators can also play an important role with pediatric and adult providers in serving individuals with IDD. These medical practices report a lack of time to coordinate care for complex patients. Local IDD service coordinators can be of great support during health care transitions and ongoing care.

<table>
<thead>
<tr>
<th>Pediatric Providers</th>
<th>Adult Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty breaking bond with youth and family</td>
<td>Lack of knowledge of pediatric and congenital conditions</td>
</tr>
<tr>
<td>Lack of time for counseling and coordination</td>
<td>Lack of useful medical summary and communication with prior providers</td>
</tr>
<tr>
<td>Lack of reimbursement for transition preparation</td>
<td>Youth not mature/lack self-care knowledge</td>
</tr>
<tr>
<td>Lack of adult providers to refer to</td>
<td>Lack of time/reimbursement for care coordination for complex patients</td>
</tr>
</tbody>
</table>


**Clinical Integrity and Quality Assurance**

Service delivery systems must be accountable for both clinical integrity of the service provided and assurance of the quality of care received. This is typically done through tracking outcome measures and regulating systems to monitor quality.

**Measuring Outcomes**

Measuring outcomes for individuals with intellectual disabilities are two-fold. The traditional medical measures for quality health care are vital and any system must be able to track the medical outcomes specifically for this population. Senate Bill 7 calls for a system to improve quality and reduce potentially preventable events. These types of outcomes can be tracked through existing acute care data measures in the managed care program but must be tracked separately for this population to understand the actual impact of on this population.

In addition, outcome measures for long-term services and supports must align with the goals and desired outcomes of the individual and family. The Person Directed Plan, developed by the individual, family and Local IDD Authority, defines and develops the outcomes for that individual. The provider implementation plan links into the system to achieve the outcomes.
This is critical in both the current and future system design to ensure preservation of the tenets of self-direction and self-determination.

**Quality Assurance**

The Department of Aging and Disability Services (DADS) has played a critical role over time, developing policy, providing oversight and operating programs that demonstrate a deep understanding of the needs of people with intellectual disabilities, their families and their communities. Their expertise provides the leading voice for models that incorporate services, including medical and long-term services and supports, along with an emphasis on self-determination, family involvement and a life long focus.

In addition, DADS plays the lead role for certification, licensure and regulation of providers of long-term services and supports. For HCS and Texas Home Living certification is done on an annual basis and at the program level. Individual staff are not licensed and do not have a Medicaid number. This role is vital in any service model to maintain high quality providers and to ensure protection of individuals in the community. DADS should continue to lead and revise regulatory functions as needed to ensure:

- Continuous monitoring of the health and welfare of each individual who receive home and community-based services and supports or institutional care
- Individual outcomes, associated with services set through the person centered plan, are monitored and reported
- High standards are in place for training for staff who provide services, supports or oversight of the person centered plan
- Quality assurance systems employ methods that maximize individual independence and control

**Public Education**

The acute and long-term care systems for persons with intellectual disabilities have changed over the past several years and will continue to change over the next years. Changing language is a common occurrence in health care delivery, although definitions may or may not directly translate from the old language to the new language. The language change from mental retardation to intellectual disability is an example of a language change in which the definition has stayed the same. Long-term services and supports for individuals with intellectual disabilities look different than long-term services for individuals with physical disabilities. Managed care organizations have service coordinators and Local IDD Authorities have service coordinators, same title but different functions. To eliminate this unnecessary confusion, a change in title for the Local IDD Authority Service Coordination or Health Plan Service Coordination may be warranted.
As changes unfold, stakeholders must remain informed and understand the goals and operational details of any system redesign. As language and systems change, the changes must be clearly articulated to the public.

**Stakeholder Involvement**
Development of any model must incorporate the input of stakeholders in the design and management of a new system. Stakeholders include individuals with intellectual disabilities and their support networks, advocacy organizations, provider organizations and managed care organizations. Senate Bill 7 created an Advisory Committee to advise HHSC and DADS on the implementation of the acute care services and long-term services and supports redesign for individuals with intellectual and developmental disabilities. The SB 7 IDD System Redesign Advisory Committee should be empowered to provide input to HHSC in the development of all reports and legislative recommendations HHSC is required to submit to the Legislature regarding system redesign.

As decisions are made on models of care, stakeholders should have access to education on understanding rights and responsibilities so that informed healthcare decisions can be made. In addition, advocates must be well-versed in system operations including contracts, reporting, outcomes and the appeals process for all programs to ensure the system is held accountable for authorizing vital services for this vulnerable population.

**Informing Support Networks**
With significant changes in the service delivery system, the State must design a plan for education of the support networks of individuals with intellectual disabilities. Support networks may include family members, designated advocates, friends, employers, and/or faith-based and other community organizations. Support networks should receive timely information on system changes, impact to individuals served and information on how to effectively support and advocate for individuals in service in the new system.

**Financing**
The legislature has directed, through Senate Bill 7, that HHSC consider a variety of factors before deciding on how to manage long-term services and supports for individuals with IDD. In addition to stakeholder input, experience with pilot programs and providing attendant and habilitation services, the legislature requires a determination of cost-effectiveness. Understanding the financing of long-term services and supports is critical in determining cost-effectiveness of any model.

**Adequate Rate Structures**
Rate structures should encourage the most appropriate use of services and be adequate to provide quality community-based support services and health care. In acute care, rates should
be structured to encourage providers to open their practices to people with intellectual
disabilities and allow adequate time during visits to address complex needs.
Rate structures should be designed to support the complexity and intensity of the services and
supports needed by individuals.

As focus shifts over the coming years to outcomes and as emphasis increases in areas such as
community employment, rate structures must be reviewed in a timely manner and adjusted as
needed to meet the needs of the changing service delivery system. As part of this process, the
rate structure for targeted case management provided by the IDD Local Authority needs to be
reviewed to ensure the design meets the needs of populations being served, including the
varying intensity of services needed.

As new responsibilities surrounding the Preadmission Screening and Resident Review process
and subsequent case management for individuals in nursing facilities continue to evolve,
current payment models may need to be adjusted in order to ensure reimbursement
methodologies are appropriate to ensure the needs of the individuals are met and appropriate
costs associated with the services are covered.

**Rate Enhancements**
Beginning September 2010, HHSC began the Attendant Compensation Rate Enhancement
(ACRE) program in the HCS, TXHML, and ICF programs to promote stability among direct care
staff. ACRE adds 25 enhanced payment rates per service for which providers may enroll based
on agreeing to spend at least 90% of their total attendant revenues, including enhanced add-on
rate revenues, on attendant compensation which includes salaries, payroll taxes, benefits, and
mileage reimbursement. The ACRE program is divided into day habilitation services and non-
day habilitation services for HCS and TXHML and into day habilitation and residential services
for ICF. ACREs includes the following services at the present time:

As the ACRE program is designed to enhance salaries and benefits for direct care staff, it is
important that any future change in the means for making payment incorporate ACREs into the
payment methodology in order to ensure stability of the provider system.
Assessing Cost-Effectiveness of Managed Care Models

In the existing service delivery model in Texas, long-term care costs are controlled through waiting lists for specialized services and supports for individuals with intellectual disabilities. In addition, the assessment tools sets the Level of Need, which defines the maximum dollar value of benefits for the year per individual. In essence, the state has two significant budget controls existing in the current program: waiting lists and individual budget caps.

Health plans that operate in STAR and STAR+PLUS report 8% to 17% administrative overhead to manage Medicaid funds on behalf of the state (SFY 2012). The 2013 LBB Governmental Efficiency and Effectiveness Report estimates DADS administrative costs at 1%\(^5\). This average 12% administrative cost is substantially higher than the administrative overhead that DADS incurs to manage Medicaid waiver funds. Applying the 12% average in administrative costs for health plans, the legislature would need to appropriate an additional $97 million in general revenue to cover the higher administrative costs otherwise services would be reduced to cover the new costs.\(^6\) When considering the cost-effectiveness of moving long-term services for individuals with IDD into managed care, the current costs of the services, waiting lists and the administrative costs for managed care companies must be considered.

Moving Forward

As Senate Bill 7 contemplates the path forward for managing acute and long-term services and supports for individuals with intellectual disabilities, the legislative body took great care to lay out a process to examine and evaluate all factors before choosing a path for reform.

The Texas Council appreciates the requirements for analysis and evaluation. From our perspective, people with intellectual disabilities and their families today need a protective hand, organized resources and legislative oversight to ensure community living remains a viable option over the course of their live—in much the same way a protective hand, organized resources and legislative action was once necessary to promote development of a community based system as an alternative to institutional care.


\(^6\) This does not include adjustments for either the additional profit retained by insurance companies or the premium tax revenue collected by the Comptroller.
As we consider the future, there are four key pieces that system reform should bring to the Medicaid service delivery system for individuals with IDD and their families. If the system can achieve these gains, then we believe the new system design should move forward.

- Waiting lists for long-term services and supports are eliminated.
- Resources for long-term services and support tailored specifically for the needs of this population must be preserved.
- Community options must be available to individuals who choose them over institutional care.
- Independent service coordination and independent ombudsman services must be available to all individuals with intellectual and developmental disabilities.
Appendix A

Texas Medicaid Acute Care Services

- Ambulance service
- Audiology services, including hearing aids, for adults and children
- Behavioral Health Services
- Prenatal care
- Birthing services
- Cancer screening, diagnostic, and treatment service
- Chiropractic services
- Dialysis
- Durable medical equipment and supplies
- Emergency Services
- Family planning services
- Home health care services
- Hospital services, inpatient and outpatient
- Laboratory
- Mastectomy, breast reconstruction, and related follow-up procedures
- Medical checkups and Comprehensive Care Program (CCP) Services for children
- Oral evaluation and fluoride varnish in the Medical Home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age;
- Optometry, glasses, and contact lenses
- Outpatient drugs and biologicals
- Drugs and biologicals provided in an inpatient setting
- Podiatry
- Prenatal care
- Preventive services including an annual adult well check for patients 21 years of age and over
- Primary care services
- Radiology, imaging, and X-rays
- Specialty physician services
- Therapies – physical, occupational and speech
- Transplantation of organs and tissues
- Vision services