TEXAS
Department of Aging and Disability Services

Senate Committee on Health and Human Services
Interim Charge #5

Department of Aging and Disability Services

Commissioner Chris Traylor

July 31, 2012

Eligibility

- To qualify for Medicaid long-term services and supports, individuals must meet both financial and functional eligibility criteria.

- Eligibility criteria vary across different programs and services.

- The Health and Human Services Commission (HHSC) determines financial eligibility, while the Department of Aging and Disability Services (DADS) or a DADS contracted partner agency is responsible for functional eligibility.

Eligibility

- Financial Medicaid eligibility is automatically established if a person is eligible for Supplemental Security Income (SSI).
  - SSI is a federal income supplement program designed to help people who are aging, blind or have disabilities and who have little or no income.
- If a person is not SSI eligible or not currently financially eligible:
  - HHSC determines financial eligibility for home and community based waiver programs using the same criteria for persons in institutional settings. (Income level 300% of SSI income level, or $2,094 per month for an individual.)
- Functional eligibility is defined as an individual's need for services resulting from a physical, intellectual or developmental disability.

Medicaid Waivers

Federal laws and regulations provide flexibility for states to design waiver programs to address the needs of a specific population.

- A “waiver” is an exception to the usual Medicaid requirements, granted to a state by the Centers for Medicare and Medicaid Services (CMS), to provide services in home and community-based settings rather than an institution.
- A state’s authority for waivers comes from the federal Social Security Act.
- A state must ensure cost neutrality of a waiver compared to the cost of the institutional entitlement.

Medicaid Waivers

- Waiver programs provide community-based services and supports to an individual who would have qualified for admission to a nursing facility or an intermediate care facility for individuals with an intellectual disability or a related condition (ICF/IID) (waive off either nursing facility or ICF/IID eligibility).
- Unlike the entitlements, which are automatically available to individuals statewide who meet the eligibility criteria, waiver programs can limit:
  - Scope of eligibility
  - Geographical location in which services are provided
  - Scope of services
  - Amount of services
  - Number of people served
  - Delivery model of services

DADS Medicaid Waiver Programs

Nursing Facility Waiver Programs

- Community Based Alternatives (CBA)
- Medically Dependent Children Program (MDCP)

ICF/IID Waiver Programs

- Home and Community-based Services (HCS)
- Community Living Assistance and Support Services (CLASS)
- Texas Home Living (TxHmL)
- Deaf Blind with Multiple Disabilities (DBMD)

Case Management and Service Provision

Waiver/State Plan Service	Case Management	Functional Assessment	Direct Services	Consumer Directed Service (CDS) Option	Utilization Review	Clarifications
Community Based Alternatives (**CBA**)	DADS	HCSSA completes the Medical Necessity and Level of Care (MN/LOC) *** DADS completes the Needs Assessment *** Medicaid claims administrator makes determination	HCSSA	Yes	DADS	
Medically Dependent Children Program (**MDCP**)	DADS	DADS completes the MN/LOC *** Medicaid claims administrator makes determination	HCSSA or DADS contracted provider	Yes	DADS	
Home and Community-based Services (**HCS**)	Local authority	Local authority completes enrollment assessment *** HCS provider completes ongoing assessment *** DADS completes authorization	DADS contracted provider; some local authorities are also HCS providers	Yes	DADS	DADS has final approval on programmatic eligibility

NOTE: Financial eligibility is determined by Medicaid for the Elderly and People with Disabilities (MEPD) when there is no existing Medicaid coverage.

Case Management and Service Provision

Waiver/State Plan Service	Case Management	Functional Assessment	Direct Services	Consumer Directed Service (CDS) Option	Utilization Review	Clarifications
Community Living Assistance And Support Services (**CLASS**)	Case Management Agency	Direct Service Agency (DSA) completes assessment *** DADS completes authorization	HCSSA	Yes	DADS	DADS has final approval on program enrollment
Deaf Blind with Multiple Disabilities (**DBMD**)	Provider Agency	Provider Agency completes assessment *** DADS completes authorization	HCSSA and/or ALF	Yes	DADS	DADS has final approval on program enrollment
Texas Home Living (**TxHmL**)	Local authority	Local authorities make assessments *** DADS completes authorization	DADS contracted provider; some local authorities are also TxHmL providers	Yes	DADS	DADS has final approval on programmatic eligibility

NOTE: Financial eligibility is determined by Medicaid for the Elderly and People with Disabilities (MEPD) when there is no existing Medicaid coverage.

Strategies to Lower Costs and Improve Services

- Conduct utilization management and review across all entitlement and waiver programs to ensure individuals receive the services and supports they need – no more and no less.
- Types of reviews include:
  - concurrent (randomly sampled individuals currently enrolled in the program)
  - prospective (pre-authorization reviews based on specific program criteria or thresholds)
  - Medical Necessity/Level of Need reviews
  - retrospective reviews (hospice only)
- Methods include:
  - face-to-face visits with individuals receiving services
  - desk reviews of service justification documentation
  - combination of face-to-face and desk review
- Utilization review conducted by DADS registered nurses and Qualified Intellectual Disability Professionals.

Parental Income

- TxHmL is the only waiver program that considers parental income in the financial eligibility determination process, since eligibility for this program is based on SSI eligibility.
- States have the option under federal rules to require parents to contribute to the cost of their children's care.
- Cost-sharing can be requested through co-payments or premiums in accordance with federal regulations.
- Only certain families would be eligible for cost-sharing, depending on the family income, and federal regulations protect specific groups of individuals from cost-sharing.

Ability to Enforce Cost Sharing

- Participation in cost-sharing would have to be voluntary for DADS programs.

- Because of the Maintenance of Effort requirements of the Affordable Care Act, the state, until 2019, cannot deny services to a child for the parent's failure to contribute to the cost of the child's care.

Policy in Other States

- Examples of states that have implemented parental fee programs:
  - Idaho, Kansas, Minnesota and Wisconsin
- Idaho:
  - collects fees if family income is 185% of Federal Poverty Level (FPL) or greater.
  - fees range from 0.54% to 5%, based on monthly gross income.
  - fees are capped at $241.60 per week.
- Kansas:
  - collects fees if family income is 200% of FPL or greater.
  - **does not** deny services to a child if the parent fails to pay the fee.
  - individuals at 200% of FPL pay a $10 monthly fee; individuals at 601% of FPL pay a $174 monthly fee.
- Minnesota:
  - families with income between 100% - 174% of FPL are charged $4 monthly fee.
  - sliding fee scale could range from 1% - 13.5%, based on family's adjusted gross income.
- Wisconsin:
  - collects fees if the family income is 330% of FPL or greater.
  - **does** deny services to a child if the parent fails to pay the fee.
  - charges an annual fee between 1% - 41% of service costs, depending on the family's income.

Parental Supports

- Parents provide extensive support to children with medical needs.
- Medicaid entitlement and waiver programs complement parental support.
- Parents may not receive payment for supports they are obligated to provide their children
- CMS directs states to ensure waiver services do not supplant the supports parents are obligated to provide including:
  - food, clothing, shelter, child care, education and medical and dental care beyond what is reimbursed through Medicaid; and
  - participation in service planning.

Coordination of Acute and Long-Term Care Services

- Two community based programs currently integrate acute care and Long-Term Services and Supports (LTSS).
  - Program of All-inclusive Care for the Elderly (PACE):
    - Uses a comprehensive care approach, providing an array of services for a capitated monthly fee.
    - Provides all health-related services, including in-patient and out-patient medical care and specialty services such as dentistry, podiatry, social services, in-home care, meals, transportation, day activities and housing assistance.
    - Currently provides community based services in El Paso, Amarillo and Lubbock for individuals age 55 or older who qualify for nursing facility admission.
  - STAR+PLUS:
    - Managed care organizations are responsible for coordinating acute care and long-term services and supports through the use of a service coordinator.
    - Services can be provided to individuals age 21 or older who qualify for nursing facility admission and who live at home or in a contracted assisted living facility.

Coordination of Acute and LTSS - Waiver Provider Incentives

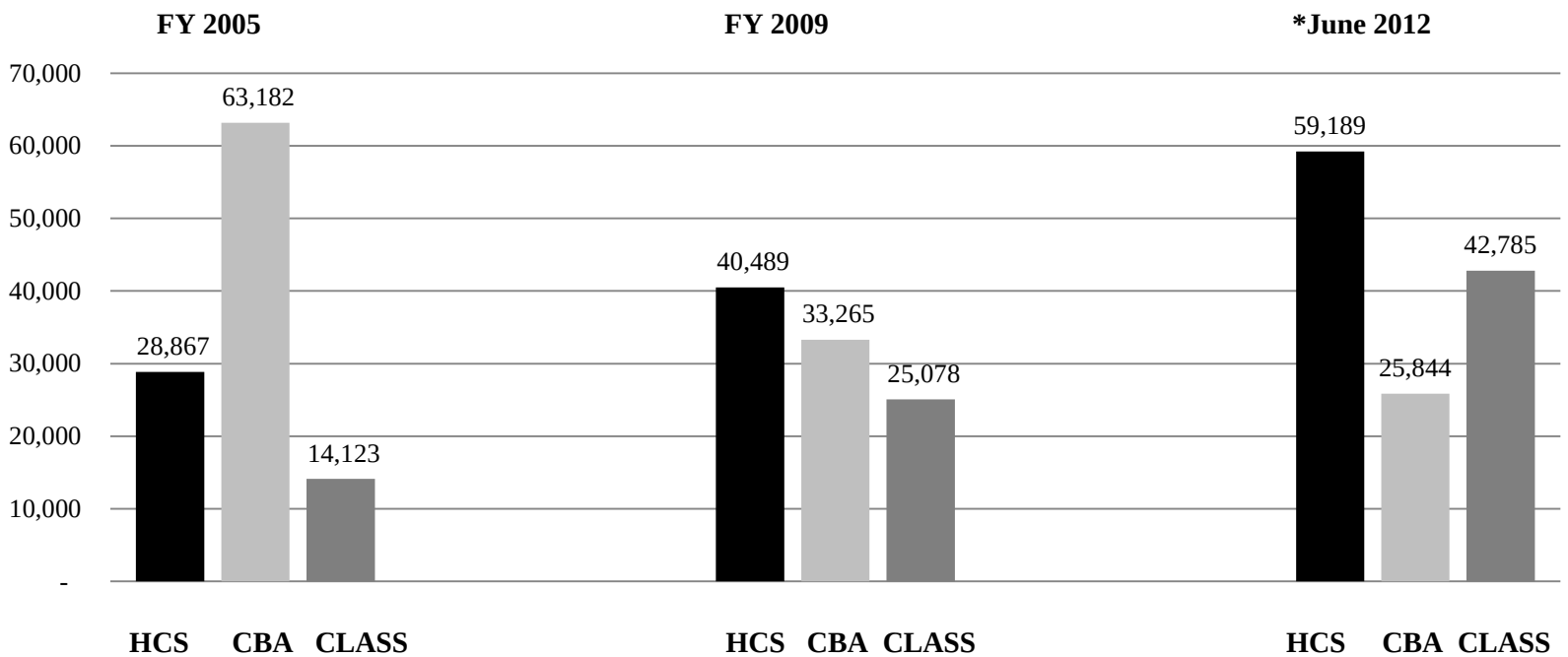
- Opportunities for outcome based payments:
  - Texas could develop quality payments to community LTSS providers based on measurable acute care outcomes. For example:
    - TMF Health Quality Institute CMS Care Transitions Project:
      - The project's goal was to reduce 30-day rehospitalizations by a minimum of 2% through improved quality of patient transitions.
      - Included 14 communities in the U.S., including Harlingen Hospital Referral Region, which included Cameron, Hidalgo, and Willacy counties.
      - Six hospitals and numerous other providers participated, including 16 skilled nursing facilities, 50 home health agencies and three in-patient rehabilitation facilities.
    - Outcomes:
      - Rehospitalizations from home health agencies decreased from 16.5% to 12.5%.
      - Rehospitalizations from skilled nursing facilities decreased from 29% to 23.8%.
      - Rehospitalizations from in-patient rehabilitation facilities decreased from 16.7% to 16.3%.

Demographic Trends

- Life expectancy for individuals with intellectual and developmental disabilities (IDD) has steadily increased over the last several decades.
  - Average age at death for persons with IDD increased from 18.5 years to 66.2 years over six decades (an increase of 258%) .
  - Life expectancy for people with IDD is similar to that of the general population, ranging from the mid 50s for those with more severe disability, to the early 70s for adults with mild/moderate IDD.
- The number of adults in the U.S. with IDD age 60 years and older is projected to nearly double from 641,860 in 2000 to 1.2 million by 2030.
- DADS IDD programs serve approximately 3,000 people who are over age 60.
  - Between 2001 and 2011, the number of people over 60 receiving services in ICFs/IID, SSLC s, or IDD waivers increased by 84%.
  - During this same period, the percentage of State Supported Living Center (SSLC) residents over the age of 60 increased from 11% to 18%.
- As the baby boom generation ages, further increases are expected.
  - Even if no new enrollment occurs, we can expect a 40% increase in the number of people over 60 receiving IDD services in the next 10 years.
- There is a significant number of individuals with behavioral health needs.
  - Nearly two-thirds of the overall SSLC population has a dual diagnosis.
  - 36% of individuals in the HCS waiver have a dual diagnosis.

Interest Lists

Number of Individuals on Interest Lists for Selected Waivers



*** CBA counts include individuals on the IL for CBA as well as STARPLUS**

Community First Choice (CFC)

- Would provide HHSC and DADS an ongoing 6% enhanced Federal Medical Assistance Percentage to provide community-based attendant services and supports through a state plan amendment.

- Services must be provided on a statewide basis without regard to age, type or nature of disability, severity of disability, or the type of community-based attendant services and supports the individual needs to lead an independent life.

- Participating states must provide attendant services to assist with activities of daily living, instrumental activities of daily living, and health related tasks through hands-on assistance, supervision and/or cueing.

Current System Challenges

- Concern that waiver program costs may limit the state's ability to serve more people
- Desire to serve more people in a cost effective manner by providing the type and amount of services most appropriate to their needs
- Need to provide individuals with behavioral support services
- Desire for increased flexibility in housing

SB 7 Redesign Objectives

- Cost effective system
  - Allows for increased number of people to be served
- Improved access - a better coordinated information and assessment process would ensure individuals:
  - receive information about all available programs and services and how to apply for services;
  - are assessed using tools that yield consistent and reliable results across the state; and
  - receive the scope, amount, and duration of services they need without receiving a package of services they may not need.
- Coordination of acute and LTSS

SB 7 Redesign Objectives

- Increased quality
  - Explore an outcome based reimbursement system to promote better quality of care and reduce acute care expenditures
- Person Centered – any redesigned LTSS system must be person centered, ensuring that individuals:
  - are actively involved in their service plan development;
  - can easily learn about and apply for LTSS;
  - are aware of, and can easily access the consumer directed services option for all LTSS; and
  - receive services based on the needs identified in the individual's assessment.

LTSS Redesign for Individuals with IDD

New 1115 Waiver

- Would test multiple IDD service delivery models, including capitated and non-capitated models.
- All models would include:
  - Robust objective assessment process that more precisely connects services to actual needs
  - Service coordination (acute and LTSS)
  - Behavioral intervention teams to provide intensive, short term behavioral support services
  - Extensive stakeholder involvement

Coordination with DFPS for Children in Conservatorships

- As of June 30, 2012 there are 64 children with IDD in DFPS licensed facilities.
  - DFPS receives 192 priority HCS waiver slots per biennium for DFPS youth transitioning out of foster care to provide the necessary resources for their continued care.
  - DADS and DFPS have been working to better utilize HCS to ease the transition from a DFPS licensed facility to the community.

- DADS has reserved ten HCS waiver slots for children in DFPS conservatorship and residing in General Residential Operations (GROs).
  - The ten slots (five each year) are being carved out of current HCS appropriations.
  - GROs are DFPS–licensed facilities that provide residential child-care to 13 or more children or young adults.
  - These operations include residential treatment centers and formerly titled operations known as emergency shelters, basic child care operations and operations serving children with an intellectual disability.

APPENDIX

Eligibility and Enrollment Process
Community Based Alternatives (CBA)

- Individuals age 21 years and older.
- DADS case managers conduct face-to-face, in home assessments to determine need for services.
- A home health agency conducts a medical necessity and level of care (MN/LOC) assessment (Minimum Data Set (MDS) based).
- The State's Medicaid contractor determines the medical necessity and the level of care based on the Resource Utilization Group (RUG).
- DADS case managers finalize the individual service plan and authorize the services.
- Services can be received in home, assisted living or adult foster care settings.

Eligibility and Enrollment Process
Medically Dependent Children Program (MDCP)

- Individuals age 20 years and younger.
- DADS case managers conduct face-to-face, in home assessments to determine need for program services.
- DADS registered nurses conduct a medical necessity and level of care (MN/LOC) assessment (MDS based).
- The State's Medicaid contractor determines the medical necessity and level of care based on the RUG.
- DADS case managers finalize the individual service plan and authorize the services.
- The individual must live with a family member or with a foster family (no more than four children are unrelated).

Eligibility and Enrollment Process
Home and Community-based Services (HCS) & Texas Home Living (TxHmL)

- No age limit.
- Local Authority assesses and documents eligibility to ensure the individual:
  - Has a primary diagnosis of intellectual disability or related condition (e.g., autism, cerebral palsy, spina bifida, down syndrome) with coexisting cognitive deficit (I.Q. of 75 or less).
  - Has mild to extreme impairment in adaptive functioning (e.g., requires ongoing assistance with activities of daily living, behavior intervention).
- Service planning team develops individual plan of care in accordance with the individual's person directed plan.
- DADS staff reviews the proposed plan and authorizes the enrollment.

Eligibility and Enrollment Process
Community Living Assistance and Support Services (CLASS)

- No age limit.
- Direct service agency assesses and documents eligibility to ensure the individual:
  - Has a primary diagnosis of related condition (e.g., autism, cerebral palsy, spina bifida, down syndrome).
  - Has moderate to extreme impairment in adaptive functioning (e.g., requires ongoing assistance with activities of daily living, behavior intervention).
  - Has an ongoing need for habilitation services that support an individual to reside in a community setting. Services can include training an individual to acquire, retain and improve self-help, socialization and daily living skills or assisting the individual with activities of daily living.
- Direct services agency registered nurses conduct face-to-face assessments to determine if required criteria are met.
- Service planning team develops individual plan of care.
- DADS staff reviews the individual plan of care and, if appropriate, authorizes funding for services.

Eligibility and Enrollment Process
Deaf Blind with Multiple Disabilities (DBMD)

- No age limit.
- Provider agency assesses and documents eligibility to ensure the individual:
  - Has a primary diagnosis of deaf blindness or a condition that leads to deaf blindness (can have a diagnosis of rubella or Charge syndrome) and have a coexisting disability (e.g., intellectual disability, related condition).
  - Has moderate to extreme impairment in adaptive functioning (e.g., requires ongoing assistance with activities of daily living, behavior intervention).
- Provider agency staff conducts face-to-face assessments to determine if required criteria are met.
- Service planning team develops individual plan of care.
- DADS staff reviews the individual plan of care and, if appropriate, authorizes funding for services.

People with IDD in the General Population (estimates)

We have broad estimates of the number of people in Texas who have an intellectual or developmental disability:

	Total	Any ID or DD	ID Only	Priority Population	Autism Spectrum Disorders	Any Special Education
Total	25,149,000	453,000	176,000	126,000	276,600	N/A
21 and over	17,155,000	309,000	120,000	86,000	188, 700	N/A
Under 21	7,991,000	144,000	56,000	40,000	87,900	443,000
Under 18	6,866,000	124,000	48,000	34,000	75,500	N/A
Estimated Percentage of the Total Population	100%	1.80%	0.70%	0.50%	1.1%	9%