
HMA

HEALTH MANAGEMENT ASSOCIATES

*Final Report
Pilot to Serve Persons with
Intellectual and Developmental Disabilities*

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*Research and Consulting in the Fields of Health and Human Services Policy, Health Economics
and Finance, Program Evaluation, Data Analysis, and Health System Restructuring*

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TABLE OF CONTENTS

Executive Summary	2
Introduction	4
Project Overview	5
Analysis of Four States	7
Overview of Texas System.....	16
Description of Proposed Options	21
Summary of Stakeholder Input.....	27
Overview of HMA “Findings”	29
Pilot Recommendation and Rationale.....	40
Pilot Design for a Non-Capitated Care Management Program	43
Pilot Duration and Evaluation.....	43
Geographic Scope.....	44
Utilization Management / Utilization Review	44
Use of a Standard Assessment Tool.....	46
Provider Network	48
Service Coordination	48
Waiver Development and Timelines	49
Opportunities Under Federal Reform	50
Pilot Costs.....	50
What Federal Requirements State Must Meet.....	53
Pilot’s Effect on Preventing Institutionalization	53
Main Barriers to Implementing the Pilot	53
Required Changes to State Policy	54
Conclusion	55
Appendices	56
Appendix A: Texas HCBS Waiver Crosswalk.....	56
Appendix B: STAR+PLUS Experience Rebate.....	60
Appendix C: Overview of Louisiana’s Per Case Rate-Setting Initiative	62
Appendix D: Cost Savings Analysis of a Capitated Fully Integrated Managed Care Pilot.....	63

EXECUTIVE SUMMARY

The 81st Texas Legislature directed the Texas Health and Human Services Commission (HHSC) and the Texas Department of Aging and Disability Services (DADS) to develop a plan to implement a managed care pilot for individuals with Intellectual and Developmental Disabilities (I/DD). HHSC contracted with Health Management Associates (HMA) to develop a recommended pilot model and implementation plan.

In order to develop a recommended pilot model, HMA reviewed other state systems, sought stakeholder input, reviewed data regarding I/DD service utilization and costs, and developed costs savings estimates related to possible options for the pilot model.

HMA developed three proposed pilot options for consideration and shared these options with stakeholders and tested the cost savings opportunities of these options. The three pilot options proposed by HMA were:

- Option 1: Non-Capitated Enhanced Care Management;
- Option 2: Capitated, Non-Integrated, Managed Long-term Care; and
- Option 3: Capitated, Integrated, Managed Long-term Care.

HMA's analysis of cost savings estimated that the capitated models are not likely to yield net savings to the State without applying savings assumptions that would be unjustified, given the lack of data regarding the level of cost inefficiencies in the Texas I/DD system. Additionally, HMA's analysis found little evidence to support cost savings by managing acute care services under a capitated model. In the absence of the ability to achieve cost savings under a capitated model, HMA recommends that Texas pursue a pilot that includes the key elements described in Option 1: Non-Capitated Enhanced Care Management.

The selection of Option One, a Non-Capitated Enhanced Care Management Model, was informed by the need to identify and pursue strategies to make waiver services more cost-effective, which is a critical component to funding additional waiver slots. Piloting this model would provide an opportunity for Texas to test strategies such as use of utilization management guidelines and development of more cost-effective forms of residential care while avoiding a major redesign of the I/DD service system until there is evidence to justify this level of change.

This recommendation against using a capitated model should not be interpreted to mean that capitation is not an appropriate model for the I/DD services. Capitation offers some significant benefits. These benefits include the ability to offer more flexible services, integrate care and make resource decisions based on cost-effectiveness. Additionally, the movement away from more costly and generally more restrictive provider-owned housing to other supported living options, when appropriate, would likely be accelerated under a managed care model because the managing entity would have a significant financial incentive to provide the most cost-effective service. However, the potential benefits of capitation do not outweigh the costs of the pilot at this time. In order to be cost-effective, the overhead and administrative costs associated with a capitated model would need to be reduced.

While a capitated model that used the Mental Retardation Authorities (MRAs) to manage I/DD services (a possible scenario within Option Two) would eliminate some of the administrative costs associated with use of commercial MCOs, it could pose risks for the financial viability of the MRAs, which have limited managed care experience, and for consumers, since capitation creates incentives to reduce service levels in ways that may not be clinically appropriate. Although these risks can be managed by strong state oversight and use of risk-sharing arrangements to minimize the financial exposure of MRAs, there is not enough evidence that capitation would create savings sufficient to justify the risks and effort involved with significantly restructuring the I/DD service delivery system.

Thus, the recommendation to pursue Option One is an acknowledgement that before Texas can make an informed decision about whether capitation is an effective model for I/DD services, Texas should first test two assumptions:

1. that management of I/DD services offers opportunities for savings; and
2. that MRAs, if given the necessary tools and latitude, can apply the tools of managed care to harness these savings.

A pilot using a Non-Capitated Enhanced Care Management approach can serve as a tool for the State to test these assumptions. Additionally, a key focus of the pilot would be developing cost-efficiencies with the Home and Community-based Services (HCS) waiver that could translate to funding new waiver slots.

In order to make informed decisions about how to structure I/DD services in the future, HHSC and DADS will need to carefully evaluate the impact of the pilot. Ultimately, the evaluation of the pilot will need to determine if the savings potential is of sufficient magnitude to purchase additional waiver slots and therefore justify expansion of the pilot to a statewide redesign of the I/DD service system.

HMA recommends that the pilot be conducted for a three-year period. The pilot will entail costs to the State, but these costs are estimated to be outweighed by potential savings achieved by increased management and oversight of I/DD services.

This pilot would not address other elements of the Texas I/DD system that stakeholders have almost uniformly expressed concern with, namely the imbalance of Texas' investment in community-based services verses institutional services. While this pilot can help Texas achieve cost efficiencies within community-based I/DD services, specifically those services within the HCS waiver, it would not correct this historic imbalance.

INTRODUCTION

As a result of legislative direction, HHSC and DADS are considering how to best develop a managed care pilot to provide services to people with I/DD. Managed care for people with I/DD is still a relatively new approach. Only a few states have implemented managed care that includes long-term care services for people with I/DD. In these states, the managing entity is the traditional community-based providers or the state agency serving persons with I/DD rather than commercially managed MCOs.

The limited experience of states in using managed care models for people with I/DD is largely a reflection of the significant challenges to implementing managed care for I/DD services. People with I/DD generally have long-term support needs that are focused on daily, consistent habilitation. Given this, their service patterns tend to offer less obvious and less apparent opportunities for savings than service patterns for people with more episodic patterns of care—such as people with mental illness or acute medical care needs. In states that have implemented managed long-term care, there is generally less certainty about the potential for savings from managing acute care services for people with I/DD (hospital, physician services, etc.).

However, a handful of states have adopted managed care approaches for I/DD services that appear to have met some key objectives, such as increasing access to services, allowing for more flexibility in services offered, and helping to “rebalance” the I/DD service system toward a greater use of home and community-based services. While managed care is a relatively new approach for I/DD services, there are some state examples which suggest that the principles of managed care can be harnessed to improve services for people with I/DD. These state examples are highlighted in this report.

States considering applying managed care approaches in serving people with I/DD can pursue either capitated or non-capitated approaches. The basic difference between these approaches is the assumption of financial risk on the part of the entity responsible for managing services.

Non-capitated models pose less of a concern that the managing entity will have an incentive to underserve individuals but offer less budget certainty and potential for service improvements via increased service flexibility. In a capitated model, the managing entity can substitute services and provide enhanced services based upon the individual needs of the member that may extend beyond the current covered services. This may lead to an overall lower cost of care and provide consumers with services that are more appropriate and responsive to their unique needs. However, capitated models, because they entail financial risk to the managing entity, can create incentives for the managing entity to reduce the amount of services provided to individuals. As a result, successful capitated models require a significant degree of state oversight to ensure any service reductions are appropriate.

An additional consideration in pursuing a managed care approach is whether the anticipated savings are likely to outweigh the additional costs of administering and overseeing the managed care model. In managed care models that apply to large populations, states can spread these administrative and oversight costs, making it less difficult to achieve overall savings.

However, when managed care is applied to smaller populations, it becomes harder for states to recoup sufficient savings to cover the fixed costs associated with instituting a managed care model.

Some states that have applied managed care principles to their I/DD service systems have made the policy decision to make home and community-based service (HCBS) waivers an entitlement. However, making HCBS waivers an entitlement is a separate state policy and financial decision and is not a direct outgrowth of the use of managed care or Medicaid waiver authority to deliver I/DD services. Managed care tools and principles can be part of a larger strategy to create cost savings but, on their own, may not generate the level of saving required to meaningfully increase the number of waiver slots.

PROJECT OVERVIEW

Legislative Direction

The 81st Texas Legislature directed HHSC and DADS to develop a plan to implement a managed care pilot for persons with I/DD. An excerpt of the language from Section 48 of Senate Bill 1, 81st Legislature, Regular Session, Article II - Special Provisions Relating to All Health and Human Services Agencies, follows:

It is the intent of the Legislature that HHSC and DADS shall jointly design a plan to implement a capitated or non-capitated pilot to serve persons with intellectual and developmental disabilities. The agency may contract to conduct a study, which shall include input from individuals receiving services, their families, service providers, mental retardation authorities, advocate organizations, and other interested parties. The plan shall include managed care models employed by other states for this population.¹

To address these requirements, HHSC issued a Request for Quote (RFQ) seeking a consultant to perform the activities necessary to develop a plan to implement a capitated or non-capitated pilot to serve persons with I/DD. The RFQ defined persons with I/DD as individuals receiving services in an Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) or from one of the following 1915(c) ICF/MR waivers: Community Living Assistance and Support Services (CLASS), Deaf Blind Multiple Disability (DBMD), Home and Community-based Services (HCS), and Texas Home Living (TxHmL).

As a result of a competitive procurement process, HHSC selected Health Management Associates (HMA) to perform this scope of work. HMA is a national consulting firm specializing in the fields of health system restructuring, health care program development, health economics and finance, program evaluation, and health data analysis. HMA has offices in Lansing, Michigan; Chicago, Illinois; Indianapolis, Indiana; Columbus, Ohio; Washington, DC; Tallahassee, Florida; Austin, Texas; Sacramento, California; Boston, Massachusetts; New

¹ Senate Bill 1, Article II, Section 48, 81st Texas Legislature, http://www.lbb.State.tx.us/Bill_81/6_FSU/81-6_FSU_0909_Art1_thru_Art2.pdf

York City, New York; and Atlanta, Georgia. More information on HMA is available at: <http://www.healthmanagement.com/>.

Methodology

In developing a recommended pilot option, HMA's approach was informed by the requirements of the RFP, which required both a review of other state systems and collection and inclusion of stakeholder input. Below is a brief summary of HMA's activities to meet these requirements.

Review of other state systems. To evaluate managed care models that include services for individuals with I/DD, HMA reviewed four state programs—Arizona, Michigan, Wisconsin and Vermont. Each state has implemented a form of capitated risk-based managed care that includes institutional and HCBS waiver services for individuals with I/DD. HMA used the findings from this research on other states' models to inform the recommendation of type of pilot and to suggest some key considerations in implementing the proposed pilot.

Stakeholder input. HMA gathered stakeholder input through four public hearings held in four cities. Times of the meetings included a mix of business hours and non-business hours. The choice of cities was informed by likelihood of maximizing stakeholder input. HMA sought input from stakeholders to determine what areas would be likely to maximize stakeholder involvement and also fulfill the requirements of having meetings in varied Texas locations. Prior to the public hearings, HHSC posted a report developed by HMA that outlined the three proposed pilot options and summarized the experiences of other states in developing managed care models of the I/DD population. The public meeting schedule and report were posted on the HHSC website. Notice of the meeting was also emailed to key stakeholders identified by HHSC, DADS and HMA. HHSC collected written comments to the report and forwarded those comments to HMA. HMA summarized the content of the stakeholder input for HHSC and DADS and used the input to help inform and refine the development of the recommended pilot option. The schedule of public meetings is below.

- **Fort Worth:** Wednesday, June 23, 3:00-5:00, Fort Worth Botanical Gardens, 3220 Botanic Garden Boulevard, Fort Worth, TX
- **El Paso:** Friday, June 25, 11:00-1:00, El Paso Marriott, 1600 Airway Blvd., El Paso, Texas
- **Longview:** Monday, June 28, 5:00-7:00, Holiday Inn Express Longview North, 300 Tuttle Circle, Longview, Texas
- **Austin:** Tuesday, June 29, 3:00-5:00, Austin City Hall, 301 W. Second St., Austin, TX

Data review and analysis. HMA used publicly available information and submitted a variety of data requests to HHSC and DADS to obtain information on the current I/DD and managed care service systems in Texas and to analyze trends in costs and utilization of services. HMA also interviewed state staff to gain insight into key concerns with the system and to understand various initiatives underway that had the potential to inform the selection of a pilot option.

Goals and Objectives

HMA, with input and approval from HHSC and DADS, developed a set of goals and objectives for the I/DD pilot. HMA assessed the various pilot options in terms of their relative strengths and weaknesses in achieving these goals and objectives. The final recommendation of the proposed pilot option was made according to the degree to which the selected option was judged as able to meet the following goals and objectives:

- Increasing consumer access to services through increasing waiver slots;
- Promoting high quality care;
- Allowing consumer choice;
- Providing services in a cost-efficient manner;
- Preventing unnecessary institutionalization;
- Allowing for necessary coordination of care across service delivery systems; and
- Allowing for feasibility of implementation within Texas' current Medicaid infrastructure.

ANALYSIS OF FOUR STATES

HMA reviewed four state programs—Arizona, Michigan, Wisconsin and Vermont—to evaluate those states' use of managed care models for individuals with I/DD. Each state has developed a distinctly different program design. A brief overview of each of the four states' approaches to delivering I/DD services is described below. Additionally, a comparison table is provided at the end of this section that displays key features of the four state programs.

Arizona

Arizona's Medicaid program operates under a unique, statewide managed care structure known as the Arizona Health Care Cost Containment System (AHCCCS). AHCCCS arranges for provision of all Medicaid services using risk-based managed care contracts. Medicaid recipients who *do not* have long-term care needs, primarily low-income families and children, receive their managed care services from health plans that are competitively procured and include governmental (county) entities, private for-profit and not-for profit health management organizations (HMOs). Individuals with I/DD who do not have long-term care needs receive their Medicaid services from one of the health plans.

Medicaid recipients *with long-term care needs* receive all of their Medicaid services, including home and community-based services (HCBS) and institutional services, under a managed care arrangement overseen by the Arizona Long-term Care System (ALTCS), a part of Medicaid. ALTCS is "split" into two population groups: 1) aged persons and persons with physical disabilities; and 2) persons with I/DD.

ALTCS contracts with nine program contractors to provide most Medicaid services, including long-term care and behavioral health services, through managed care contracts. Eight of the

program contractors are regional health plans that provide acute/medical services to aged persons and persons with physical disabilities. Arizona serves 22,339 ALTCS members with I/DD.

The remaining program contractor is the Department of Economic Security/Division of Developmental Disabilities (DES/DDD). DES is a separate state agency from Medicaid and is the statutorily-authorized division responsible for providing services to persons with I/DD. DDD is required by state statute to contract with Arizona Medicaid (and vice-versa). DDD negotiates a managed care contract with AHCCCS. The contract specifies DDD's responsibilities for Medicaid members with I/DD who have long-term care needs. DDD is responsible for delivering or arranging for delivery of all services included in the monthly capitation payment:

- Acute care services (hospital, physician, lab, x-ray, etc.) delivered by sub-capitated health plans;
- Behavioral health services provided through Regional Behavioral Health Agencies under the terms of an Interagency Agreement; and
- Long-term care services including HCBS for persons with I/DD, provided fee-for-service by HCBS providers that serve individuals with I/DD.

According to state officials interviewed for this report, approximately 85 percent of Arizonans with I/DD served by ALTCS reside in their own home, a family home or a shared home (not owned or leased by a provider). Three percent reside in state institutions. HCBS are an entitlement in Arizona, authorized by the Arizona legislature and available to individuals with I/DD at "immediate risk of institutionalization." According to Arizona Medicaid, substantial cost savings have been achieved by ALTCS even with the entitlement to HCBS.

Michigan

Michigan implemented a managed long-term care program, the Michigan Managed Specialty Services and Supports Program (MSSSP), in 1998. The program operates under the authority of two Medicaid waivers: a Section 1915(b) waiver and a Section 1915(c) waiver.

The MSSSP is delivered by Prepaid Inpatient Health Plans (PIHPs). The PIHPs are a single Community Mental Health Services Program (CMHSP) or a collaborative of numerous CMHSPs (in more rural areas of the State). The CMHSPs are the traditional county-based organizations serving persons with mental illness, substance abuse or I/DD. The PIHPs are selected through a competitive procurement, but the procurement is opened to non-CMHSP providers only if the CMHSP in a service area is unable to enter into a contract with the State. To date this has not occurred.

The PIHPs receive capitated per member per month payments for Medicaid behavioral health, substance abuse and long-term care services, including HCBS waiver services. The HCBS waiver services are available only to individuals with I/DD. Since 2010, the PIHPs have received two managed care payments each month for the Medicaid covered services:

- One payment is based on all Medicaid eligibles within the PIHP region and covers mental health, developmental disability and substance abuse state plan services, including targeted case management and special children’s Medicaid services as well as additional services funded from savings (which are similar to the HCBS waiver services but available to all members).
- The second payment is based on the subset of Medicaid eligibles that are also enrolled in the Habilitation Supports Waiver (persons with I/DD at the ICF/MR level of care) and covers the cost of these services.

The PIHPs are responsible for serving everyone in their service area who needs the services covered by the MSSP no matter what “level of care” they are or what their primary diagnosis is as long as they are Medicaid eligible. There is no waiting list for HCBS waiver services for individuals with I/DD—anyone who needs and qualifies for Habilitation Supports Waiver services receives these services. In other words, a person with I/DD who does not meet ICF/MR level of care and who is Medicaid eligible in any eligibility category can receive services from the PIHP as long as the services are medically necessary. Michigan serves over 219,000 persons in the PIHPs annually, and over 39,000 are persons with I/DD. The PIHPs also contract for state-funded services separate from the Medicaid services.

There are no remaining private ICFs/MR in Michigan and only one institutional unit serving individuals with I/DD at the state psychiatric hospital. Michigan’s history of changes to the residential system for individuals with I/DD began in 1978, when most institutional services were provided at state institutions and a smaller portion at nursing homes for persons with mental retardation. Quality of care problems in Michigan’s institutions for persons with mental illness and/or persons with I/DD prompted efforts to develop community-based options, and legislation was enacted changing zoning laws statewide to permit construction of six-bed facilities anywhere in the State. The objective was to replace state institutions with less costly small ICFs/MR. Eventually, between 700 and 800 six-bed ICFs/MR were created, typically operating under contract to the state institutions and in some instances on the grounds of the institution. The ICFs/MR operated as cost-based providers.

With the advent of the PIHPs, the PIHPs were given the option to continue to operate the facilities as ICFs/MR or to “convert” the facilities to HCBS waiver homes (adult foster care homes). Providers overwhelmingly chose the HCBS waiver option as a way to achieve cost-savings resulting from elimination of the ICF/MR costs related to licensure and certification. At the time of this “conversion,” fears were raised by state surveyors around the ability of the homes to provide a high quality of care absent the ICF/MR regulatory oversight. As a result, the State developed an extensive quality oversight system for the facilities, including developing fire-safety requirements similar to the ICF/MR requirements but suited to the community-based group setting. The State also transitioned individuals with I/DD remaining in the state institutions to community settings. Transitions began with the lowest need individuals and are expected to be completed in the next year with movement of the last approximately ten highest need individuals. Typically, these individuals have severe behavior issues.

State interviewees noted that the system capacity has to be built gradually and trust must be developed over time to accomplish the shift away from highly-regulated facilities to the community-based options of today. Interviewees also noted the results have been positive—there have been bumps on the road but in general individuals have done well and thrived in community-based settings.

Wisconsin

Wisconsin operates two managed care programs that include long-term care services: Family Partnership (“Partnership”) and Family Care. Partnership includes all Medicaid services and predominantly serves frail elders. Family Care is the larger program and serves a larger proportion of individuals with I/DD. Family Care was implemented in 2000 and operates under the authority of a 1915(b) waiver and two 1915(c) waivers (one for elders and individuals with physical disabilities and the other for individuals with I/DD). Family Care began as a pilot and is now operating in 53 counties with enrollment of over 26,000 individuals.

Family Care covers long-term care (including nursing home, ICF/MR and HCBS waiver services), behavioral health services, and state plan HCBS, such as home health and therapies but not acute care services.

Family Care MCOs must be certified by Wisconsin Department of Health Services as meeting all requirements of statute and rule including requirements related to adequacy of the network, expertise in long-term care and the ability to manage a network within the capitation payment. In addition, the MCOs must demonstrate the capacity for financial solvency and stability. The MCOs are not required to be licensed HMOs.

Family Care implementation is typically preceded by up to three years or longer of planning in the region(s) where implementation is scheduled. In addition, Wisconsin state staff have a very close relationship with MCOs. The State reports that daily contact with the MCOs to respond to questions and provide technical assistance is typical. Once Family Care is fully implemented in a county or region, HCBS become an entitlement.

Family Care is one aspect of Wisconsin’s long-term care system transformation. The State has also implemented a comprehensive nursing facility and ICF/MR restructuring program and a State Center reduction initiative. ICF/MR restructuring includes mandated court review of each individual’s community-based plan. If the court finds that the community is the most integrated setting suited to the individual with I/DD’s needs, the court orders community services. Counties must serve the individual in the community in accordance with the court finding or assume 100 percent of the cost of institutional care. Since starting this restructuring in 2006, more than 50 percent of ICFs/MR have closed.

HCBS are an entitlement in Wisconsin once Family Care is fully implemented in a county or region. The entitlement was authorized by the Wisconsin legislature. Wisconsin serves over 26,000 persons in Family Care; about 9,100 are persons with I/DD. The State believes their overall long-term care program changes are rebalancing the long-term care system. Initial evaluations have found Family Care to be cost-effective overall and to achieve savings in some areas and for some groups.

Vermont

Vermont is operating its entire Medicaid program, except long-term care for elders and adults with physical disabilities, under a Section 1115 Waiver: The Global Commitment Waiver. The state Medicaid agency has entered into a managed care arrangement with the federal government; essentially, the state Medicaid program is the managed care organization.

The waiver's sole impact on the agency serving individuals with I/DD is to leverage Medicaid matching funds for two previously unmatched service types: employment supports and family supports. Services remain fee-for-service, and there are no Medicaid HMOs in Vermont. The additional federal financial participation that results from matching family support funding is returned to the waiver and not specifically to the agency responsible for serving individuals with I/DD. (Division of Disability and Aging Services, Department of Disabilities, Aging & Independent Living, Developmental Disability Services).

Vermont has no ICFs/MR and no residents with I/DD in state institutions. Vermont has implemented a "priority" system (State System of Care Plan) for provision of services and supports for individuals with I/DD. In FY 2008, the Vermont Division of Disability and Aging Services provided supports to 3,545 people with developmental disabilities in Vermont.

There were 241 people on Vermont's Applicant List at the end of June 2008, representing people who are eligible for services based on their disability but whose needs do not meet the State System of Care Plan's funding priorities.

Table 1 on the following page provides a comparison of key features of the study states' I/DD services.

Table 1: Comparison of Key Features – Study States

Feature	Arizona Long-term Care System (ALTCS)	Michigan Managed Specialty Services and Supports	Wisconsin Family Care	Vermont Global Commitment
Enrollment	Access to all Medicaid services is through DD agency that holds a contract with Medicaid	Everyone who needs behavioral health & long-term care services &/or HCBS waiver services for persons with I/DD must enroll in a PIHP	In Family Care (FC) counties, enrollment is voluntary.	All Medicaid recipients, except aged persons and person with physical disabilities are enrolled in Global Commitment
Population covered	Persons with I/DD	Children & adults who require specialty services and supports due to MI, SA or I/DD	Adults with physical disabilities, DD and frail elders	All persons except persons in Choices for Care waiver (persons at nursing home level of care)
Level of Care (LOC) requirements	At immediate risk - nursing home or ICF/MR	Only applicable to HCBS waiver services offered by PIHPs	Nursing home or ICF/MR or at-risk	NA
Includes HCBS waiver services	HCBS waiver-like services HCBS are an entitlement	HCBS are an entitlement	HCBS are entitlement once FC is fully implemented in a county	Waiver-like services (converted from 1915(c) waiver)
ICF/MR services	Fewer than 12 facilities and declining	1 state hospital with an ICF/MR unit 10-12 people	Private ICFs/MR declining	No ICFs/MR
Self-directed services?²	Y	Y	Y	Y
Reimbursement	DD Agency PMPM, fully at-risk, with required reinsurance Sub-capitated health plans – shared risk	PMPM, with shared risk (risk corridors)	PMPM Risk shared first 3 years then full risk	No change to DD agency except access to matching funds for certain services
County, Traditional Organizations or HMOs?	DD Agency for I/DD; Sub-capitated Health Plans for medical	PIHPs are county CMHSPs	Community-Based MCOs	No HMOs or managed care organizations
Authority	1115 waiver	1915(b)/(c) waivers	1915(b) and two 1915 (c) waivers	1115 waiver
Statewide	Y	Y	N (53 counties)	Y

² In Michigan and Wisconsin a budget amount is made available by the managed care entity to the participant to purchase services and supports. In Arizona and Vermont consumers hire their own employees to provide HCBS waiver services.

Common Themes Across Four Study States

HMA's review of these four states' experiences with managed care for people with I/DD yielded some common themes. These included:

- ***Institutional and ICF/MR Beds Have Been Substantially Reduced or Almost Eliminated.*** The four states reviewed have transitioned, or are close to transitioning, out of the private or state ICF/MR “residential” model to HCBS waiver residential settings and to individuals’ homes and other supported living arrangements. They have also either substantially reduced their state institutional population or are in the process of doing so.
 - In Michigan, the Prepaid Inpatient Health Plans (PIHPs), comprised of one or a group of Community Mental Health Programs (county-based organizations), chose to transition from ICF/MR settings to waiver settings because it was cost-effective to do.
 - In Wisconsin, a multi-pronged approach was employed by implementing an entitlement to HCBS with implementation of Family Care and placing counties at-risk for ICF/MR expenditures. This included requiring court-ordered review of community plans for persons with I/DD and a court determination of which setting was the most integrated setting that could meet the individuals needs—HCBS or ICF/MR.
 - In Arizona, approximately 85 percent of persons served by the I/DD agency either live in their own home, family home or a shared home not owned by a provider.
- ***HCBS Are an Entitlement in Arizona, Michigan and Wisconsin.*** Arizona and Michigan offer HCBS to all individuals who meet an institutional level of care. Wisconsin also offers HCBS as an entitlement once Family Care is fully implemented in a region or county, which typically takes up to three years.
- ***Traditional I/DD Providers Are the Managed Care Organization in Two States.*** The two states implementing risk-based managed care for institutional *and* HCBS services for persons with I/DD (Michigan and Wisconsin) either contract exclusively with managed care organizations that were the traditional providers (Michigan) or include these providers (Wisconsin) as eligible MCOs.
 - In Michigan, the Prepaid Inpatient Health Plans are comprised of one or a group of Community Mental Health Service Programs (county-based organization).
 - An MCO in Wisconsin must be an entity that is legally able to enter into a risk-based contract. Family Care MCOs may be: a county; a group of counties acting cooperatively; a long-term care district; a privately held managed care organization; an HMO or similar organization regulated by the Office of the Commissioner of Insurance; a federally-recognized Wisconsin Indian Tribe; or a group of any of the above entities working under a contractual agreement.

- ***Move toward Regionalization. Michigan and Wisconsin Have Regionalized some Aspects of Their Programs.*** Michigan has 49 Community Mental Health Service Programs (CMHSPs) but 18 Prepaid Inpatient Health Plans (PIHPs). The CMHSPs had (since the mid 1980s) been operating under a “global budget” comprised of multiple state and federal funding streams. The regionalization of the 49 CMHSPs in order to form the PIHPs provided a more efficient and financially viable system for delivery of the contracted services and management of funds and permitted expansion of HCBS to individuals who did not meet institutional level of care (funded from the savings achieved through managed care). The CMHSPs continue to function as the single entry points for access to behavioral health and I/DD services. In Wisconsin, some counties have formed Long Term Care Districts (originally called Family Care Districts), which are regional units of government created specifically to plan and administer services to eligible frail elderly people and people with physical and developmental disabilities. The Long Term Care Districts may elect to become either a Resource Center providing information and referral, eligibility determination and case management services, or a Family Care managed care organization (called Care Management Organizations in Wisconsin), but may not be both.

Cost Savings

According to Arizona Medicaid, substantial cost savings have been achieved by ALTCS even with the entitlement to HCBS. Arizona Medicaid estimated that although savings were reduced as a result of expanding access to HCBS, they were still substantial, approaching \$870 million in 2006 (compared to an estimated savings of \$992 million if access to HCBS had been limited). However, Arizona supports the vast majority of persons with I/DD in home settings (non provider-owned).³ Arizona also has a rigorous preadmission screening and targeting program that identifies persons at “immediate risk” of institutionalization, which likely contributes to cost savings. Both of these features are not readily transferable to Texas.

A 2005 study by APS Healthcare examined Family Care costs during a two-year period concluded that all but two of the Family Care groups had total long-term care costs less than their comparison group counterparts (individuals with physical disabilities and those members with no prior waiver experience before enrollment in Family Care in the four non-Milwaukee County CMOs). The study also revealed that Family Care produces Medicaid savings both directly by controlling service costs and indirectly by favorably affecting Family Care members’ health and abilities to function so that they have less need for services. Significantly lower costs were noted for the following Family Care groups relative to the comparison groups (expressed as average individual monthly costs) for:

- The non-Milwaukee members, as a group (-\$517);
- The non-Milwaukee frail elder members (-\$722);

³ Senator Smith’s Medicaid Roundtable: Testimony of Anthony Rodgers, Director, Arizona Health Care Cost Containment System. September 13, 2006.

- The non-Milwaukee members with physical disabilities (-\$503); and,
- The Milwaukee County frail elder members (-\$565).

The only Family Care group for which average individual monthly costs did not differ significantly from comparison group individuals were individuals with developmental disabilities in the non-Milwaukee CMO counties.⁴

In state fiscal year 2002, Michigan spent \$1.8 billion on specialty services, serving over 195,000 people. Total Medicaid capitation payments were \$1.52 billion, and grant awards totaled \$318 million. These funds served over 161,000 people with mental illness and over 31,000 people with developmental disabilities. An independent evaluation concluded that the transition to a managed care model reduced costs for each target population. Estimated savings for mental health services were \$0.01 per eligible person per month (PEPM), savings for addiction disorders services were \$0.12 PEPM, and savings for developmental disabilities services were \$10.16 PEPM.⁵

There is some disagreement among researchers concerning the validity of the cost-savings estimates associated with managed long-term care as well as the “transferability” of savings from state to state. In “The Cost-Effectiveness of Noninstitutional Long-Term Care Services: Review and Synthesis of the Most Recent Evidence” (2006),⁶ Gabrowski notes that “Although the recent literature did not unequivocally support any one model, managed care and consumer-directed care were both identified as potential mechanisms toward providing services more efficiently, although this conclusion hinges on the specific features of the various programs.” He notes that most prior evaluations have had methodological problems and that new evaluations using more rigorous analytical models are needed to provide a more accurate savings analysis.

In “Do Non-institutional Long-Term Care Services Reduce Medicaid Spending? Home and community-based services help people with disabilities stay in their homes while reducing long-term care spending,”⁷ the authors found that over the long-term, growth in long-term care (LTC) spending for states with well-established non-institutional programs saw much less spending growth than states with minimal non-institutional services. There is an initial period of HCBS when overall LTC spending increases at a faster rate because of a lag in reduced institutional spending. This finding perhaps argues for the more aggressive rebalancing efforts as undertaken in states like Michigan and Wisconsin in order to accelerate reduced institutional spending.

⁴ APS Healthcare, Inc. “Family Care Independent Assessment: An Evaluation of Access, Quality and Cost Effectiveness For Calendar Year 2003 – 2004.” October 7, 2005. Retrieved May 2, 2010 from: <http://dhs.wisconsin.gov/lcicare/pdf/FCIndepAssmt2005.pdf>

⁵ Centers for Medicare and Medicaid Services Brief, *Promising Practices in Home and Community-Based Services. Michigan -- Person Centered Planning for People with Mental Illness, Addiction Disorders, and Developmental Disabilities*, Updated December 16, 2004, available at: <https://www.cms.gov/PromisingPractices/Downloads/mipcp.pdf>

⁶ D. Gabrowski, “The Cost-Effectiveness of Non-institutional Long-Term Care Services: Review and Synthesis of the Most Recent Evidence,” *Medical Research and Review*, February 2006: Vol. 63, No. 1, available at: <http://www.npaonline.org/website/download.asp?id=1656>

⁷ H. Stephen Kaye, Mitchell P. LaPlante, and Charlene Harrington, *Health Affairs*, January/February 2009.

OVERVIEW OF TEXAS SYSTEM

Texans with I/DD who are Medicaid-eligible have access to Medicaid-funded habilitation, residential and support services. Described below are the key Medicaid services for people with I/DD that would likely be included or impacted by a pilot. In order to provide context for the system in which an I/DD managed care pilot would operate, this section provides a broad overview of Medicaid-funded services. However, it will be helpful for readers to bear in mind that the target population for this pilot, as directed by HHSC, is persons receiving services in an ICF/MR or from one of the following 1915(c) ICF/MR waivers: CLASS, DBMD, HCS, and TxHmL.

Medicaid Waiver Services

Texas has eight Medicaid HCBS waiver programs that provide long-term services and supports:

- Three are for participants who otherwise meet nursing facility level of care:
 - STAR+PLUS (which is a managed long-term care program);
 - Community-Based Alternatives (CBA); and
 - Medically Dependent Children Program (MDCP).
- Four are for participants who otherwise meet ICF/MR level of care:
 - HCS;
 - CLASS;
 - DBMD; and
 - TxHmL.
- One is for participants who otherwise meet either nursing facility or ICF/MR level of care:
 - Consolidated Waiver Program (CWP).

These waiver programs are administered by DADS, with the exception of STAR+PLUS, which is administered by HHSC and is mandatory for adults meeting eligibility criteria. An individual should be enrolled in only one HCBS waiver program at a time. Legislative appropriations determine the availability of waiver services. The most common route to enrollment in a waiver program is through the interest lists. Individuals become aware of available programs through a variety of sources, including MRAs, area agencies on aging (AAAs), aging and disability resource centers (ADRCs) and DADS local offices. Demand typically outweighs the availability of community services, so names of interested individuals are registered on interest lists. When an individual comes to the top of a list, the eligibility determination process begins (to include both a functional and a financial assessment). While on an interest list, many individuals receive other services.

HCBS Waivers

The four HCBS waivers for Medicaid enrollees who otherwise meet ICF/MR level of care are the HCS, CLASS, DBMD and TxHmL waivers. Of the four I/DD waivers, HCS is by far the largest (accounting for approximately 75 percent of all I/DD waiver enrollments), and the DBMD waiver is the smallest. While these waivers cover many of the same services, the HCS waiver offers the most comprehensive set of services. (Thus, the HCS Waiver is the focus of much of the discussion in this paper regarding potential cost savings and policy changes.) Additionally, the waivers have different eligibility criteria. A detailed comparison of covered services can be found in Appendix A. Below is a brief, high-level overview of these four HCBS waivers.⁸

Home and Community-based Services (HCS)

Eligibility: Serves individuals of any age with MR (IQ below 70) or a related condition with an IQ below 75.

Enrollment and Interest List Size: There were 18,266 individuals receiving HCS services and 45,884 on the interest list as of July 31, 2010.

Services and Supports: Adaptive aids, behavioral supports, counseling and therapies, day habilitation, dental, financial management, minor home modification, nursing, residential assistance, supported home living, supported employment, support consultation.

Setting: Services may be provided to individuals who live at home, in a foster home or in a three- or four-person group home.

Sample Individual Profiles:

- A 35-year-old man living with his parents who are paid as his foster care providers. The parents provide assistance with activities of daily living, and the individual receives dental services through the HCS program.
- A 27-year-old woman living in a group home with three other women receives assistance with activities of daily living and training on meal preparation and housekeeping from the staff in the home.

Community Living and Assistance and Support Services (CLASS)

Eligibility: Serves individuals of any age who have a disability other than MR that originated before age 22 and affects the person's ability to function in daily life—for example, epilepsy, autism spectrum disorders, spina bifida or cerebral palsy.

Enrollment and Interest List Size: There were 4,330 individuals receiving CLASS services and 32,121 on the interest list as of July 31, 2010.

Services and Supports: Adaptive aids, habilitation services, medical supplies, behavioral supports, minor home modifications, nursing, specialized therapies, respite.

⁸ Information for the HCBS Waiver summaries was derived from HHSC website, DADS website and HHSC legislative briefing presentation at: http://www.hhsc.State.tx.us/news/presentations/2010/presentation_022310.pdf

Setting: Services are provided to individuals who live at home.

Sample Individual Profile: A 50-year-old woman with cerebral palsy who receives habilitation services and massage therapy. The CLASS program has also provided home modifications to make her bathroom wheelchair accessible.

Deaf Blind Multiple Disabilities (DBMD)

Eligibility: Serves individuals of any age with deaf-blindness and one or more other disabilities that impair independent functioning.

Enrollment and Interest List Size: There were 150 individuals receiving DBMD services and 312 on the interest list as of July 31, 2010.

Services and Supports: Adaptive aids, medical supplies, behavioral support services, case management, chore services (heavy housework), habilitation, nursing, intervener services (to assist with communication/community access), occupational, physical and speech therapy, orientation and mobility, respite.

Setting: Services may be provided to individuals who live at home or in a group home or small contracted assisted living facility.

Sample Individual Profile: A 25-year-old man with deafness, blindness and mild cerebral palsy who lives in a DBMD-contracted assisted living facility. He receives physical therapy and intervener services.

Texas Home Living Waiver (TxHmL)

Eligibility: Serves individuals of any age with MR (IQ below 70) or a related condition with an IQ below 75.

Enrollment and Interest List Size: There were 870 individuals receiving TxHmL services as of July 31, 2010. There is no separate interest list for TxHmL; names are drawn from the HCS interest list.

Services and Supports: Adaptive aids, behavioral support, dental, minor home modifications, skilled nursing, specialized therapies. Cost of waiver services is capped at \$15,000 per person per year.

Setting: Services are provided to individuals who live in their own home or their family's home.

Sample Individual Profile: A 21-year-old woman with diagnosis of MR living with her parents. In the past year, she has received day habilitation outside the home (training and activities to help an individual with a developmental disability achieve greater mental, physical, and social development), respite and dental services.

Table 2 below provides a comparison of the waivers and ICF/MR program in terms of costs and interest list size.

Table 2: Key Texas I/DD Programs – Number Served and Average Costs

Program	Average Monthly Persons Served SFY 2010	Average I/DD Services Annual Cost Per Person SFY 2010	Average Acute Care/Other Services Annual Cost Per Person	Interest List: Persons on the List / Percent of Individuals on the Interest List for More than 2 Years.
ICF/MR				
State Supported Living Ctrs.	4,512	\$126,972	NA	Entitlement, no interest list
Community-based ICFs/MR	6,037	\$55,080	\$5,153	
Waivers Related to ICF/MR Level of Care				
HCS Waiver	17,017	\$41,400	\$4,513	45,884/ 60.6%
CLASS Waiver	4,671	\$41,124	\$15,209	32,121 / 57.9 %
DBMD Waiver	155	\$47,400	\$3,339	312 / 4.1%
TxHmL Waiver	994	\$11,016	\$4,744	No interest list
Total	22,837			

Table Sources:

1. Persons served and annual costs from the 2010-2011 General Appropriations Act, DADS Key Measures. Note that ICF/MR programs and waivers offer services in a variety of settings. Average costs stated are average of all settings.
2. Average acute care and other non-I/DD costs for waivers are from 2008 CMS 372 reports for each waiver.
3. Average acute care costs for community based ICF/MR are from HHSC Strategic Decision Support, based on data from FY 2009 using eligible members and paid amounts.
4. Interest list counts and wait times are as of July 31, 2010 and were accessed at: <http://www.dads.State.tx.us/services/interestlist/>.

Table Notes:

1. SSLC Acute Care Costs: Physician, dental, and some pharmacy services are included in the daily reimbursement for SSLC. This partially accounts for some of the higher cost.
2. DBMD Interest List: Some persons on the DBMD interest list have reached the top of the list multiple times and declined services, yet choose to remain on the list

Role of Local Mental Retardation Authorities (MRAs)

Local Mental Retardation Authorities (MRAs) serve as the point of entry for publicly funded mental retardation programs, whether the program is provided by a public or private entity. MRAs provide or contract to provide an array of services and supports for persons with mental retardation. They are responsible for enrolling eligible individuals into the community-based ICFs/MR and two of the Texas HCBS waivers: HCS (the largest waiver serving persons with MR) and TxHmL. MRAs are also responsible for maintaining the local interest lists for waiver

programs. Additionally, MRAs are responsible for Permanency Planning for individuals under 22 years of age who live in an ICF/MR, nursing facility, or a residential setting of the HCS Program.

MRAs play a key role in assisting individuals who wish to live in an HCS group home. The MRA is responsible for informing the individual of the array of options and whether or not there is an available “slot” in any of the waivers for which the individual may be eligible. (If there is not a slot available, the MRA places the individual on the HCS waiver interest list.) If there is a slot, the individual selects from among available residential providers if he or she elects group home placement.

Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR)

ICF/MR services are an optional Medicaid service that Texas has chosen to include in its Medicaid benefit. Once a state chooses to include ICF/MR services as a Medicaid benefit, it becomes an entitlement. ICF/MR services include 24-hour residential services, habilitation, medical services and skills training. The Texas ICF/MR benefit includes two categories of ICF/MR:

- Community-based ICF/MR. These are community-based residences for people who have:
 - mental retardation and mild to extreme deficits in adaptive behavior;
 - an IQ of 75 or below with a related condition that began before the person turned 22 and mild to extreme deficits in adaptive behavior; or
 - a related condition with moderate to extreme deficits in adaptive behavior.

The owner/operator of each community-based ICF/MR may determine additional specific admission criteria for their facility and may maintain their own interest list. A person may select a particular ICF/MR; however, the ICF/MR must have a vacancy, and the ICF/MR provider must approve the admission. Community ICFs/MR vary in size as follows: small—serves up to eight people; medium—serves between nine and 13 people; and large—serves 14 or more people. Most community-based ICF/MR programs are small (8 beds or fewer) and most are privately operated. The average monthly persons serviced for SFY 2010 was 6,037.⁹

- State Supported Living Centers (SSLCs). Texas has 13 campus-based ICFs/MR, each of which serves approximately 100 to 600 people. Facility staff provide intensive and specialized residential services for residents with severe or profound mental retardation and those with mental retardation who are medically fragile or who have behavioral problems. Although the ICF/MR Program criteria includes people with only a related condition, state law limits admissions to SSLCs to people with mental retardation who

⁹ Texas Department of Aging and Disability Services website:
http://www.dads.State.tx.us/providers/MRA/explanation/dads245_mra_svs.pdf

have significant medical or behavioral needs. The average monthly persons served for SFY 2010 was 4,512.

Funding trends for ICF/MR and HCBS waivers are moving in opposite directions, as Texas continues efforts to “rebalance” the I/DD service system. No additional funding for new ICFs/MR has been appropriated in a number of years. In contrast, the State is engaged in a multi-year effort to increase HCS waiver funding and capacity. Table 3 below shows that the general trend in the HCS waiver program has been for slots to increase.

Table 3: Census and Cost Trends for HCS Waiver

HCS Waiver	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010 (Budgeted)
Average number of individuals served per month	10,149	11,798	13,386	15,107	17,255
Average monthly cost per individual served (all funds)	\$3,230	\$3,224	\$3,422	\$3,443	\$3,450

Source: DADS Reference Guides: <http://cfoweb.dads.State.tx.us/ReferenceGuide/>

DESCRIPTION OF PROPOSED OPTIONS

HMA developed three options for an I/DD pilot in Texas. These options were described in the stakeholder report and formed the basis for stakeholder feedback. The proposed options included both capitated and non-capitated approaches and were informed by (but not identical to) the models used in other states.

The following assumptions apply to each of the three options that HMA considered.

- The pilot options do not contemplate any managed care arrangements that would apply to SSLCs or assume any reductions in the numbers of SSLC residents.
- Implementing any of the managed care pilot options would be a complex undertaking and would require a major service system redesign, even within a pilot area. All of the options would require careful planning prior to implementation and an extensive implementation process.
- An overarching goal of all of the pilot options would be to create additional waiver slots by delivering more cost-effective services. The states that implemented managed long-term care for persons with I/DD, Michigan and Wisconsin, have focused on cost-effective HCBS residential and supported living options, such as foster care, family home, and shared homes. To contain costs under any of the options and to make the transition that the study states have made, the managed care entity in the pilot area would need to promote and increase the number of lower-cost supportive living options, such as adult foster care, family home, and shared housing.

- Achieving meaningful cost savings will require some flexibility in setting size, such as allowing an increase in bed size of HCS group homes, to either five or six beds.
- Under any of the pilot options, increasing the array of available services and consumer-directed services would be a key objective.
- None of the three pilot options would create an *entitlement* to HCBS. Each option is designed to create incentives to manage I/DD services more cost-effectively and to direct any savings to serving additional people. For Texas to eliminate interest lists and make HCBS an entitlement (which some of the states profiled in this document have done) would require additional funding for community-based I/DD services.
- Individuals in the DBMD waiver would not be included in the pilot, because of the small size of the population (fewer than 200 people served on average each month) and the different set of needs of the population in this waiver compared with the other I/DD waivers.

Option One: Non-Capitated Enhanced Management for Persons with I/DD

Following the review of stakeholder input and analysis of potential cost savings associated with management of acute and I/DD services, HMA revised and refined Option 1. These revisions are reflected in the description below. (Note: Option One is described in greater detail beginning on page 40.)

This option is *not* a capitated, risk-based managed care model, but rather uses an enhanced management approach: an MRA would be challenged to create necessary incentives and adopt necessary utilization management guidelines to make the HCS waiver more cost-effective. The HCS waiver is the focus of this option since it represents the overwhelming majority of enrollees in the I/DD waivers and also uses residential settings that could be converted to non-provider owned housing to achieve cost efficiencies.

The pilot MRA(s) would be selected through a competitive procurement process. DADS could choose to select only one MRA/pilot site or multiple pilot sites. The selected MRA would be charged with using a managed care approach to make services provided within the HCS waiver more cost-effective. In exchange for taking on greater utilization management activities, the MRA would be given increased funding to support additional utilization management functions, provider and community outreach to develop housing options and to fund flexible and non-traditional services necessary to move individuals to their own or shared housing (e.g., payment of security deposit on an apartment).

The purpose of the pilot would be to determine if the MRA, if given enhanced funding and resources and clear performance objectives, could successfully apply managed care strategies to achieve significant enough cost savings to fund additional HCS waiver slots. Managed care strategies that could be effective in achieving cost savings in the HCS waiver program could include: requiring prior authorization for residential services, particularly for individuals at lower levels of need; allowing for some service substitution or flexible funding to help individuals live in less restrictive/more independent settings; and the application of utilization

management guidelines that would recommend the type and intensity of services for individuals according to their functional need and available supports.

Similarly, the pilot would also test whether those same managed care strategies could yield sufficient savings to create a decrease in the cost of an additional HCS waiver slot. Finally, this pilot would also test whether an MRA could successfully develop other non-provider owned settings, such as supports delivered to individuals residing in their own home or a shared home, and would help identify the particular incentives or tools necessary to achieve this conversion from provider-owned group homes.

The pilot would be designed to test the impact of the following strategies on cost, quality, and individual satisfaction:

1. Allowing for six-bed HCS group homes.
2. Shifting from provider-owned group homes to foster homes or own or shared homes.
3. Using a uniform assessment and utilization management guidelines to drive service allocation decisions.

The pilot program could be implemented as a competitive grant eligible only to MRAs in good standing with DADS. Selection criteria would be based on the MRAs demonstrated ability to implement managed care approaches designed to increase consumer-controlled housing and link service decisions to objective criteria. DADS could decide either to establish the grant award amount up front or to negotiate with the selected MRAs to establish a grant budget with acceptable budget parameters. Grant budgets would likely be in the range of \$200,000 - \$250,000 per year, over a three-year grant period, but the size would ultimately depend on the scope of the grant activities. Any savings that the MRAs in the pilot achieved over an established baseline of expenditures would be required to be used to purchase additional waiver slots or to fund flexible services necessary to help an individual live more independently.

If the pilot were deemed successful, then the various strategies used within the pilot (e.g., six-bed HCS group home, utilization management/prior authorization requirements) would be considered for expansion on a statewide basis. Should these functions be adopted statewide, they would likely create incentives for the MRAs to develop regional partnerships to meet the new requirements.

In contracting with the MRA or MRAs for the pilot program, DADS would set performance expectations and reporting requirements for the pilot area. For example, DADS could set targets for conversion to non-provider-owned housing.

Depending upon the level of utilization management that would be applied to the HCS waiver services, the state might need to develop a new 1915(c) waiver for the pilot area(s) and amend the existing HCS waiver to exclude the pilot areas. Federal regulations require that if a state wants to provide different service arrays or operate a 1915(c) waiver differently in different parts of the state, the state must apply for a separate waiver for each area. In other words, where the waiver is in effect, the waiver must operate consistently in all the areas served by the waiver.

This pilot option would serve both adults and children.

Option Two: Fully Capitated, Non Integrated, Managed Long-Term Care for Persons with I/DD

Under this approach, a managed care organization (MCO) would be competitively procured by DADS and would be at-risk for all I/DD services for eligible individuals in the pilot area. The MCO or MCOs for this pilot would receive an actuarially determined capitation rate for all services under the pilot.

With the exception of service coordination, all GR-funded services provided by the MRAs would remain outside of the pilot and continue to be provided by the MRAs as they are currently. Capitation would be for I/DD services only and would *not* include acute Medicaid or behavioral health services. All acute care and behavioral health Medicaid services would continue to be managed in the current Medicaid structure.

The managed care organization (MCO) for this pilot option could be an MRA with managed care experience, an MRA in partnership with an experienced MCO, a qualified non-profit entity, a qualified for-profit entity, or other organization able to bear financial risk under Texas law. Creating a model that made the MRA or a consortium of MRAs the MCO would be most similar to the Michigan model. The MCO would be procured based on an RFP issued by DADS. The RFP would set standards for qualified bidders: all bidders would have to demonstrate the capability to perform MCO operations and would also have to demonstrate significant experience in managing services for the I/DD population.

The MCO would be paid on a capitated basis (a per member per month payment) and would be either fully or partially at-risk. The reimbursement would include a risk-adjusted capitation payment that is commensurate with the risk of the consumers served by the plan. Because of the anticipated small enrollment in the MCO, it is likely that the financing arrangements would need to include risk-corridors or stop-loss mechanisms, particularly in the first few years of the pilot program. The MCO would be required to provide the full range of current services available under community-based ICF/MR services and HCBS waiver services that are the same as or similar to the services now included in the HCS, CLASS and TxHmL Waivers.

The MCO would be encouraged (through financial incentives and the ability to redirect institutional spending) to increase HCBS, especially services that support families, consumers in their own homes and consumer-directed services. Under this Option (as well as Option Three below), the MCO would have authority, through a prior authorization process, to manage individuals' entrance to community-based ICFs/MR.¹⁰ Although the State would still control licensing of the ICF/MR program, the MCO would be responsible for managing utilization of community-based ICF/MR beds. This element of the model is critical to the ability to create cost savings by giving the MCO the necessary control to ensure that individuals are being served in the most cost-effective setting. In order to support this function, both this option and Option

¹⁰ Although ICF/MR is an entitlement once a State elects to include this service in its Medicaid plan, States are permitted to control access to the service through the use of medical necessity criteria.

Three would require that service coordination be provided by the MCO, which would involve a change to the MRA's role in performing service coordination for the HCS Waiver.

Mandatory enrollment in the MCO would require a 1915(b) waiver. It is likely that CMS would require enrollees to have a choice of MCO, which would necessitate contracting with at least two MCOs, but there is also the possibility that Texas could negotiate with CMS to allow choice to be offered at the provider level as opposed to the MCO level. Michigan has been able to secure this latitude from CMS, but it is not certain that the same latitude would be granted to Texas.

As a capitated model, Option Two would also allow the State to collect increased revenue generated by the premium tax.

Enrollment in this pilot option would be mandatory for adults and voluntary for children.

Option Three: Fully Capitated, Integrated Managed Long-Term Care for Persons with I/DD

Option Three would integrate I/DD services with the acute and behavioral health services currently covered as STAR+PLUS benefits. This could be achieved by utilizing the existing STAR+PLUS health plans or by developing a new STAR+PLUS option that serves only persons with I/DD, with a separate new procurement. Utilization of the STAR+PLUS model offers some administrative and start-up efficiencies, since the basic managed care structure and oversight system for the pilot already exist. Development of a separate and new STAR+PLUS could face challenges in securing participation of two separate MCOs since the size of the eligible population may be too small to attract the choice of MCO that CMS requires states to offer.¹¹

As background, STAR+PLUS currently serves elders and persons with disabilities who receive Supplemental Security Income (SSI) or who qualify for the Community-based Alternatives (CBA) waiver services. Enrollment is mandatory for adults on SSI and voluntary for children on SSI. Individuals enrolled in a HCBS waiver or residing in an institutional setting are not eligible to participate in STAR+PLUS. STAR+PLUS incorporates outpatient acute care services as well as long-term care services (Primary Home Care, Day Activity and Health Services, and for eligible enrollees, CBA Waiver services). Commercial MCOs contract with HHSC and receive an actuarially determined capitated monthly payment. The capitation payment amount varies depending on which STAR+PLUS service area the member lives in and whether or not they are also entitled to *Medicare*. If the member is eligible for CBA Waiver services, the capitation rate reflects the additional cost to provide that array of services.

There are *two suggested scenarios* under Option Three:

- a. Based on a successful negotiation between current STAR+PLUS health plans and HHSC/DADS, I/DD services would be incorporated into the existing STAR+PLUS program in the pilot area. The I/DD population would have a separate, actuarially

¹¹ In some cases, CMS has granted States exemptions to this requirement of choice among MCOs, but this exemption occurs on a case by case basis and cannot be guaranteed.

determined capitation rate that reflects access to specific HCBS waiver services. Prior to a contract amendment to add I/DD services, the health plan or plans would need to demonstrate that they have the experience and expertise, either in-house or through a partner organization, to manage services for individuals with I/DD. From an administrative standpoint, this approach could be the easiest to implement, but it would limit the potential MCOs to the existing STAR+PLUS plans in the pilot area, assuming they were interested in providing I/DD services and were determined to have the necessary experience (directly or through contracted providers including the MRAs) to meet the needs of persons with I/DD.

- b. Alternatively, HHSC, with DADS' assistance, could issue a new Request for Proposal (RFP) for a new integrated managed care program that would include acute care, behavioral health and I/DD services for the pilot area. This approach would be more difficult and take more time to implement, as it would require a new procurement within the pilot service area. Unlike scenario one, this scenario would allow an MRA to bid to be the MCO either independently or in partnership with a commercial MCO.

Regardless of which of the above scenarios was used, the State would need to obtain federal approval (amending the STAR+PLUS Waiver and obtaining a new HCBS waiver for I/DD services or developing a new 1915(b) and 1915(c) waiver) and the MCOs would be required to demonstrate readiness to manage I/DD services. The State would define standards that the MCO would need to meet to demonstrate their readiness and ability to serve the I/DD population. MCO's could develop formal partnerships with MRAs to help them meet these requirements; or alternatively, the State could also require an MCO to have a contract with an MRA to provide certain key services.

As with Option Two above, the MCO(s) would be required to provide the full range of current services, including non-state ICF/MR services, and HCBS waiver services that are the same as or similar to the services now included in the HCS, CLASS and TxHmL Waivers.

The MCO would be encouraged (through financial incentives and the ability to redirect institutional spending) to increase HCBS, especially services that support families, individuals in their own homes and consumer-directed services. Under this Option, the MCO would have the authority to offer HCBS to individuals seeking non-state ICF/MR services. Although the State would still control licensing of the ICF/MR program, the MCO would be responsible for managing utilization of community-based ICF/MR beds. This element of the model is critical to the ability to create cost savings by giving the MCO the necessary control to ensure that consumers are being served in the most cost-effective setting. In order to support this function, both this option and Option Three would require that service coordination be provided by the MCO.

Option Three would also permit the MCO to offer supplemental services not otherwise covered under the state plan or through the HCBS waivers—authority available to states through Section 1915(b) waivers. For example, under a capitated model, the MCO could choose to pay for the security deposit on an apartment for an individual seeking to leave a provider-owned residential setting and live more independently using supported living services. This type of

flexibility is harder to achieve in non-capitated models, because funding is tied to specific services. In addition, the MCO would be able to offer individuals service substitution, where a less-expensive and more desirable service is substituted for a higher-cost and less desirable service. Service substitution may only be authorized for individuals who agree to this arrangement. In this manner, Option Three provides the greatest flexibility in services of the three options.

As a capitated model, Option Three would also allow the State to collect increased revenue generated by the premium tax. While pursuit of premium tax revenues alone should not be considered sufficient cause to select a capitated model, in instances where capitation supports larger policy goals, it is an added benefit.

The option would use the experience rebate mechanism used in STAR+PLUS to ensure that savings were appropriately shared between the MCO and the State. For an explanation of the STAR+PLUS experience rebate, see Appendix B.

Enrollment in this pilot option would be mandatory for adults and voluntary for children.

Table 4 below provides a comparison of the three proposed options.

Table 4: Comparison of Options

I/DD Pilot Options	Option One: Non-Capitated Enhanced Care Management	Option Two: Fully Capitated Non-Integrated Managed Care	Option Three: Fully Capitated, Integrated Managed Care
Enrollment	Children and adults	Mandatory for adults Voluntary for children	Mandatory for adults Voluntary for children
Uses risk-based capitation?	No	Yes	Yes
Integrates I/DD services with other services (e.g. acute care)?	No	No	Yes
Who can be MCO?	No MCO MRA role is enhanced	Any entity that meets specific requirements to bear financial risk.	Existing STAR+PLUS plans or any entity that meets specific requirements to bear financial risk.

SUMMARY OF STAKEHOLDER INPUT

HMA solicited and received stakeholder input on the three pilot options. The process to solicit stakeholder input consisted of:

- holding a series of public meetings;
- accepting written and oral comments at the public meetings; and
- accepting written comments via email, fax or United States mail.

Input was received from a broad array of stakeholders. A total of 84 individuals attended the stakeholder meetings, and 32 individuals /organizations submitted written comments.

There was significant diversity of opinion from stakeholders, even within specific interest groups, such as among consumer advocates. However, stakeholder comments followed some general trends, which are summarized below.

- Almost all stakeholders commented that any attempt to gain greater cost efficiencies and undertake meaningful redesign of the I/DD service system should encompass all components of the system, and thus an analysis of the effects of closing or consolidating State Supported Living Centers (SSLCs) should be undertaken.
- Consumers and advocates offered mixed input regarding their support for managed care for people with I/DD. Some consumers expressed opposition to the use of managed care for individuals with I/DD based on the belief that managed care would lead to reductions in service and limit opportunities for individualized service delivery approaches. Other consumer and advocate stakeholders noted that managed care holds the potential to provide more flexible and therefore appropriate services and also to provide more cost-effective services, which can translate into expanded service capacity.
- Managed Care Organizations (MCOs) supported the use of managed care for people with I/DD and were generally supportive of the use of an integrated model such as STAR+PLUS for this purpose.
- Providers of services and supports for people with I/DD were generally in opposition to the use of managed care for people with I/DD based on concerns that managed care approaches would entail a reduction in services.
- While there were limited comments about support for options other than those described by HMA in the Stakeholder Input Report, some stakeholders suggested that the State consider developing a model that would match benefit “packages” to an individual’s level of need, level of natural supports and living environment.

Additional comments with direct relevance to the selection of a model for a managed care pilot for individuals with I/DD are summarized below.

- *HCS bed size.* Some stakeholders indicated that they would not support the increase of HCS bed size to six beds (which was one of the potential changes to the current delivery system HMA cited as necessary under the pilot to increase cost-effectiveness of services).
- *ICF/MR System Concerns.* Many consumers and advocates commented that the focus of services should be to develop individual and shared housing and ensure that services are not tied to housing; individuals should have a “key to the front door and a lease.” Comments also noted that ICF/MR facilities do not offer individuals choice regarding

where they live, are expensive, are in conflict with a person-centered approach, prevent affordable and integrated housing and violate ADA and Olmstead by preventing people from receiving services in the most integrated setting. Finally, cost of ICF/MR facilities was addressed, with comments that the current ICF/MR system mandates payment of a “package” of services and supports that families and people with disabilities do not necessarily want or need and thus inhibits a cost-efficient use of scarce Medicaid funding.

- *End Date for a Pilot.* Many stakeholders commented that Texas has a history of continuing pilots indefinitely and recommended that any pilot program have a clear end date. These stakeholders commented on the need to establish meaningful benchmarks to evaluate the pilot and timelines for ending or expanding the pilot program.
- *Assessment Tool.* Multiple stakeholders commented on the importance of implementing a sound assessment tool if a managed care model is adopted so that decisions that link need to funding can be based on objective and sound criteria. Many stakeholders expressed support for the use of the American Association on Intellectual and Developmental Disabilities Support Intensity Scale (SIS) as an assessment instrument.
- *Integration of I/DD Services with Acute and Behavioral Health Services.* Some stakeholders commented that people with I/DD have multiple needs across various service systems (e.g., acute care, mental health), so an integrated system lays the groundwork for a more coordinated approach. Some stakeholders commented that coordination of long-term services with acute and behavioral health care services is particularly important, citing that fact that according to the National Association of Persons with Developmental Disabilities, approximately one-third of all people with I/DD have a psychiatric disorder. Some of these stakeholders also noted that studies demonstrate that individuals with I/DD have higher rates of medical problems compared to people without disabilities and that having a mental health or intellectual disability may elevate risk for other health problems in individuals with I/DD.
- *Oversight and Implementation of the Pilot.* Some stakeholders commented that the pilot should be developed and overseen with input from an ongoing advisory council of advocates and family members that has a meaningful rather than a token role.
- *Pilot Site Selection.* Stakeholders recommended that the selection of a pilot site should give weight to areas that have a history of strong and productive collaboration between key stakeholders.

OVERVIEW OF HMA FINDINGS

HMA’s recommendation about which pilot option to pursue was informed by our findings stemming from the review of other state systems, stakeholder input and the analysis of the current Texas I/DD system.

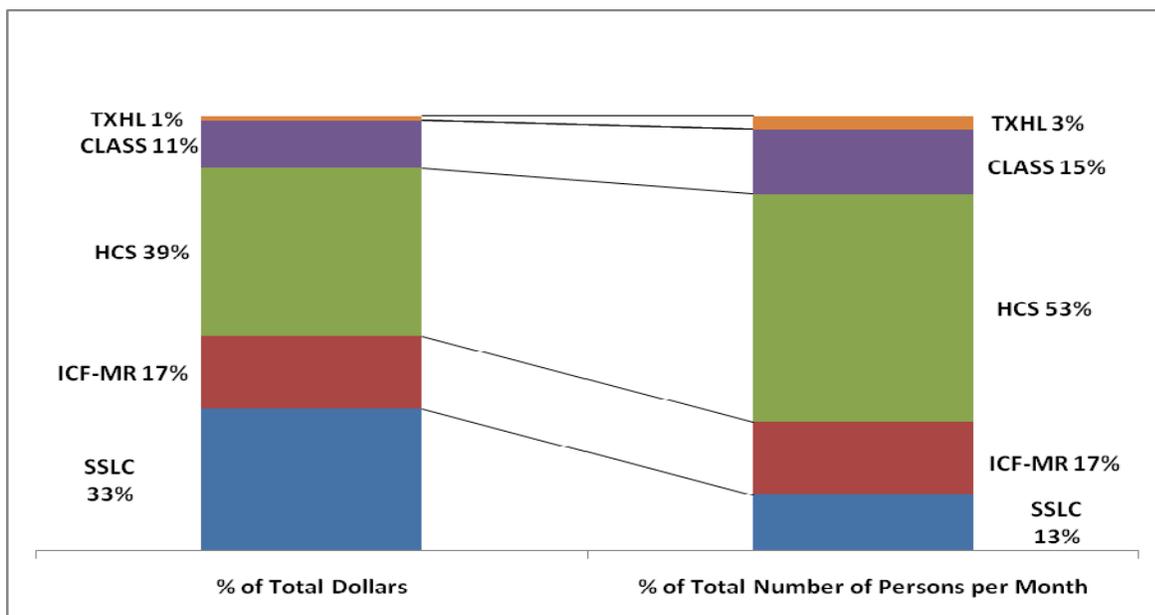
The most salient of HMA’s findings is that existing Texas state policy decisions hinder cost-effectiveness within the I/DD services delivery system. In particular, the continued use of the SSLCs, limitations on HCS group home bed size and the reliance on provider-owned residential

facilities in lieu of consumer controlled housing have limited Texas' I/DD system from achieving cost efficiencies and therefore realizing savings that could fund additional waiver slots. Each of these policy issues is described below.

Continued use of SSLCs

State Supported Living Centers use a disproportionate amount of resources relative to the number of individuals served. SSLCs account for 33 percent of the total dollars appropriated to the SSLCs and the four waiver programs included in this study, but serve only 13 percent of the individuals in these programs. Figure 1 below provides a comparison of costs versus number of individuals served.

Figure 1: I/DD WAIVER PROGRAMS AND SLCC COSTS



Unless some of these funds can be freed-up through SSLC closure or consolidation, the ability to rebalance the system and achieve savings is significantly hampered. While closure of the SSLCs may not be feasible in the short term, consolidation could also create significant cost savings. As noted earlier in the report, study states that have implemented managed care for persons with I/DD did so while rebalancing their I/DD service system (largely through the elimination or reduction of large ICFs/MR), thus expanding the pool of funds available to develop flexible, community-based services. Table 5 provides the budget breakdown of SSLCs, ICF/MR and waiver budgets.

Table 5: SSLC, ICF/MR and I/DD Waiver Budgets

Strategy Number	Strategy Name	SFY 2010-2011 TOTAL BUDGET	% of Total Budget	Average Number Persons Served per Month	% of Total Number of Persons Served per Month
A.8.1.	SSLC	\$ 1,283,835,479	33%	4,433	13%
A.7.1.	ICF-MR	\$ 656,100,759	17%	5,954	17%
A.3.2.	HCS	\$ 1,537,646,396	39%	18,501	53%
A.3.3.	CLASS	\$ 422,349,242	11%	5,144	15%
A.3.4.	DBMD	\$ 14,846,073	<1%	157	<1%
A.3.7	TXHL	\$ 21,947,328	1%	994	3%
TOTAL		\$ 3,936,725,277		35,182	

Limits on HCS group home bed size

While the small size of HCS group homes creates fewer institutional environments, it also makes provision of HCS more expensive than it would be if fixed costs could be spread across a greater number of residents.

This issue highlights the challenge states face in navigating conflicting policy goals and advocate and stakeholder sentiments. On one hand, some advocates and policy makers are interested in seeking more cost-effective ways of delivering services in order to harness the savings to create additional waiver slots. On the other hand, state policy has been to move away from providing residential services in large settings. However, smaller residential settings are generally more expensive to operate on a per capita basis, since costs are spread over fewer individuals. (As a case in point, large ICFs/MR are less costly on a per capita basis than smaller ICFs/MR.) To achieve cost savings of sufficient size to yield a meaningful increase in new waiver slots, the historic opposition to larger HCS residential options will likely need to be addressed. In particular, allowing for HCS group size to increase to six beds may be a necessary component to a broader strategy to achieve cost savings that can fund new waiver slots.

Reliance on provider-owned residential facilities, whether HCS residential or community-based ICFs/MR

Provider-owned housing tends to replicate many of the aspects of larger institutions, such as providing all services offered to all residents, which drives up costs and hinders consumer control. The use of other residential settings when appropriate is both more cost-effective and offers individuals greater autonomy and independence. Importantly, other states that have implemented managed care have moved away from a provider-owned residential model. As noted earlier, in Arizona, approximately 85 percent of persons served by the I/DD agency either live in their own home, a family home or a shared home not owned by a provider.

Within the HCS waiver, consumers can live in a variety of settings with different levels and types of support provided. These living arrangements include:

- Group Homes, which offer either Residential Assistance (four-bed model) and Supervised Living (three-bed model), use 24-hour shift staff services that provide direct personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene); assistance with meal planning and preparation; securing and providing transportation; assistance with housekeeping; assistance with ambulation and mobility; reinforcement of specialized therapy activities; assistance with medications and the performance of tasks delegated by an RN; supervision of individuals' safety and security; facilitating inclusion in community activities, use of natural supports, social interaction, participation in leisure activities, and development of socially valued behaviors; and habilitation, exclusive of day habilitation.
- Foster Care that provides HCS foster/companion care to individuals of all ages in a home-like environment as an alternative to living in a group home. Foster/companion care is provided to individuals who live in a residence in which no more than three individuals are living at any one time and in a residence in which the program provider does not hold a property interest.
- Own Home or Family Home, in which individuals can access Supported Home Living (SHL), a waiver service that helps individuals living in their own or their families' homes learn, retain, or improve their skills related to activities of daily living. Services include teaching personal grooming and cleanliness, bed making and household chores, preparing and eating food, and the social and adaptive skills necessary to reside in their own home in the community. SHL provided to individuals residing with their family members is designed to support rather than supplant the family and natural supports. Services are delivered on an hourly basis in amounts determined by the individual's needs. SHL is not a 24-hour service. Individuals residing in their own homes receive SHL as necessary to support them in their independent residence. The provider of supported home living must not live with the individual.

If Texas pursued policies that caused a shift away from the existing model of provider-owned housing, the average cost per person would likely be reduced. As shown in Table 6 below, the average monthly per-person cost for all waiver services for individuals who reside in non-provider-owned residential settings like foster care or a shared home is considerably less than for consumers in either HCS provider-owned settings (e.g., supervised living or residential support settings) or in ICFs/MR.

For example, the average monthly cost of all HCS waiver services¹² for a consumer at LON 5 (the most common LON) residing in their own or a family home is \$1,813, but for a consumer at the same level of need the average monthly cost for all waiver services is \$5,115 if living in a supervised living setting and \$4,676 if in a small ICF/MR.

This table also shows that for both medium and small ICFs/MR, average per capita monthly costs are actually less than the average monthly costs of all services provided to individuals in

¹² A full listing of the HCS waiver services can be found in Appendix A, Texas HCBS Waiver Crosswalk.

HCS group homes, which underscores the need to make HCS waiver services more cost-effective if Texas is to continue the policy of growing the HCS program.

Table 6: Average Monthly Cost by Living Arrangement, According to Level of Need

LON Type, by Severity ¹³	HCS Waiver Residential Settings			ICF/MR Settings	
	Supervised Living and Residential Support ¹⁴	Foster Care	Own Home or Family Home	Small ICF/MR (0-8 beds)	Medium ICF/MR (9-13 beds)
LON 1 – Intermittent	\$4,716	\$2,754	\$1,251	\$4,092	\$3,224
LON 5 – Limited	\$5,115	\$2,958	\$1,813	\$4,676	\$3,757
LON 8 – Extensive	\$5,585	\$3,540	\$2,695	\$5,509	\$4,592
LON 6 – Pervasive	\$6,422	\$4,471	\$4,162	\$6,833	\$6,085
LON 9 – Pervasive +	\$10,672	\$7,367	\$10,905	\$12,434	\$11,809
All LONs	\$5,303	\$3,146	\$1,762	\$4,851	\$3,630
Total Number of Individuals in Setting	5,470	7,833	3,422	4,271	591
Percent Individuals in HCS Residential Settings	33%	47%	20%		

Source: Texas Health and Human Services Commission, based on costs for January 2010.

Some possible explanations for the differences in cost by setting despite serving persons assessed as having the same of level of need include:

- Settings that use a daily rate (e.g., ICFs/MR and HCS group homes) tend to provide all residents with most or all of the services included in the rate, whether the individual needs each service or not.
- Reimbursement for any type of “congregate” setting is often calculated using a staffing model rather than an individual, needs-based model. This approach can lead to higher costs because efficiencies in staffing are typically not achieved until a certain facility size is reached. (For example a 12-bed facility is likely more cost-effective than a 4-bed facility.)
- Persons residing at home often receive care from their family members in the form of uncompensated care. If the person leaves the family home, the uncompensated care may need to be provided by an HCBS waiver provider.

While reducing the use of provider-owned housing would be a major undertaking in Texas, other states have successfully made this transition, and it is a critical element to achieving a more cost-effective delivery system. In addition to the potential cost efficiencies that could accompany this transition away from provider-owned housing, some consumers and advocates may support this model as one that fosters greater individual choice, control and autonomy. Of critical importance in developing more consumer-controlled options are:

¹³ When arrayed by severity, LON 8 precedes LON 6.

¹⁴ These are three and four bed HCS group homes.

- access to adequate housing including apartments with on-site supports and shared rental homes, (which typically requires creative financing and extensive collaboration across state and federal systems); and
- an array of home and community-based services that is sufficient to provide the right mix of home supports while ensuring health and welfare and maximum autonomy.

Other key findings are described below.

Acuity Distribution Is Similar Across the HCS Waiver and the ICF/MR Programs

As Table 7 below shows, within both the ICF/MR and HCS Waiver programs, the distribution of acuity is almost identical, indicating that the needs of the individuals served within the HCS programs and the ICF/MR programs are likely similar. Given the similar acuity levels of consumers in these programs, it is reasonable to assume that if additional HCS slots could be created that were more cost-effective than ICF/MR placement, then consumers could successfully transition to these slots if persons on the interest list have a similar profile.

Table 7: Acuity Distribution: Community-based ICFs-MR vs. HCS Waiver

Level of Need	Community-based ICF-MR	Percent of Community-based ICF/MR	HCS Waiver	Percent of HCS Waiver Total
LON 1 – Intermittent	1,410	23%	5,089	29%
LON 5 – Limited	3,127	51%	7,685	44%
LON 8 – Extensive	1,032	17%	3,376	19%
LON 6 – Pervasive	492	8%	1,366	8%
LON 9 – Pervasive +	18	0.3%	51	0.3%
TOTAL	6,079	100%	17,567	100%

Source: Texas Health and Human Services Commission, Client Assignment and Registration System as of March 2010

Individuals with I/DD Have Co-Occurring Disorders that May Benefit from Integrated Care

One objective of managed care for people with I/DD is to foster integration of I/DD and other services, specifically acute medical and behavioral health services. Thirty percent to 35 percent of all persons with intellectual or developmental disabilities are believed to have a psychiatric disorder.¹⁵ Additionally, people with I/DD have a higher prevalence of health problems than the general public, and their health needs are often unrecognized and unmet.¹⁶ Given the common interface of medical and mental-health problems in people with I/DD, and the disparity in

¹⁵ National Association for Persons with Developmental Disabilities and Mental Health Needs website, Information on Dual Diagnosis, available at: <http://www.thenadd.org/pages/about/ddinfo.shtml>.

¹⁶ SA Cooper, C. Melville, and J. Morrison, "People with intellectual disabilities," *BMJ* 2004;329:414-5.

health care they often face, there may be benefits to developing a system that encourages coordination of acute and behavioral health care for people with I/DD.¹⁷

Individuals with I/DD Already Receive Some Services under Managed Care

Although individuals enrolled in any of the HCBS waivers for persons with I/DD (HCS, CLASS, DBMD, TxHmL) are excluded from the STAR+PLUS program when they gain access to the waiver, during the time that they are on the interest list for the waiver, and as long as they are otherwise eligible for STAR+PLUS, they receive all STAR+PLUS services through their STAR+PLUS MCO. Thus, adults on an I/DD waiver interest list who live in a STAR+PLUS service area are already receiving acute care and some behavioral health services¹⁸ in a managed care model. I/DD services delivered by the MRA are not part of the STAR+PLUS array of covered services and thus are delivered outside of managed care. Table 8 below provides a count, by STAR+PLUS area, of the number of unique individuals who are on a waiver interest list and who are enrolled in STAR+PLUS.

Table 8: Individuals Enrolled in STAR+PLUS and on Waiver Interest Lists; Calendar Year 2009¹⁹

STAR+PLUS Service Delivery Area (SDAs include multiple counties)	CLASS	HCS & TxHmL	Total Number <u>Unique</u> Individuals on Waiver Waiting List and Enrolled in STAR+PLUS
Bexar	106	80	150
Harris	96	131	190
Nueces	37	31	58
Tarrant	1	0	1
Travis	33	25	48

Source: Health and Human Services Commission, Response to HMA Data Request

Notes:

1. Individuals can be enrolled in multiple waivers.
2. HCS and TxHmL use a combined interest list.

Texas is Making Improvements in Rebalancing the I/DD Service System but Still Lags Behind Most Other States

The federal Centers for Medicare and Medicaid Services (CMS) has defined rebalancing as “reaching more equitable balance between the proportion of total Medicaid long term support expenditures used for institutional services (i.e., nursing facilities and ICFs/MR) and those used

¹⁷ H. Kwok H. and PW Cheung, “Co-morbidity of psychiatric disorder and medical illness in people with intellectual disabilities,” *Current Opinion in Psychiatry*, September 2007. 20(5):443-9.

¹⁸ Rehabilitation and Targeted Case Management are carved out of STAR+PLUS and STAR and are provided by the Local Mental Health Authorities.

¹⁹A significant number of the individuals on the interest list for the I/DD waivers are children (so are voluntary for STAR+PLUS) or have Medical Assistance Only and therefore may not be eligible for STAR+PLUS.

for community-based supports under its state plan and waiver options.” States’ efforts to rebalance their long-term care systems are judged by the proportion of funds devoted to institutional vs. community-based services. In Texas, despite efforts to rebalance the system, Medicaid long-term care expenditures for individuals with MR/DD are still disproportionately skewed toward institutional services relative to most other states.²⁰ Additionally, Texas spends proportionally less on HCBS waiver services than most states. Table 9 below illustrates these differences:

Table 9: Percent of I/DD Spending on HCBS Waiver in 2006²¹

State	Percent of I/DD Spending on HCBS Waiver Services
Texas	29 percent
Arizona	70 percent
Florida	54 percent
Michigan	60 percent
Mississippi	11 percent
Vermont	83 percent
Wisconsin	48 percent

However, Texas has made some notable improvements in rebalancing efforts which can support and inform future I/DD policy decisions. As noted earlier (in Table 3), Texas has been engaged in a multi-year effort to increase waiver slots. From 2006 to 2010, the number of HCS waiver slots increased by 70 percent.

In addition, in 2006, DADS announced their intent to decrease large community-based licensed ICF/MR beds by a total of 461 by the end of fiscal year 2011 as part of Texas’ Money Follows the Person Demonstration (MFP). (MFP Demonstration is a federally funded grant that states apply for that provides enhanced matching funds in order to support the transition of persons from institutional to community-based settings.) DADS began accepting applications from private providers for assistance in voluntarily closing ICFs/MR that have nine or more beds, with priority given to large facilities with 14 or more beds. Each resident of the ICFs/MR that closed voluntarily was given several options for where he or she wanted to move, including the opportunity to live in a community (non-ICF/MR) setting through the MFP Demonstration. The State has surpassed the original goal of 461 beds and has taken 600 licensed ICF/MR beds off line. Of the individuals in the ICFs/MR slated for voluntary closure, 80 percent chose to enroll into the HCS waiver (the waiver slot was paid for with demonstration funds and was not

²⁰ B. Burwell et. al., “Medicaid Long-term Care Expenditures in FY 2008,” Thomson Reuters, Cambridge, MA, December 2009, available at: http://www.hcbs.org/files/165/8249/2008LTCExpenditures_final.pdf

²¹ Braddock, David, Hemp, Richard, and Rizzolo, Mary. *The State of the States in Developmental Disabilities 2008*. University of Colorado, Department of Psychiatry and Coleman Institute for Cognitive Disabilities. Table 7, Page 26.

counted against existing waiver slots) and 85 percent to 88 percent of those individuals chose to live in HCS group homes.²²

The results from this demonstration reveal that given access to a waiver slot and funding to a ready “home,” persons with I/DD who have previously resided in larger institutional-type settings generally do prefer to live in community settings. In addition, some ICF/MR providers appear ready to get out of the institutional business and perhaps could play an important role in a rebalanced system. Finally, dependence on more costly (compared to own home/family home) group home settings remains a problem. Texas will need to aggressively develop other settings, such as foster care or supports delivered to individuals residing in their own home or a shared home, to allow for realignment that does not entail new funding.

Funds to continue the Money Follows the Person demonstration through 2016 were included in the Health Reform bill, and Texas state staff have indicated that the State will apply (and expects to receive) continued funding to move individuals out of large institutions.

Texas’ Current Tax Structure Creates Incentives for Capitated Models.

There are two relevant tax provisions that apply to the services and proposed models discussed in this analysis: ICF/MR Quality Assurance Fee (QAF) and the HMO premium tax.

ICF/MR QAF. DADS currently collects a 5.5 percent tax applied to all community-based ICFs/MR, based on the gross receipts paid to a facility. The tax is collected by DADS on a monthly basis. The purpose of the quality assurance fee is to improve the quality of care provided to persons with mental retardation by supporting and/or maintaining an increase in reimbursement to facilities that participate in the Medicaid program. The use of the fees is subject to legislative appropriation, and historically the legislature has chosen to include this tax revenue in the DADS budget for ICF/MR services. Under a managed care pilot, the QAF would still be collected. However, over time, if the pilot were successful in converting usage of ICF/MR to other less institutional settings, the amount of the QAF collected on an annual basis would decline.

Premium Tax. A new source of revenue to the State for services to persons with I/DD would be available to Texas under a capitated model. Currently, most Medicaid services for persons with I/DD are provided in the fee-for-service system. Under either of the capitated models, managed care premium payments would expand, and additional premium tax would be payable to the State. The State benefits from a favorable federal matching funds treatment of premium tax. Historically, HHSC has not received an appropriation for premium tax paid by Medicaid health plans because current policy is to send the funds directly to the Comptroller’s office, where they become a part of the general fund.

The current premium tax in Texas is 1.75 percent of premiums paid. While the premium tax rate is lower than the QAF rate, it applies to a broader pool of individuals and services. Thus, in a

²² Interview with Marc Gold, Director, Promoting Independence Initiative, Texas Department of Aging and Disability Services, conducted August 14, 2010.

capitated pilot, any decline in revenue generated by the QAF would likely be more than made up by new revenue generated as a result of the premium tax.

Opportunities for Savings Are Insufficient to Make HCBS an Entitlement

Much of the public comment collected during the stakeholder process noted that a key goal of the pilot should be creating savings to fund an entitlement to HCS services and therefore an elimination of the waiting list. While making HCBS waivers an entitlement would be consistent with what occurred in the development of the STAR+PLUS program for CBA services, it is highly unlikely that sufficient savings could be generated in a pilot to make this possible.

In the original STAR+PLUS pilot in Harris County, early studies demonstrated cost-effectiveness even with the increased cost of opening CBA services to all who qualified. A 2003 study by Texas External Quality Review Organization, the Institute of Child Health Policy, showed savings in acute care with increases in less expensive community based care. The study found the following results:

- Inpatient rates were 28 percent lower for STAR+PLUS beneficiaries than for a matched control group of SSI voluntary participants in the STAR program.
- Emergency room visits were 40 percent lower for STAR+PLUS beneficiaries than for a matched control group of SSI voluntary participants in the STAR program.²³

It is important to view these findings with some caution since there have been no additional studies in recent years or since the expansion of STAR+PLUS outside of Harris County related to these data points. Given the changes to the STAR+PLUS program over time, including exclusion of inpatient hospital and nursing facility services, these studies would need to be conducted again to determine if the findings are applicable in the service areas outside of Harris Service Area.

The STAR+PLUS expansion of CBA services was funded primarily through a reduction in more expensive inpatient hospital costs. To see if a similar reduction in acute care costs could reasonably be assumed to fund an entitlement to HCBS waivers, HMA compared the acute care costs between STAR+PLUS and the I/DD waiver participants to determine the potential for savings to fund new waiver slots. The comparison indicates that STAR+PLUS members have significantly higher acute care costs than persons with I/DD enrolled in the HCBS waivers, even after being in a managed care program.

As the table below illustrates, there does not appear to be a significant potential for savings from the management of acute care for persons with I/DD because of the lower costs for persons enrolled in the HCS waiver compared to the acute care costs of STAR+PLUS enrollees, who are already in a managed care environment. Stated another way, only if the acute care costs of most waiver enrollees *exceeded* the acute care costs of the STAR+PLUS enrollees would there be sufficient reason to anticipate potential savings through managed care approaches within the

²³ Texas Health and Human Services Commission, *Financial Impact of Proposed Managed Care Expansion in Texas*, February, 23, 2010, available at: http://www.hhsc.State.tx.us/pubs/022305_FIPPMCE.html#ex

waiver populations. Thus, the analysis of acute care costs does not support an assumption that there are saving opportunities in managing acute care for individuals with I/DD sufficient to fund an HCBS waiver entitlement.

Table 10: Cost Comparison: Acute Care Costs for STAR+PLUS and I/DD Waivers SFY 2009, Ages 21-64

Program	Inpatient Average Amount Per User	Outpatient Average Amount Per User	Professional Claims Average Amount Per User
STAR+PLUS	\$8,180	\$2,989	\$4,921
HCS	\$3,704	\$542	\$1,593
TxHmL	\$4,170	\$631	\$1,926
CLASS	\$6,887	\$1,206	\$4,076
ICF/MR	\$2,678	\$367	\$923

Source: HHSC Strategic Decision Support, July 2010.

Note: The DBMD waiver data was not reviewed. The waiver has approximately 155 participants total.

In addition, in the original STAR+PLUS program, the most expensive services, inpatient hospital and nursing home services (limited to 4 months), were included in the model. This gave the MCO an opportunity to shift the delivery of services to a less expensive setting and generate savings. In the I/DD pilot program, State Supported Living Centers are the most expensive service setting and are excluded from this pilot. By removing this service, it becomes even more difficult to shift between more expensive institutional services and less expensive community-based services.

The Impact of Moving to Independent Service Coordination from HCS Providers to the MRA Is Not Yet Known

The 81st Texas Legislature mandated that DADS transfer case management functions within the HCS waiver from the HCS provider to the MRAs.²⁴ Implementation occurred statewide on June 1, 2010. The intent of this change was to improve the objectivity with which decisions about services were made and to foster individual choice.

The degree to which this shift of service coordination affects the type and amount of services chosen has yet to be determined, because of the short time that this policy change has been in place. Once sufficient time has elapsed to allow for an assessment of the impact of this policy change, it will be very helpful to determine any impact on service utilization patterns, particularly any changes that increase the use of non-provider-owned residential settings.

²⁴ Senate Bill 1, Article II, Section 48, 81st Texas Legislature, http://www.lbb.State.tx.us/Bill_81/6_FSU/81-6_FSU_0909_Art1_thru_Art2.pdf.

PILOT RECOMMENDATION AND RATIONALE

Pilot Recommendation

HMA’s recommendation of a delivery model for the proposed pilot was made according to the degree to which the selected option was judged as able to meet the goals and objectives established by HHSC and DADS at the beginning of the project. These goals and objectives were also vetted with stakeholders. They include the following:

- Increasing individual access to services through increasing waiver slots
- Promoting high quality care
- Allowing individual choice
- Providing services in a cost-efficient manner
- Preventing unnecessary institutionalization
- Allowing for necessary coordination of care across service delivery systems
- Feasibility of implementation of the model within Texas’ current Medicaid infrastructure.

Each proposed option was evaluated according to the ability of the pilot to meet the goals. HMA’s analysis included a review of the costs and potential saving of each model and an assessment of the models’ ability to create cost savings, coordinate care across delivery systems and fit into the existing framework of the Texas Medicaid system.

	Option 1: Non-Capitated Enhanced Management	Option 2: Capitated, Non-Integrated, Managed Long-term Care	Option 3: Capitated, Integrated, Managed Long term Care
Ability to achieve net cost savings to fund additional waiver slots	Savings Estimated to Outweigh Costs: Yes	Savings Estimated to Outweigh Costs: No	Savings Estimated to Outweigh Costs: No
Allowing for necessary coordination of care across service delivery systems	I/DD services, behavioral health and acute care would continue to be managed and provided in separate systems.	I/DD services, behavioral health and acute care would continue to be managed and provided in separate systems.	The management entity would be charged with coordinating the acute, behavioral health and I/DD services.
Feasibility of implementation within Texas’ current Medicaid infrastructure	Would likely require amendment to HCS waiver and new waiver for pilot area(s).	Would require a new procurement and waiver	Could be done via contract amendment to STAR+PLUS, and waiver amendments.

Given the goals of the project and the uncertainty about the level of savings available from more tightly managing I/DD services, HMA recommends the **Option 1, a Non-Capitated Enhanced Management model**. This Option would provide enhanced funding to an MRA selected by DADS to test the effects of implementing stronger utilization management linked to a uniform assessment and allowing for increased HCS group home size.

	Option 1 – Non-Capitated Enhanced Management	Option 2 – Capitated, Non-Integrated, Managed Long-term Care	Option 3 – Capitated, Integrated, Managed Long term Care
Increasing individual access to services through increasing waiver slots (e.g. ability to achieve cost savings or generate new revenue)	●	○	○
Allowing for necessary coordination of care across service delivery systems	○	○	●
Feasibility of implementation within Texas’ current Medicaid infrastructure	●	○	◐

Guide: ○ Not met, ◐ Partially met, ● Fully met

A **Non-Capitated Enhanced Management** pilot can serve as a tool for the State to test strategies intended to yield cost efficiencies (in order to secure additional waiver slots) and improve consumer direction and quality of care that, if successful, would eventually be applied on a statewide basis. The goal of the pilot would be to test and assess:

1. The impact on per capita costs and individual well being and satisfaction associated with increasing HCS group home size to six beds.
2. The effectiveness of managed care strategies to successfully shift the use of residential settings away from HCS group homes to consumer-controlled housing.
3. The impact of the use of strong utilization management guidelines linked to a standard assessment to help support and justify service allocation decisions.

Rationale for Recommendation

The selection of Option One, a Non-Capitated Enhanced Care Management Model, was informed by the need to identify and pursue strategies to make waiver services more cost-effective, which is a critical component to funding additional waiver slots. Using this model as the pilot would provide an opportunity for Texas to test strategies intended to yield cost efficiencies and improve consumer direction and quality of care that, if successful, could be applied on a statewide basis.

This recommendation against using a capitated model should not be interpreted to mean that capitation is not an appropriate model for the I/DD services. Capitation offers some significant benefits. These benefits include the ability to offer more flexible services, integrate care and make resource decisions based on cost-effectiveness. Additionally, the movement away from more costly and generally more restrictive provider-owned housing to other supported living options, when appropriate, would likely be accelerated under a managed care model because the managing entity would have a significant financial incentive to provide the most cost-effective and clinically appropriate service.

However, as illustrated in Appendix D, using a capitated model that relied on commercial MCOs (Option 3) would also require that the State expend significant resources in developing, implementing and overseeing the model. MCOs would require fees to cover administration and profit, and the State would also need to fund various start up and ongoing costs, such as eligibility system changes and use of enrollment brokers. These are all legitimate expenses when the State can reasonably expect a savings from the program that will cover these costs and still yield a net benefit to the State. In the case of this pilot, there is not sufficient knowledge about whether the I/DD service system presently offers the potential to achieve enough savings to justify these expenses to the State.

While a capitated model that used MRAs to manage I/DD services (Option 2) would eliminate some of the administrative costs associated with use of commercial MCOs, it would still pose risks for the financial viability of the MRAs, which have limited managed care experience, and for consumers, since a capitated model creates incentives to reduce service levels in ways that may not be clinically appropriate. While these risks can be managed by strong state oversight and use of risk-sharing arrangements to minimize the financial exposure of MRAs, there is little reason to undertake a system redesign that poses a possible threat to both traditional providers and the consumers of care unless there is a reasonable assumption that the savings available justify the risks and efforts involved with significantly restructuring the service delivery system.

Thus, the recommendation to pursue Option One is an acknowledgement that before Texas can make an informed decision about whether capitation is an effective model for I/DD services, Texas should first test two assumptions:

3. that management of I/DD services offers opportunities for savings; and
4. that MRAs, if given the necessary tools and latitude, can apply the tools of managed care to harness these savings.

If an evaluation of the pilot concludes that the I/DD service system offers significant potential for achieving cost efficiencies while also preserving quality of care, then HHSC and DADS can better assess whether more vigorous attempts to achieve cost efficiencies are warranted. These attempts could include capitated managed care or could instead rely on instituting enhanced management and oversight functions at the state and MRA level, similar to the activities that

Texas has instituted in its Resiliency and Disease Management program for behavioral health services.²⁵

If the I/DD service system is assessed as offering significant opportunities for savings, then the next question before the State is whether MRAs can operate with sufficient objectivity and rigor to capture these savings. If the pilot MRA(s) demonstrate that they can apply managed care strategies effectively, then there is limited reason to pursue the use of commercial managed care vendors, which require that the State pay significant amounts toward administration and profit in order to realize those savings.

If, on the other hand, the MRAs are assessed as not able to effectively apply managed care strategies, then the State should consider the use of commercial health plans. For example, MRAs' connections to and reliance on support from local elected officials and funders may challenge their ability to make objective decisions on resource distribution. However, before the State pursues any options that would minimize the expertise and experience that MRAs have in serving people with I/DD, the ability of the MRA to realize efficiencies in provision of waiver services should first be tested.

Ultimately, the evaluation of the pilot will need to determine if the savings achieved from the above strategies are of sufficient magnitude to purchase additional waiver slots.

PILOT DESIGN FOR A NON-CAPITATED CARE MANAGEMENT PROGRAM

Pilot Duration and Evaluation

The duration of a pilot should be long enough to reasonably test the pilot's ability to achieve its goals. HMA recommends a pilot duration of three years to allow sufficient time to fully implement the pilot and collect and evaluate data.

The State should conduct a formal evaluation at the mid-point and conclusion of the pilot. As part of the development of the pilot, the State should refine the key questions that the pilot should test and develop a strategy to ensure that the data to support this evaluation is collected early enough to provide baseline information against which the pilot's impact can be judged. The decision about continuation or expansion of the pilot should be directly linked to the results of this evaluation. (The cost of this evaluation is included in cost estimates of the pilot implementation.)

Examples of performance data to collect in the evaluation could include:

- Average cost per person, pre and post the pilot;
- Rate of ICF/MR conversion to HCS residential setting;
- Percent of individuals in non provider owned housing, pre and post the pilot;

²⁵ For more information on the RDM program, see: <http://www.dshs.State.tx.us/mhprograms/RDM.shtm>

- Average total Medicaid costs by level of care for individuals in various HCS residential settings, pre and post;
- Percent of individuals employed, pre and post the pilot;
- Percent of individuals with improvement of behavioral stability, pre and post the pilot;
- Monitoring of complaints and appeals; and
- CAHPS (Consumer Assessment of Healthcare Providers and Systems) or other satisfaction survey of individuals and/or Legally Authorized Representatives (LARs)

Geographic Scope

The geographic scope of the pilot would be dependent upon which MRA or MRAs were selected to participate. DADS could decide to make a determination to select one rural and one urban area to determine if there are key differences in outcomes that could be attributed to setting.

Utilization Management / Utilization Review

Utilization management (UM) generally consists of activities designed to ensure services will be utilized appropriately through prior authorization activities. Utilization review (UR) activities examine services that have already been provided to identify patterns of excessive use or inappropriate use.

States typically require that HCBS waiver services be authorized based on one or more of the following:

- The coverage and limitations specified in the approved HCBS waiver application;
- Limitations contained in state regulations including Medicaid medical necessity requirements and waiver-specific requirements; and/or
- An individual's assessed level of need, which may include use of a uniform assessment instrument.

Managed care entities typically apply guidelines for health care service use based on nationally recognized evidence-based standards. Such standards exist for a range of health care services, including home care, chronic care and care management. However, generally accepted standards for appropriate utilization of services like habilitation, personal care, respite care, and environmental modifications are not generally applied in I/DD settings, although support for this tactic (as evidenced by stakeholder feedback) and state experience in this arena is growing.

According to the Center for Health Care Strategies, a number of states (e.g., Colorado, Georgia, Louisiana, Oregon and Wyoming) are considering or have adopted payment systems that establish case rates or individual funding levels that are linked to an individual's need as determined by a standard assessment.²⁶ A brief overview of the approach used by Louisiana for

²⁶ Gretchen Engquist, et.al., "Innovations in Medicaid-Funded Long-Term Care," Center for Health Care Strategies (May 2010), p. 20-21. http://www.chcs.org/usr_doc/LTSS_Innovations.pdf

developing funding levels for individuals with developmental disabilities is provided in Appendix C.

The pilot would be designed to move the I/DD system to one that uses utilization management guidelines linked to a standard assessment to drive service utilization decisions. A standard assessment would assign individuals to a package of services. Services outside of this package would require prior authorization. This process should start with the HCS waiver and be expanded to the other waivers serving persons with I/DD over time. UM guidelines would be based on available literature and research regarding best and emerging practices. This strategy would be similar to the approach used in the Resiliency and Disease Management process the Department of State Health Services has employed for publicly funded mental health services.

Thus, within this pilot, the MRA(s) would be required to adhere to state-defined utilization management guidelines for the HCS pilot that would be developed to direct individuals to the most appropriate but least expensive service settings.

The pilot MRA site(s) could have a role in assisting DADS in developing and/or reviewing existing UM guidelines to be implemented. This collaboration would help to ensure that the UM guidelines adopted are feasible for the MRAs to implement and would also help establish buy-in from the other MRAs should the strategies of the pilot eventually be expanded statewide.

The development of the utilization management guidelines should prioritize creating guidelines for access to supervised living and residential supports services within the HCS waiver. The pilot MRA(s) and DADS should also evaluate whether establishing a prior authorization process for any requests for group home placement for individuals at lower acuity levels (i.e., levels 1 and 5) would help to ensure that the service was used only for those individuals for whom more independent living settings were not appropriate or available.

The use of utilization management guidelines and/or prior authorization processes does not conflict with federal policy regarding HCBS waiver services. HCBS waiver services are not a menu of services from which any service may be selected. Waiver participants have the choice of waiver services *for which they have a demonstrated need*. However, as is discussed later, HCBS waiver services must be uniformly available to waiver participants, so some changes to Texas' existing HCS waiver would likely be required in order to implement a prior authorization process.

Finally, implementation of a more rigorous UM process in the pilot area(s) than has historically been used in Texas may prompt local stakeholder concerns and opposition. Any time a state undertakes to more carefully manage Medicaid services, there is the possibility of appeals by individuals and their families when management results in a reduction or termination of a service. The state must have clear, written requirements in place, especially in state regulation or incorporated by reference into state regulation, in order to ensure that service utilization decisions made in accordance with these requirements will be upheld on appeal.

Use of a Standard Assessment Tool

The MRAs in the pilot will need to implement a UM system that is appropriate for persons with I/DD. As noted earlier, the UM guidelines should be linked to a standard assessment tool. The use of a uniform assessment tool tied to a specific level or amount of support can help ensure that services are not inappropriately withheld or overutilized and can also help states make more objective comparisons of the effectiveness of different services.

DADS could decide to require a specific tool in advance of issuing the grant or could work with the pilot MRA(s) to select and test a tool. HMA recommends that DADS select the standard assessment tool in advance of selecting the pilot sites and make the use of this tool a requirement of grant funds. DADS would be responsible for purchasing the tool and providing the necessary training on the tool.

Texas currently uses the Inventory for Client and Agency Planning (ICAP) to assign individuals to a Level of Need, which is tied to funding levels for persons in ICF/MR and in HCS. A number of other states, including Illinois, Montana, Tennessee and Wyoming, also use the ICAP. The ICAP is a structured evaluation of adaptive and problem behaviors that gathers information on diagnosis, disability type, personal characteristics, functional limitations and service needs.

In recent years, states' I/DD systems have become increasingly interested in using standard assessments to inform resource allocation decisions. Reviews of states' patterns of spending for I/DD services have indicated that many states have concerns that spending is not sufficiently tied to need but is instead a reflection of location, agency bias and local funding and expectations.^{27,28} In response to these concerns and other needs, some states have developed tools to project the specific amount of service a person may require. For example, Louisiana uses a process to tie assessment to funding levels, as described in Appendix C.

As attention on the use of standard assessments to inform resource allocation decisions has grown, states have begun to re-evaluate their assessment tools. While both the ICAP and SIS are used by states to inform resource allocation, programs that use the assessment to tie need to funding levels generally favor use of the SIS, which is regarded as providing a more comprehensive evaluation of an individual's needs and existing supports.²⁹

The SIS is designed to comprehensively assess a person's capabilities and assign a score based on these outcomes. The SIS is published by the American Association for Persons with Intellectual and Developmental Disabilities (AAIDD).³⁰ The SIS evaluates practical support requirements of an adult with an intellectual disability. Through a positive interview process,

²⁷ Gretchen Engquist, et.al., "Innovations in Medicaid-Funded Long-Term Care," Center for Health Care Strategies (May 2010), p. 20-21, available at: http://www.chcs.org/usr_doc/LTSS_Innovations.pdf

²⁸ K. Charlie Lakin, Robert Prouty, Kathryn Coucouvanis "Long-Term Service and Support Expenditures for Persons with ID/DD Within the Overall Medicaid Program," *Mental Retardation*: February 2005, Vol. 43, No. 1, pp. 68-72. [http://www.aaidjournals.org/doi/abs/10.1352/0047-6765\(2005\)43%3C65%3ALSASEF%3E2.0.CO%3B2](http://www.aaidjournals.org/doi/abs/10.1352/0047-6765(2005)43%3C65%3ALSASEF%3E2.0.CO%3B2)

²⁹ Gretchen Engquist, et. al., "Innovations in Medicaid-Funded Long-Term Care," Center for Health Care Strategies (May 2010), p. 20-21. http://www.chcs.org/usr_doc/LTSS_Innovations.pdf

³⁰ More information about the use of the Supports Intensity Scale is available at: http://www.sageresources.org/resources/Individual%20Budgets%20Using%20SIS_FINAL.pdf

the SIS measures support requirements in 57 life activities and behavioral and medical areas. The assessment is done through interviews with the individual and those who know the person well. The SIS measures support needs in the areas of home living, community living, lifelong learning, employment, health and safety, social activities, and protection and advocacy. The Scale ranks each activity according to frequency, amount, and type of support to generate a score that can be used as the basis for developing an individual budget that represents the amount of funding a person has available to purchase HCBS waiver services and supports. States using the SIS include Colorado, Georgia, Louisiana, North Carolina, Pennsylvania, Rhode Island, Utah, Virginia and Washington.

A review of the ICAP as compared to the SIS in Table 11 below highlights the strengths and weaknesses of these tools.

Table 11: Strengths and Weaknesses of the ICAP and SIS³¹

ICAP		SIS	
Strengths	Weaknesses	Strengths	Weaknesses
Reliable psychometrics	Minimal health status information	Reliable psychometrics	Best administered by skilled individuals
Ability to distinguish individual behavior differences	Deficit based	Identifies frequency and intensity of support needs	Inter-rater reliability is less strong
Available for children and adults	Does not capture natural supports (non-paid caregivers)	Evaluates employment support needs	No child version
	Inadequate coverage of vocational supports	Assists in individual support planning	

During public hearings and in discussions with state staff, there was considerable support for the SIS. Making the shift to a new standard assessment would entail some costs to the State, both to purchase the tool, to provide necessary training and to make the necessary infrastructure changes, such as re-programming of eligibility systems. However, a sound standard assessment that can support and inform resource allocation decisions is a critical element of achieving cost efficiencies.

Texas may want to explore other options before deciding on which tool to require within the pilot, although HMA would recommend that HHSC and DADS give strong consideration to the SIS.

³¹ “State Resource Allocation Strategies and Challenges,” Presentation By Charles Moseley of National Association of State Directors of Developmental Disability Services to the Maryland Developmental Disabilities Administration, January 14, 2008.

Provider Network

A key responsibility and expectation of the pilot MRA(s) will be to develop the capacity within their service delivery area for individuals to reside in their own home, shared housing or in foster care settings. This will require active involvement in identifying and creating affordable and appropriate residential settings that are not provider owned. These activities will need to address historic issues of lack of affordable and accessible housing and will require that the pilot MRA(s) play an active role in helping their community develop consumer controlled housing for people with I/DD.

Most communities do not have a sufficient supply of accessible and affordable high-quality housing to break free of the provider-owned model. In some instances, housing with onsite supports is the best option for individuals, and this is a model that is being used successfully in many urban areas. Housing development for persons with special needs is often led by not-for-profit local groups who use a combination of HUD funds, grant funds and financing to convert existing buildings to apartments or to construct new apartments. Joint ownership programs can also be pursued. Because up-front development costs are high, there must be some assurance of occupancy and of funding to support on-site services. In addition, some costs like rental deposits, utility deposits and furnishings not typically covered under a HCBS waiver must be funded.

The pilot MRA(s) will need to actively participate in the local planning process that may include HUD, local planning groups, housing collaboratives, health care organizations including FQHCs and RHCs, and other organizations to develop an array of housing options, including housing with onsite supports. These settings could be mixed use and serve the elderly, persons with I/DD and persons with behavioral health issues and could bring together multiple interest groups and stakeholders. The efforts of the pilot MRA(s) and DADS should be to consider ways to free-up funding now “tied” to high cost settings. MRAs will need to work with the existing and potential provider base to propose creative ways to reduce group home and ICF/MR utilization and to gradually replace and grow residential alternatives.

MRAs will also need to develop a concerted outreach and education program to existing HCS group home providers to encourage them to convert, where appropriate, to a six-bed model. DADS should consider whether some percentage of the grant funds would be allowable to help partially offset providers’ costs in making this conversion. MRAs will need demonstrate to the provider community that the goal of this conversion is to create savings necessary to fund additional waiver slots so that, to the degree that this conversion can be accomplished successfully, the providers’ consumer base will grow.

Additionally, the MRA will need to work with the provider base to help create profiles of individuals who do best in smaller versus larger residential settings. This information should be used to help inform the utilization management guidelines.

Service Coordination

Effective June 1, 2010, the HCS case management functions were transferred from the HCS provider to the MRAs. This change supports the goal of the pilot to give the MRA the authority

and responsibility to more proactively assist individuals in locating appropriate housing and creatively helping individuals overcome barriers to living in more independent settings. Within the pilot, the role of service coordination may need to be expanded to also include assistance in locating affordable housing, finding an appropriate roommate, securing household goods, creating linkages with housing providers, etc.

The funding provided to the pilot MRA(s) would be eligible to be used to support an expanded role for service coordination where necessary.

Waiver Development and Timelines

A managed long-term care program typically requires the use of one or more Medicaid waivers. The specific type of waiver(s) required depends on the program design.

1915(b) Waivers

If a state wants include any of the following features in its managed long-term care program, a 1915(b) waiver is required:

- Require persons to enroll into managed care;
- Limit the number of managed care organizations that may provide the covered services; and
- Use savings achieved by the MCOs to provide additional services to enrollees—services not otherwise covered by Medicaid (such as specific dental services like preventive care or non-prescription (over the counter) drugs).

A 1915(b) waiver is not required if enrollment is entirely voluntary and if any willing and qualified provider of the managed care services may participate. Instead, a state may use 1915(a) state plan authority to implement managed care.

A state may include any “state plan” services under a 1915(b) waiver, including physician services and hospital services, or may use the 1915(b) authority to develop a specialty program, such as managed behavioral health services and managed long-term care services.

The option recommended for this pilot would *not* require enrollment into managed care and would therefore not require that the State use a 1915(b) waiver.

HCBS / 1915(c) Waivers

States typically include HCBS waiver services in a managed long-term care program and may also include any other state plan services desired. In some states these services include home health and state plan personal care services. They might also include behavioral health services. A fully integrated managed care program would include all Medicaid services. An HCBS waiver may serve the following groups:

- Persons who are 65 years of age or older and persons with physical disabilities who would otherwise require nursing home services);
- Persons with I/DD who would otherwise require ICF/MR services; or

- Persons with a mental illness who would otherwise require nursing home or psychiatric hospital services.

A state may also include in any of these groups who would otherwise require hospital services. Implementation of a waiver for persons either at nursing home or hospital level of care is most common for persons with AIDS, spinal cord injuries or traumatic brain injuries.

States are required to implement methods to ensure the appropriate utilization of Medicaid services. They are permitted to apply utilization management and prior authorization processes to all Medicaid services including HCBS waiver services. Persons enrolled in a HCBS waiver must have access to all covered services, although each service must be determined necessary. The methods used to administer the waiver must be applied uniformly to all waiver participants. In addition, while a HCBS waiver may be implemented on less than a statewide basis, a single HCBS waiver cannot be implemented differently in different parts of a state except as part of a phase-in process approved by CMS.

In order for Texas to implement prior authorization or other mechanisms to ensure appropriate utilization of services in the pilot area(s), but not outside of the pilot area, Texas would likely need a new HCBS waiver for the pilot area. If new requirements were utilized statewide, an amendment to the HCS Waiver would likely suffice. Development and approval of a new HCBS waiver would likely take between nine and twelve months.

Opportunities Under Federal Reform

States now have the option to provide HCBS without a waiver using the state plan HCBS Section 1915(i) option. There are some important differences between the HCBS waiver and the HCBS option. Under the 1915(i) SPA option:

- A state must provide HCBS to persons who have functional limitations but who do not meet institutional level of care (the “needs based group”). They may also elect to serve persons at institutional level of care in addition to the needs-based group.
- A state may not use a waiting list (although a state may take up to five years to phase-in all eligible persons and services).

A state may be concerned about the increased cost to serve the “needs-based” group as well as the entitlement to these services. It is likely that many states will continue to use HCBS waivers as the primary means of covering alternative services to persons at risk of institutional care, even if they decide to serve a “needs based group.”

If a state decided to implement state plan HCBS, these services would be included in the managed care program without the need for a HCBS waiver (just as home health services may be included under the 1915(a) state plan option or 1915(b) waiver).

Pilot Costs

As noted earlier, the pilot would be most easily structured to resemble a competitive grant application made by DADS to the selected MRA(s). If DADS pursued this approach, the grant guidelines could specify a total not-to-exceed amount of grant funding available per site and

allow the MRAs to develop their own budgets within these guidelines that reflected the grant’s goals and objectives and allowable and non-allowable expenses. Alternatively, DADS could make grant funding only for specific budget line items, such as staff and overhead.

In either approach, the total amount of grant funding necessary to realistically support an MRA’s activities under the pilot would be in the range of \$200,000 to \$250,000 per year, over a three-year grant period, but the size would ultimately depend on the scope of the grant activities. In addition to costs to the MRA(s), there would also be costs to DADS to purchase the SIS tool and necessary training and technical support. DADS would also need to fund a pilot evaluation, which HMA recommends include both a mid-point evaluation to ensure the pilot is on track and to provide input on any necessary mid-course corrections and a final evaluation which will be the principle source of determining if the pilot met the stated objectives and whether expansion should be considered.

Below is a high level overview of the estimated total costs for establishing the pilot, which includes funds to the MRA and other costs to DADS. These figures are intended to illustrate range of likely costs, but they should be reviewed and refined by DADS and HHSC staff before a final budget for the pilot is created.

MRA Pilot Costs:

Activity	Number Staff	Salary	Fringe (20%)	Total
Utilization Management Staff (charged with performing assessments and other UM activities)	2	55,000	\$22,000	\$132,000
Provider Outreach Staff	1	50,000	\$10,000	\$60,000
Administration (10%)				\$19,200
Flexible Funding (for purchase of supports not allowable under HCS e.g., security deposit on rental apartment). ³²				\$5,000
Annual Estimated Total				\$216,200
Total for 3-Year Pilot Period				\$648,600

³² A new rule project within DADS, once complete, will make transition assistance services (TAS) available to persons moving to HCS from an ICF/MR or nursing facility. TAS provides necessary items, such as security deposits, household items, furniture, or one time cleaning expenses needed by an individual transitioning from an institution to the community. TAS is a once-in-a-lifetime service, has a limit of \$2,500, and is paid with waiver funds from the individual’s waiver budget. The flexible funds used in the pilot would supplement these funds.

DADS Pilot Costs:

Activity		Total
Pilot Evaluation		\$100,000
SIS Purchase and Training ³³	Year 1 Purchase of SIS Tool and Training (assumes 5,000 assessment completed and all UM staff trained)	\$138,000
	Years 2 & 3 Ongoing Use of SIS Tool and Updated Training (assumes 500 assessment and reassessments conducted)	\$38,000
Total		\$276,000

Total Pilot Costs for Three Year Period: \$924,600, assuming only 1 MRA participates. Costs would increase if multiple MRAs were included in the grant.

While this pilot will entail costs to the State, these costs are estimated to be outweighed by potential savings achieved by increased management and oversight of I/DD services. For example, even a modest shift from provider-owned residential settings to consumer-controlled housing is likely to cover the costs of the pilot. HMA calculated the impact of transitioning persons in Level of Need 1 and 5 (the lowest two acuity levels and the levels that have the largest percentage of waiver participants) from HCS Supervised Livings and Residential Supports to Foster Care or Own Home Settings, with a goal of moving from 33 percent Supervised Living in Year 1 to 20 percent over a five-year period. For the purposes of this pilot, the Year 3 savings would apply. This savings estimate is highlighted in Table 12, below.

Table 12: Pilot Savings Potential

	New Supervised Living	Numbers Shifted Each Year	Total Cumulative Each Year	Statewide Savings	Harris County Savings
STATEWIDE					
Total In HCS Program: 16,725					
Year 1 No change to Supervised Living	5,740	0	0	0	0
Year 2 Supervised Living at 31%	5,185	555	555	\$ 1,143,300	\$ 403,566
Year 3 Supervised Living at 28%	4,683	502	1,057	\$ 2,177,420	\$ 768,593
Year 4 Supervised Living at 25%	4,181	502	1,559	\$ 3,211,025	\$ 1,133,439
Year 5 Supervised Living at 20%	3,345	836	2,395	\$ 4,933,700	\$ 1,741,515
Total over 5 Years		2,395	5,566	\$ 11,465,445	\$ 4,047,113
Note: Savings represent the cost differential between foster care and supervised living, a blended average for LON 1 and LON 5. Savings in Harris represent 35% of the total, based on the total number of individuals in Harris as a percent of the total HCS program.					

Furthermore, the investment in the development and implementation to institute the use of a standard assessment that will drive resource allocation decisions will likely yield costs savings

³³ The price of the SIS is based on volume of assessments conducted, so should the State use the SIS on a Statewide basis, the costs would be reduced because of larger volume.

once fully implemented. When Louisiana introduced the use of a standard assessment linked to resource allocation decisions, the State measured an average annual savings per service plan of \$17,917.³⁴ It is difficult to quantify the impact of the linking the assessment tool to resource allocation in Texas; however, we do believe a more stringent application of utilization management criteria can result in additional program savings. For example, a 1.0 percent savings through enhanced utilization management, would result in an annual savings of \$1.9 million in I/DD service costs in a pilot the size of Harris County.

What Federal Requirements State Must Meet

States are not required to make HCBS an entitlement as a condition of implementing managed long-term care. States that have made HCBS an entitlement in these types of programs have done so at the direction of their state legislature. Some states have projected they will generate enough cost-savings from using managed care to expand access to HCBS (Wisconsin and Michigan, as well as Texas for the STAR+PLUS program).

While a state is not required to provide HCBS to everyone and end the waiting list, the federal government does require that the state explain how they manage their waiting list and who has priority access to HCBS waiver services. This requirement applies to all HCBS waivers and is not related to the use of managed care.

Pilot's Effect on Preventing Institutionalization

This pilot would not address a key element of the Texas I/DD system that stakeholders have almost uniformly expressed concern with, namely the imbalance of Texas' investment between community-based services and institutional services. While this pilot can help Texas achieve cost efficiencies within community-based I/DD services, specifically those services within the HCS waiver, it does not correct this historic imbalance. Efforts to prevent institutionalization will require a comprehensive rebalancing of the I/DD system to harness the resources currently devoted to SSLCs. However, while this pilot cannot achieve that larger purpose, it is assumed that it will yield cost efficiencies that can eventually be applied on a statewide basis that will translate into savings to fund additional waiver slots. The addition of these waiver slots will allow Texas to make inroads on the prevention of institutionalization.

Main Barriers to Implementing the Pilot

The barriers Texas will likely encounter in implementing this recommendation are stakeholder opposition and securing sufficient resources to fund the program, particularly since savings, though expected, are not assured.

First and foremost among the barriers to implementing managed care strategies is the potential for widespread opposition. Individuals and their families may fear that they will not have access to the type and intensity of services that they believe necessary. Existing providers may fear they will lose business and may resent requirements imposed by managed care (being

³⁴ Gretchen Engquist, et.al., "Innovations in Medicaid-Funded Long-Term Care," Center for Health Care Strategies (May 2010), p. 20-21, available at: http://www.chcs.org/usr_doc/LTSS_Innovations.pdf

subject to prior authorization or being required to implement specific practices including evidence-based practices). A strong outreach and education effort that precedes the pilot's launch and that is used to collect information to refine the implementation of the pilot is a critical element of a successful pilot. Individuals, families, state staff, providers, contractors and administrative law judges need to be educated concerning the scope of covered services and limitations in order to promote appropriate utilization of services and to reduce the need for time-consuming and costly appeals. Texas should be prepared to address this potential issue by ensuring that a comprehensive outreach and education campaign to prepare the community for the change in services proceeds and helps to inform implementation of the I/DD pilot.

The efforts undertaken prior to the launch of STAR+PLUS into Harris County offer an example of an effective and comprehensive campaign to both educate and involve community stakeholders in anticipation of a major service delivery change. In this case, the State contracted with a non-profit advocacy organization to do a portion of the necessary outreach, particularly to individuals, family members, advocates, traditional providers, and other key community stakeholders. This outreach campaign included numerous public forums, educational materials such as brochures and videos and provided key information to the state staff about stakeholder concerns that could be addressed in subsequent materials and stakeholder communications. Additionally, the efforts Texas undertook to educate local stakeholders in advance of the Resiliency and Disease Management program may also serve as a model for community outreach and education.

An additional barrier Texas is likely to encounter in implementing the recommended model is securing the necessary resources to fund the pilot. This will be particularly challenging given the State's existing budget climate. Setting clear expectations for expected savings that can be converted to additional waiver slots may help to justify the upfront expense. It will also be helpful to have clear performance expectations that must be met at the pilot's mid-point evaluation to justify continued funding for the remainder of the pilot period.

Required Changes to State Policy

Implementing the pilot will require allowing the HCS group home providers in the pilot site to operate six-bed facilities. Currently, HCS waiver recipients may live in their own or family home, in a foster/companion care setting, or in a residence with no more than four others who receive similar services. Thus, current policy limits HCS group home bed size to four or fewer individuals. In order to allow for most cost-efficient provision of HCS services, the HCS group homes in the pilot area should be permitted to have a bed size of up to six beds.

Moving from a four-bed model to a five- or six-bed model would not impact licensure requirements of the HCS group homes. Currently, HCS group homes of four residents are considered "Residential Board and Care Homes" under the Life and Safety Code. Provided that individuals can evacuate without assistance, then increasing HCS bed size would not trigger increased Life and Safety Code requirements until the facility reached 17 or more beds.

CONCLUSION

The development of a managed care pilot for I/DD services should allow Texas test strategies to make waiver services more cost-effective. Achieving these cost efficiencies can fund increased waiver slots and be part of Texas' ongoing efforts to develop more community-based care for people with I/DD. While this analysis does not recommend the use of capitation to achieve cost savings, it does recommend the use of strategies often employed in managed care settings, such as use of utilization management guidelines, development of more cost-effective forms of residential care.

As noted earlier, this pilot recommendation will likely face some level of opposition from various stakeholder constituencies. However, given the historic nature of Texas' present budget deficit, and the growing acceptance in the I/DD community of adopting tools formerly applied in acute and behavioral health care, now may be an opportune time to introduce new strategies to improve the cost efficiencies of the I/DD system.

APPENDICES

Appendix A: Texas HCBS Waiver Crosswalk

	STAR+PLUS	HCS	CLASS	TxHmL	DBMD
Eligibility		Serves individuals of any age with MR (IQ below 70) or a related condition with an IQ below 75	Serves individuals of any age who have a disability other than MR that originated before age 22 and affects person's ability to function in daily life.	Serves individuals of any age with MR (IQ below 70) or a related condition with an IQ below 75 who live in their own home or their family's home.	Serves individuals of any age with deaf-blindness and one or more other disabilities that impair independent functioning
Services Settings:		Services may be provided to individuals who live at home, in a three or four-person group home or a foster home.	Services are provided to individuals who live at home.	Services are provided to individuals who live at home.	Services may be provided to individuals who live at home, or in a group home or small contracted assisted living facility.
Adaptive Aids and Medical Equipment	X	X	X	X	X
Adult Foster Care	X				
• Continued family services (similar to adult foster care)			X		
• Support family services (similar to adult foster care)			X		
Assisted Living	X				X

	STAR+PLUS	HCS	CLASS	TxHmL	DBMD
Audiology Services		X (Specialized therapies)		X (Specialized therapies)	X
Behavioral Support		X (Specialized therapies)	X	X	X
Case Management		Provided as TCM	X	Provided as TCM	X
Community support				X	X
Consumer Directed Services	X Personal Assistance	X Supported Home Living Respite	X PC and respite	X	X Residential habilitation, intervener services, and respite
Day habilitation (similar to adult day health)		X		X	X
Adult day health (similar to habilitation)			X		
Dental services	X	X	Some thru adaptive aids	X	X
Dietary services		X (Specialized therapies)	See specialized services	X (Specialized therapies)	X
Emergency Response Services (Emergency call button)	X				
Employment assistance				X	X
Financial management services		X	X	X	X
Foster care services		X			
Home Delivered Meals	X				

	STAR+PLUS	HCS	CLASS	TxHmL	DBMD
Intervener Services					X
Medical Supplies not available under the Texas Medicaid State Plan/1915(b) Waiver	X				
Minor Home Modifications	X	X	X	X	X
Nursing Services (in home)	X	X Skilled	X Skilled	X Skilled	X
Occupational Therapy	X	X (Specialized therapies)	X	X (Specialized therapies)	X
Personal Assistance Services	X		X Hab attendant similar to PAS		
Physical Therapy	X	X (Specialized therapies)	X	X (Specialized therapies)	X
Prescription drugs		X	X	X	X
Prevocational services			X		
Psychology services		X	X		
Residential habilitation			X		X
Residential assistance: supervised living		X			
Residential assistance: residential support services		X			
Residential assistance: foster/companion care		X			

	STAR+PLUS	HCS	CLASS	TxHmL	DBMD
Respite Care	X	X	X	X	X
Social work		X (Specialized therapies)			
Specialized therapies <ul style="list-style-type: none"> • musical therapy • recreational therapy • massage therapy • hippotherapy • hydrotherapy • therapeutic horse-back riding • auditory integration therapy • nutritional services • aquatic therapy 			X		
Speech Therapy	X	X (Specialized therapies)	X	X	X
Support consultation (for consumer directed service participants)		X	X	X	X
Supported employment		X	X	X	X
Supported home living		X			
Transition Assistance Services	X		X		

Appendix B: STAR+PLUS Experience Rebate

In order to ensure that some percentage of savings from the pilot come back to the State to support additional waiver slots, but to also maintain an incentive for the MCO to seek cost efficiencies, Texas should adopt an experience rebate for the I/DD pilot that is similar to the experience rebate used in STAR+PLUS. In the current STAR+PLUS program, HMOs share a portion of their profits with the State based on an “experience rebate” formula. With the expansion of STAR+PLUS into new service areas, HHSC created a formula that changes as the program matures. Under this formula, over time, the HMO is allowed to retain higher percentages of the profit earned by the plan. For example in Rate Period³⁵ 1, the State and HMO equally share in profits under 3 percent compared to Rate Period 4 when the plan retains 100 percent of the profit collected under 3 percent.

STAR+PLUS Rate Period 1

Pre-tax Income as a Percent of Revenue	HMO Share	HHSC Share
< 3%	50%	50%
> 3%	75%	25%

STAR+PLUS Rate Periods 2 and 3

Pre-tax Income as a Percent of Revenue	HMO Share	HHSC Share
≤ 2%	100%	0%
> 2% and ≤ 6%	75%	25%
> 6% and ≤ 10%	50%	50%
> 10% and ≤ 15%	25%	75%
>15%	0%	100%

³⁵ A rate period is 12 months.

STAR+PLUS Rate Period 4

Pre-tax Income as a Percent of Revenue	HMO Share	HHSC Share
≤ 3%	100%	0%
> 3% and ≤ 5%	80%	20%
> 5% and ≤ 7%	60%	40%
> 7% and ≤ 9%	40%	60%
> 9% and ≤ 12%	20%	80%
> 12%	0%	100%

For a managed care I/DD pilot, a primary goal is to increase funding available for new community-based slots and therefore reduce the interest list for services. In the HMO model, savings are kept by the health plan unless an experience rebate formula is used to share the savings (i.e., profit for the health plan), with the State. In order to maximize the funding available for new community slots while rewarding the HMO for efficiencies through profits, an experience rebate formula is needed. We would recommend the formula for all five years of the pilot be the formula used in Rate Period 1 for STAR+PLUS, to maximize the ability of savings achieved to yield additional waiver slots. Should the pilot continue or be expanded, Texas would need to re-evaluate the experience rebate as has been done under STAR+PLUS.

Experience Rebate for the I/DD Program

Pre-tax Income as a Percent of Revenue	HMO Share	HHSC Share
< 3%	50%	50%
> 3%	75%	25%

In addition to the experience rebate formula, HHSC provides additional contract provisions that allow offsets to the calculation with the impact of lowering the actual rebate owed back to the State. For example, if a plan participates in both STAR and STAR+PLUS, losses from one program can be used to offset gains (pre-tax income) to lower the overall experience rebate back to the State.

For an I/DD program to be able to capture additional funding for additional waiver slots, it is important the State treat the experience rebate provisions in the contract for this program as a stand-alone component without an opportunity for offsets from other programs. However, the offset allowed for carry forward of losses from a previous year should apply but only in relation to the I/DD program. When applied in this way, the experience rebate can be a critical component of ensuring that savings captured from the pilot can be translated into additional waiver slots.

Appendix C: Overview of Louisiana's Per Case Rate-Setting Initiative

The following is an excerpt from the Center for Health Care Strategies, Inc., briefing paper entitled "Medicaid-Funded Long-Term Supports and Services: Snapshots in Innovation,, published in May, 2010, authored by Gretchen Engquist, PhD, Cyndy Johnson, and William Courtland Johnson, PhD.

The full document can be accessed at:

<http://www.dhh.louisiana.gov/offices/page.asp?ID=77&Detail=9069>

"In developing funding levels for developmentally disabled clients, the Louisiana Office for Citizens with Developmental Disabilities was unable to rely on expenditure data because of the influence of factors unrelated to need (e.g., age, region, case management agency, and inadequate standards for case managers). To address this, the State adopted a three-pronged approach:

- Defining a service package of supports for each of seven levels of need derived from the SIS, based on professional expertise and independently developed service plans;
- Clinically validating a sample of cases to confirm the SIS assignment and the appropriateness of services/guidelines; and
- Consolidating all three sources of data — expenditures, clinical validation, and independently developed service plans — into a product the State wanted to purchase.

After completing this exercise, Louisiana published a tool titled, "Guidelines for Support Planning," that provides support coordinators/case managers with step-by-step instructions on the entire care planning and budgeting process, including tips for planning within the guidelines and the mechanism to request exceptions.

Louisiana initially applied its guidelines to 2,000 individuals on the waiting list and will gradually phase-in the application of the guidelines to existing waiver participants. The preliminary results are very encouraging: (1) the State has not had a single appeal; and (2) the State has been able to closely estimate expenditures under the funding levels. Based on the completion of 472 service plans, the average annual service cost is \$47,083 compared to a previous average of \$65,000 (adjusted down from over \$70,000 owing to additional cost-saving measures). The average annual savings per service plan equals \$17,917."

Additional information on Louisiana's initiative can be found at:

<http://www.dhh.louisiana.gov/offices/page.asp?ID=77&Detail=9069>

Appendix D: Cost Savings Analysis of a Capitated Fully Integrated Managed Care Pilot

HMA conducted an analysis regarding the potential for savings under a capitated pilot. The analysis indicated that it may be difficult to achieve savings in a capitated model, largely because of the administrative expenses and start-up costs associated with managed care. This analysis assumed that the model would use the 3a option described in this report, which would mandate enrollment of adults in the I/DD waivers into the STAR+PLUS managed care program.

In this financial analysis, HMA developed a set of basic assumptions on cost, utilization and administrative expenses to develop an estimate of the potential for cost and/or savings in a five-year pilot period if a capitated managed care pilot were to be operational in Harris Service Area. These estimates are general in nature and present an overall picture of the financing of the pilot. However, DADS and HHSC would need to work with the State's actuaries to develop a detailed analysis to set capitation rates for the program and to determine an estimate of costs and/or savings.

Statewide there are 28,874 people served per month in community ICFs/MR and the HCS, Texas Home Living, CLASS and DMBD waivers. For this analysis, it was assumed the pilot would be conducted in Harris County service delivery area with adults only and did not include the DBMD waiver, which has 155 people each month statewide. The total members to be included in the pilot would be approximately 4,391 adults age 21 or older.

Harris Service Area Members (Adults Only)

Program	Members in the Pilot each Month
HCS	3,211
TxHmL	55
CLASS	270
ICFMR	855
TOTAL PILOT	4,391

The following components were analyzed to determine the financial implications of a capitated program:

(1) Acute Care Costs

In the acute care portion of the fully capitated and integrated program, there are two primary components: outpatient services and professional (physician) services. The current STAR+PLUS program does not include inpatient hospital services or pharmacy services. Although HHSC has proposed integrating both inpatient hospital services and pharmacy services effective March 2012, this analysis assumes the current STAR+PLUS program structure (i.e., hospitals and prescription medications are not included as covered services).

For the purposes of this study, HHSC provided HMA the following data elements to analyze related to acute care expenditures for SFY 2009 for participants in the four I/DD waivers and in STAR+PLUS:

- Member months for persons with paid claims;
- Paid claims amounts for acute care services;
- Break out of claims costs and member months by age groups.

Based on the analysis of the data received, the cost and member months data for adults ages 21-64 was used to approximate the acute care costs for persons in the waivers. This age group represents the overwhelming majority of adults who would be enrolled in the pilot and the majority of costs, since persons 65 and older use Medicare coverage for the majority of their acute care services. From this data, a per member per month capitation payment for the acute care medical services was calculated and is shown in the tables below.

Outpatient Claims

Program	Per Member Per Month	Members in the Pilot each Month	Total Acute Medical Capitation for 12 Months
HCS	\$ 45.89	3211	\$ 1,768,153
TxHmL	\$ 53.34	55	\$ 35,206
CLASS	\$ 104.83	270	\$ 339,651
ICFMR	\$ 31.17	855	\$ 319,806
Total Pilot		4391	\$ 2,462,816

Professional Claims

Program	Per Member Per Month	Members in the Pilot each Month	Total Acute Medical Capitation for 12 Months
HCS	\$ 135.52	3211	\$ 5,221,977
TxHmL	\$ 163.79	55	\$ 108,101
CLASS	\$ 356.58	270	\$ 1,155,310
ICFMR	\$ 78.59	855	\$ 806,318
Total Pilot		4391	\$ 7,291,706

The total of the outpatient and professional capitation is the total capitation for acute care medical services.

Total Acute Care Capitation for Medical Services

Program	Per Member Per Month	Members in the Pilot each Month	Total Acute Medical Capitation for 12 Months
HCS	\$ 181.41	3211	\$ 6,990,130
TxHmL	\$ 217.13	55	\$ 143,307
CLASS	\$ 461.41	270	\$ 1,494,961
ICFMR	\$ 109.76	855	\$ 1,126,124
Total Pilot		4391	\$ 9,754,521

(2) Costs for I/DD Services

The long-term care costs for service provided under the four waivers for persons with I/DD was estimated based on the 2010-2011 General Appropriations Act, DADS Key Measure for SFY 2010. In addition, DADS paid-claims data was reviewed for SFY 2009 to determine the reasonableness of the appropriation bill assumptions and to determine the cost of adults compared to the cost of children. Based on these data sets, HMA calculated an approximate cost of I/DD services for pilot participants in Harris County.

This estimate does not include the highest cost services in the I/DD programs, which are the costs for residents at the State Supported Living Centers.

Program	Per Member Per Month	Members in the Pilot each Month	Total IDD Services Capitation for 12 months
HCS	\$ 3,450	3211	\$ 132,935,400
TxHmL	\$ 918	55	\$ 605,880
CLASS	\$ 3,427	270	\$ 11,103,480
ICFMR	\$ 4,590	855	\$ 47,093,400
Total Pilot		4391	\$ 191,738,160

(3) Administrative Costs

To develop the HMO administrative costs associated with the models, the current payments to STAR+PLUS MCOs for administrative and profit (known as risk margin) were incorporated into the analysis. STAR+PLUS health plans currently receive a \$10 per member per month fixed administrative fee and a 5.75 percent of premium administrative fee. In addition, a 2 percent profit margin is assumed in the rate setting process.

In addition to ongoing administrative costs, there are additional costs to implement a capitated managed care pilot. Many of these costs will only be a part of Year 1. HHSC will have additional administrative costs to develop contract amendments, conduct a thorough readiness review and monitor health plan activities. HHSC will also have the costs of systems changes with the MMIS vendor to add new members and a new plan, and enrollment broker costs for outreach and education of new members. These costs are difficult to quantify without requesting estimates of costs from the State’s vendors responsible for these activities.

(4) Premium Tax

A new source of revenue to the State for services to persons with I/DD would be available to Texas under a capitated model. Currently, persons and services related to I/DD are generally served in the Medicaid fee-for-service system, and thus the I/DD benefits are not included in the MCO capitation and, therefore, no premium tax is paid to the State for those services. Under a capitated model, new services would be included in MCO capitation, and additional premium tax will be payable to the State. The State benefits from a favorable federal matching funds treatment of premium tax. Historically, HHSC has not received an appropriation for premium tax paid by Medicaid health plans because current policy is to send the funds directly to the Comptroller's office, where they become a part of the general fund.

The current premium tax in Texas 1.75 percent of premiums paid. There is a delay in the collection of premium tax; therefore it would not be collected in the first year of a capitated managed care pilot.

In the cost scenarios, we have included the revenue generated by premium tax as an offset to additional program costs. In order for this assumption to be accurate, the legislature would need to appropriate premium tax to HHSC and/or DADS to fund the costs of a capitated managed care pilot.

Cost Scenarios

Based on the capitation expenses projected in this analysis, additional costs were calculated for HMO administrative expenses and the revenue generated through premium tax. These estimates demonstrate the impact of a capitated managed care pilot on service costs, administrative costs and the collection of premium tax revenue.

Cost Scenario 1. This cost scenario represents the most conservative estimates of the fiscal impact to the State based on a fully capitated and integrated program. In this model, persons with I/DD would be included in a pilot in the Harris County service delivery area through contract amendments with STAR+PLUS plans. This estimate assumes no reduction in medical or I/DD service costs but does assume the collection of premium tax.

Although we generally assume a HMO will have the financial incentive to decrease utilization and/or more aggressively contract with providers to generate savings, these factors deserve a more conservative approach in this analysis for two primary reasons: (1) For acute care services, this population has lower costs than the SSI population currently managed in STAR+PLUS. In essence, the service utilization and costs for acute care services are low and may be difficult to reduce further. Also, inpatient hospital services are carved out, which represents the greatest potential for savings through HMO utilization management and contracting processes. (2) No states currently capitates I/DD services to HMOs, and therefore experience to build estimates on for reductions in services and costs for I/DD services does not exist.

In cost scenario 1, the capitated managed care pilot would have a negative financial impact to the State if implemented. This scenario estimates a cost of \$12.8 million per year for operations. This scenario demonstrates that the ability to generate premium tax revenue alone is not sufficient reason to pursue a capitated I/DD pilot. This is noteworthy because in other policy

options HHSC is considering, the large size of some other elements of the Medicaid program do generate sufficient premium tax revenue to justify the adoption of capitated managed care.

Scenario 1: 12 Months of Operations

Scenario 1, Overall Cost vs. (Savings/Revenue) Fully Integrated Capitated Model

Program	Admin + Profit	Scenario 1 Premium Tax	Scenario 1 Costs vs. (Savings/Revenue)
HCS	\$ 11,614,869	\$ (2,651,957)	\$ 8,962,912
TxHmL	\$ 71,262	\$ (14,358)	\$ 56,904
CLASS	\$ 1,041,179	\$ (238,693)	\$ 802,486
ICFMR	\$ 3,942,213	\$ (912,830)	\$ 3,029,383
Total Pilot	\$ 16,669,523	\$ (3,817,839)	\$ 12,851,684

Cost Scenario 2. This cost scenario represents a less conservative, but not aggressive, estimate of the fiscal impact to the State based on a fully capitated and integrated program. In this model, persons with I/DD would be included in a pilot in Harris County service delivery area through contract amendments with STAR+PLUS plans. This estimate assumes the HMOs will be able to achieve a 5 percent savings on the cost of I/DD services and a 3 percent savings on the cost of acute care services through utilization management and contracting.

We consider this to be a less conservative approach but estimate that changes in policy direction, particularly related to utilization management, could lead to achieving these targets. One of the strategies for increased savings is a targeted approach towards utilization management of supervised residential services in the HCS program. HMA calculated the impact of transitioning persons in Level of Need 1 and 5 (the lowest two acuity levels and the levels that have the largest percentage of waiver participants) from HCS Supervised Livings and Residential Supports to Foster Care or Own Home Settings, with a goal of moving from 33 percent Supervised Living in Year 1 to 20 percent in Year 5 of the pilot. Based on statewide data and the number of persons in the pilot, this has the potential to save \$4 million over the five-year pilot period. This is not the only tool available to MCOs, but it is an example of potential opportunities to achieve cost efficiencies.

To a large degree, the overall cost impact during the first two years after implementation of a capitated managed care program is not a function of the actual MCO experience but is determined by the rate setting model. For example, if it is assumed that the utilization management function of the MCO will result in a 5 percent reduction in average cost as compared to FFS, then the premium rates will be developed with a 5 percent utilization management discount. Starting in Year 3 of the program it is typically necessary to adjust all assumptions to reflect the actual experience of the model. In a capitated managed care pilot, it will be important to evaluate the actual financial experience of the program to determine if it met the expectations of the rate setting process. If the initial savings estimates are found to have been overly optimistic and the experience-based rates are increased, then program savings are diminished and may even exceed the costs of the FFS program.

Based on the factors described for Scenario 2, the capitated managed care pilot has a cost to the State of \$2 million per year for operations. Essentially, even with the savings assumption on acute and I/DD services and the ability to generate premium tax revenue, the costs of the capitated model outweigh the savings estimated.

Scenario 2: 12 Months of Operations

Scenario 2, Overall Cost vs. (Savings/Revenue) Fully Integrated Capitated Model

Program	Acute Medical and IDD Services Cost Savings	Admin + Profit	Premium Tax	Scenario 2 Costs vs. (Savings/Revenue)
HCS	\$ (6,856,474)	\$ 11,083,492	\$ (2,522,670)	\$ 1,704,348
THL	\$ (34,593)	\$ 68,581	\$ (13,706)	\$ 20,282
CLASS	\$ (600,023)	\$ 994,677	\$ (227,379)	\$ 167,275
ICFMR	\$ (2,388,454)	\$ 3,757,108	\$ (867,793)	\$ 500,861
Total Pilot	\$ (9,879,544)	\$ 15,903,858	\$ (3,631,547)	\$ 2,392,767

Cost Scenario 3. In the financial analysis, there was concern that the small size of the capitated managed care pilot may skew the potential results of including persons with I/DD in all STAR+PLUS service areas. Part of the HMO administrative cost is fixed and part is variable, which leads to changes in costs based on number of members and capitation amounts. To determine the potential for savings if all I/DD waiver participants in STAR+PLUS service areas were included, an additional analysis was conducted.

Number of Waiver Participants Residing in STAR+PLUS Areas

Program	Members in all STAR+PLUS areas each Month
HCS	9,295
TxHmL	510
CLASS	1,259
ICFMR	4,105
Total Pilot	15,169

This estimate assumes the HMOs will be able to achieve a 5 percent savings on the cost of I/DD services and a 3 percent savings on the cost of acute care services through utilization management and contracting. With the larger number of members, the overall cost to the State in a 12 month period would be approximately \$8 million.

Scenario 3: 12 Months of Operations, All STAR+PLUS Areas

Scenario 3, Overall Cost vs. (Savings/Revenue) Fully Integrated Capitated Model All STAR+PLUS Areas

Program	Acute Medical and IDD Services Cost Savings	Admin + Profit	Premium Tax	Scenario 2 Costs vs. (Savings/Revenue)
HCS	\$ (19,847,688)	\$ 32,083,792	\$ (7,302,465)	\$ 4,933,640
TxHmL	\$ (320,773)	\$ 635,933	\$ (127,088)	\$ 188,072
CLASS	\$ (2,797,884)	\$ 4,638,144	\$ (1,060,261)	\$ 779,999
ICFMR	\$ (11,467,371)	\$ 18,038,512	\$ (4,166,422)	\$ 2,404,719
Total Pilot	\$ (34,433,717)	\$ 55,396,381	\$ (12,656,235)	\$ 8,306,430

Scenario 4. For a fully integrated capitated pilot program to pay for the additional costs associated with HMO contracts (i.e., break-even), the rate-setting methodology would need to assume a 6 percent savings over the current program for acute care and 6 percent savings over the current program for I/DD services. At that point, the savings on acute medical and I/DD services, along with the premium tax generated, covers the additional costs of administering the program. Any savings estimates above this level would begin to generate savings that could be used to fund new waiver slots. However, some additional savings would be necessary to cover the start up costs such as eligibility programming changes.

A primary interest in a capitated managed care pilot for persons receiving I/DD services is to generate savings in order to fund additional HCS waiver slots. In order to generate savings to fund additional waiver slots, HMOs would need to achieve greater than 6 percent savings. In addition, to bring savings back to the State to fund the waiver slots, the MCO contract would need an aggressive experience rebate requirement. Without such a shared savings arrangement, the MCO would retain the savings achieved and no funding would be returned to the State.