HHSC: Policy Council for Children and Families, Austin, TX., February 28, 2020

The Policy Council for Children and Families works to improve the coordination, quality, efficiency, and outcomes of services provided to children with disabilities and their families through the state's health, education, and human services systems. Members appear below:

Chris Masey, Chair Family Representative Austin	**Nicolas Morales** Youth Representative San Antonio
Margaret McLean, MSN, Vice-Chair Family Representative Dallas	**Jessica Ochoa** Family Representative Mission
Lisa Brodie Family Representative Deer Park	**Leah Rummel** Family Representative Austin
Sara Daugherty-Pineda, MSN Community Services Representative, Blue Cross Blue Shield of Texas Coppell	**Josette Saxton** General Expert Representative, Texans Care for Children Austin
Nicole Dilts, PhD Family Representative San Angelo	**Lee Sonnenberg, MA, CPP** Family Representative Lubbock
Cynthia Guiton Family Representative Missouri City	**Janis Townsend, MA** Family Representative Coppell
Julie Ivey-Hatz, PhD, LSSP Mental Health Expert Representative, Baylor University, Baylor Autism Resource Clinic China Spring	**Elizabeth Tucker** Advocacy Organization Representative, EveryChild, Inc. Austin
Mary Klentzman Faith-based Representative, Cornerstone Ranch Plano	**Silvia Vargas** Family Representative El Paso
	Laura Warren Organization Providing Services Representative, Texas Parent to Parent Austin

1. Welcome. The meeting was convened by the Chair, Chris Masey, on February 28th, 2020. A quorum was established. Mr. Blanton stated that the process is moving forward to bring on the new members.

2. Member Introduction. Members introduced themselves.

3. Review and approval of meeting minutes from May 30, 2019, and September 9, 2019. The minutes from both meetings were approved as written.

4. Presentation: Updates on Star Kids Managed Care Advisory Committee. Senate Bill 7, 83rd Texas Legislature, Regular Session, 2013 required HHSC to create the STAR Kids Managed Care Advisory Committee (SKMCAC). The SKMCAC was established to advise HHSC on the establishment, implementation and operation of the STAR Kids Medicaid managed care program. They also make recommendations for improvements through submission of an annual written report to the HHSC Executive Commissioner (EC). The Committee has been extended through December 31, 2023.

The SKMCAC members are made up of:

- Physicians and other health care providers
- Providers of home and community-based services At least one private duty nursing provider
- At least one pediatric therapy provider
- Caregivers whose children receive services under the STAR Kids program
- Representatives from Medicaid managed care organizations
- Advocates and other community organizations
- Previous member of STAR Kids program

The SKMCAC established three subcommittees:

- Subcommittee 1: Health Homes and Quality Measures (HHQM)
- Subcommittee 2: Screening and Assessment Instrument (SK-SAI), Prior Authorizations, Medically Dependent Children Program (MDCP), and Intellectual and Developmental Disabilities (IDD) Waivers
- Subcommittee 3: Transition from Pediatric System to Adult System

SKMCAC Annual Report Recommendations.

- Access to comprehensive holistic integrated health homes and transition clinics for children with significant medical and behavioral health needs.
- Service coordination through integrated health homes whether delivered by the health home or embedded in the practice.
- Longer authorizations of long-term services and supports for children with chronic conditions that are not subject to frequent changes.
- Payment to providers that allow them to support children with complex needs.
- Improvements to the SK-SAI that will ensure the tool results in referrals and better access to care including access to CFC for children with mental health conditions.
- Immediate access to MDCP waiver for children who have SSI, like the HHSC policy for adults in STAR+Plus,
- Opt-out process for families of children in MDCP and families with third party insurance or access to another Medicaid waiver,
- Strengthened transition processes for children as they enter adulthood.

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HHSC has a number of projects underway that are addressing many of the SKMCAC's concerns and recommendations:

- SK-SAI Optimization Project
- External Medical Review process (Legislatively mandated related to a review of denials or changes in service)
- New requirements for adverse determination notices
- Establish uniform process for prior authorization reconsiderations (creating a template for MCOs to use)

In addition, there are projects related to Medically Dependent Children Program (MDCP)

- Allow a child denied MDCP to be put back on the MDCP interest list in the first position or other waiver interest list in a position based on the date the child was initially placed on the MDCP interest list.
- MCOs must offer the option to their members to request a peer to peer review of SK-SAI findings resulting in denials for MDCP eligibility/meeting medical necessity criteria
- MDCP escalation help line
- Coordination and timely delivery of benefits for recipients with other insurance as primary

Questions and Comments

- There are issues at health plans related to advance purchasing by families because of the COVID-19.
- There are crisis processes.
- There should be guidance from DSHS related to families with children with special needs.
- Therapies may also be impacted because of fear of exposure.
- Families and children are scared about the world shutting down.

5. Presentation: Update on Applied Behavioral Analysis therapy rules.

Rider Direction: **32. Intensive Behavioral Intervention**. Contingent on the Health and Human Services Commission (HHSC) adding intensive behavioral intervention (IBI) as a Medicaid benefit for persons under age 20 with a diagnosis of Autism Spectrum Disorder, HHSC may expend funds appropriated above in Strategy A.1.5, Children, to reimburse for provision of IBI services.

86. Autism Program Provisions. Out of funds appropriated above in Strategy D.1.6, Autism Program:
a. Expenditures for Applied Behavioral Analysis (ABA) treatment services shall be only for children enrolled in the focused program; and
b. Health and Human Services Commission shall provide support to the Texas Autism Council and the Texas Autism Research and Resource Center.

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Autism Services Policy: Incorporation of Applied Behavioral Analysis (ABA) including Intensive Behavioral Intervention (IBI) into existing service packages for:

- Children & Youth (Birth through age 20)
- With a diagnosis of Autism Spectrum Disorder (ASD)
- Service to be delivered in:
    - Home
    - Community
    - Clinic Settings

The policy focuses on utilization of an interdisciplinary model of care including individual & legal guardian. Also including, but not limited to, the following disciplines:

- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Outpatient Behavioral Health Services

The Implementation Plan includes:

A New Medicaid Benefit

- Establish payment rate
- Public rate hearing (not yet scheduled)
- Seek approval from Centers for Medicare & Medicaid Services (CMS), as needed

Draft Policy for Public Comment

- Was posted in September 2019, responses to comments forthcoming
- Ensure sign up for GovDelivery in order to be notified about policy implementation

Implementation goal: Spring 2020

HHSC plans on engaging external and internal stakeholders throughout the implementation process. Stakeholders include:

- Parents/Caregivers/Legal Guardians
- Provider groups
- Children's advocacy organizations
- Other interested parties

HHSC Web Information: The HHS Children's Autism Program provides focused ABA services through local community agencies and organizations.

Focused ABA treatment is targeted to address a few specific outcomes instead of all developmental needs of the child. It is particularly useful when children have challenging behaviors and when improvements in social and adaptive skills are sought. Focused ABA treatment is used to target specific behaviors. The treatment might be to:

- Minimize a challenging behavior; or
- Maximize a social or adaptive skill in a specific area.

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A trained therapist provides treatment on the specific behavior. The level and intensity of treatment should be driven by the child's needs. Since the therapist is focusing on specifically defined behavior, the treatment period is shorter. The treatment through the HHS Children's Autism Program is limited to 180 hours within a 12-month period. The length of treatments received is limited to a maximum of 720 hours during the child's lifetime.

Participation in parent training is a required part of the service. Attendance for the child and the parents must be maintained at 85 percent of scheduled treatment.

Who is Eligible for Services?
A child is eligible for treatment through the Autism Program if the child:

- Has a documented diagnosis on the autism spectrum made by a qualified professional.
- Is 3 to 15 years old (services end on the child's 16th birthday).
- Is a Texas resident.

How to Find Services and Apply?
All services are provided by contractors located in communities around the state. Please call the contractor closest to your area to access services and complete the enrollment process.

HHSC stated that the draft policy has been posted and there was a record braking number of responses (555 responses). This is the first time the benefit has been implemented and the input is very valued. There is not a timeline presently for final implementation.

Services will be provided through licensed individuals. There will be a certification for technicians, and this could occur through one of three certification entities nationwide.

A spring 2020 implementation is anticipated.

Questions and Comments

- Did the rider limit the services to a diagnosis of autism? The speakers answered in the affirmative.
- The IDD pilot is looking at positive behavioral supports for people without a specific diagnosis of Autism. The speaker stated that they have language stating that with medical necessity, it could be considered.
- Direction and guidance to health plans would be important to avoid multiple different responses and approaches.
- There will have to be clear guidance for providers regarding the medical necessity. Perhaps the clarification would be in the provider manual. Staff stated that they do not have plans to do that at this time.

- What were CMS's issues with the draft policy? Staff stated that CMS received the high-level information attached to the state plan amendment (SPA). There were no concerns so far in the preliminary discussion.
- When is the rate hearing? Staff stated that has not been decided yet.
- CMS requires translation; is there a billing code added in for this? Staff stated that there are contractual requirements for MCOs.
- MCOs presently contract with folks for translation services and it is for all providers.
- Can families using the Medicaid buy-in provision access the ABA services? Staff stated that a diagnosis itself does not constitute medical necessity. The policy will be addressing how this will be determined.
- What do the service delivery system and costs look like? Staff stated that it is important to provide generalization of skills. The plan would have to generalize into the child's setting so a behavioral technician can come into the home wo work with the family. Remote delivery is an option.
- Will payment be per visit? Staff stated that reimbursement is based on 15-minute increments. The timing and place for the services would be specific to the client and written in the plan.
- Will there be some tiered levels based on severity or complexity? Staff stated that the draft policy had guidelines about intensity and frequency of service. There were numerous comments about this, and that language has been changed. The documentation can help create a roadmap to follow and make clear when progress is happening.

6. Presentation: Medicaid Buy-In (MBI) for Children and Adults. MBI is a Medicaid program for working individuals with disabilities who earn more than the allowable limits for regular Medicaid. The program offers Medicaid health care services, including community-based services and supports, to individuals with disabilities who work. Individuals must meet both financial and nonfinancial criteria and eligible individuals may have to pay a monthly premium as a condition of eligibility. Eligibility includes individuals of any age who:

- Have a disability;
- Are working;
- Reside in Texas;
- Are U.S. citizens or meet certain qualified alien status requirements; and
- Do not live in a state institution or nursing home.
- Must meet the Social Security Administration's (SSA) definition of disability regardless of age. (May already have an established disability determination by the SSA.)
- Must have a disability determination established by HHSC prior to an eligibility determination if they do not have one from SSA. (Exception: Individuals who are able to engage in any substantial gainful activity (SGA) may still meet the disability requirements).

In addition to the non-financial criteria, individuals must meet both income and resource limits.

- Only the income and resources of the person applying are considered when determining eligibility.
- Income must not be more than 250% of the federal poverty level (FPL). ($2,603 for 2020).
- Resources must not be more than the current resource limit for the Supplemental Security Income (SSI) program.
- Must not exceed $2,000 after allowable exclusions.

Gross earned income minus allowable exclusions are compared to the FPL when determining eligibility. MBI allowable exclusions include:

- $20 general exclusion;
- Earned income exclusion, $65 plus one half of the remaining earned income;
- Earned income and child tax credit payments; and
- Disability-related work expenses.

MBI allowable resource exclusions include the following:

- Retirement related accounts;
- Plan to Achieve Self Support (PASS) resources;
- Independence accounts; and
- General $3,000 MBI exclusion. When added to the other income then the limit would be effectively $5,000.
- ABLE Accounts are excluded.

An ABLE account is a tax-advantaged savings account available to individuals diagnosed with significant disabilities before age 26. Contributions can be made to the account by the beneficiary, friends or family members, but the total annual contribution must not exceed a certain limit, which is pegged to the gift tax exemption. In 2018, this limit is $15,000 – up from $14,000 in the previous year.

ABLE accounts were created by the 2014 ABLE Act, with ABLE being an abbreviation of Achieving a Better Life Experience. ABLE accounts are very similar to the educational 529 accounts and are also known as 529A accounts.

ABLE accounts are a welcome tool for the individuals with significant disabilities and their friends and family. Parents of children with severe disabilities are naturally concerned about securing enough funds to offset the lifetime costs that come with living with a disability. The funds can be used to cover qualified disability expenses- Investopedia.com

Eligible individuals may have to pay a monthly premium as a condition of eligibility. Monthly premiums:

- Are based on a sliding scale;
- Are calculated using both earned and unearned income; and
- May range from $0 to $500.

MBI for Children. Medicaid for children with disabilities with family income not more than the limit based on the family size. The program provides Medicaid benefits to eligible children with disabilities who are not eligible for Supplemental Security Income (SSI) for reasons other than disability. A family may have to pay a monthly premium as a condition of eligibility. Eligibility applies to individuals age 18 or younger who:

- Have a disability;
- Are not married;
- Live in Texas;
- Are U.S. citizens or meet certain qualified alien status requirements; and
- Do not live in a state institution or nursing home.

The family's monthly countable income is considered when determining eligibility and includes:

- The income of the child applying,
- The income of the parents living in the same household as the child, and
- The income of the child's ineligible siblings living in the same household as the child.

Countable income after exclusions must not be more than 150% of the federal poverty level (FPL) ($1,595 for 2020). There is no resource test for MBIC.

Gross earned income minus allowable exclusions are compared to the FPL when determining eligibility. Earned and unearned income are treated the same for MBIC. MBIC allowable exclusions include:

- $85 plus one-half of the remaining income (deducted at the end of the budget calculation); and
- Ineligible sibling exclusion.

The family may have to pay a monthly premium as a condition of eligibility.
Monthly premiums:

- Are based on a sliding scale;
- Are calculated using gross countable family income;
- Are based on whether the child is covered under a parent's employer-sponsored health insurance (ESI) plan and is eligible for the Health Insurance Premium Payment Program (HIPP); and
- May range from $0 to $230.

MBI and MBIC offer all the same medical healthcare services regular Medicaid offers, such as:

- Doctor/clinic visits
- Hospital stays
- Emergency care
- Vision and Hearing services
- Prescriptions
- Glasses
- Speech therapy
- Occupational therapy
- Physical therapy

- Mental health care

To apply, an individual must submit Form H1200MBI or Form H1200-MBIC to HHSC. Applications can be submitted:

- Online through YourTexasBenefits.com (The MBIC application cannot be submitted online.)
- By phone at 2-1-1 or 1-877-541-7905

After an application is received, HHSC makes an eligibility determination within:

- 45 days for applicants age 65 and older or who have an established disability; or
- 90 days for applicants under age 65 who do not have an established disability.

HHSC will notify the applicant or the authorized representative (AR) of the eligibility determination. Eligible individuals may receive MBI or MBIC related forms.

After an individual is determined eligible for MBI or MBIC, their eligibility must be re-determined at least once every 12 months. Renewal forms:

- Are mailed to the recipient or the recipient's authorized representative (AR) at least 2 - 3 months prior to the renewal due date.
- Must be completed and returned within 30 days. If not returned timely, benefits will be denied

Additional information can be found in the Medicaid for the Elderly and People with Disabilities Handbook.

- Chapter M, MBI
- Chapter N, MBIC

The H1200-MBI and H1200-MBIC applications forms can be found in the Forms section of the Handbook

Questions and Comments:

- If a person were making $2,603 or less, they probably would not receive the full benefit, correct? Staff stated that it would knock them off of SSI, but they could still get social security payment if it was based off of parental retirement.
- For the MBI for Adults, how many people are enrolled? Staff stated that it sticks around the 500 range for participants.
- The income limit with the $2,603 is slightly higher than on a Medicaid waiver? Staff stated that the amount is slightly higher.
- Is it federally capped at 250%? **A:** It is federally capped at 250%. The state has an option to exercise generous disregards.
- Does the MBI include CFC? The speaker answered in the affirmative.
- Texas chose to do 150% of federal poverty. For MBIC, the feds set 300%, but the state can choose below that. The state can include up to the 300%. Staff answered in the affirmative.

- How many people are receiving MBIC? Staff stated it is around 2,000. This is lower than the original estimate. There was an expectation that the program would have grown faster.
- Families state that they cannot afford the program.
- There were legislative proposals to go up to the 300%, but they have not gone anywhere.
- Has the funding for this program been maxed out? Staff stated that it has not reached the maximum so far.
- It appears that there are a lot of people who could qualify for this program but who have not accessed it.
- For CHIP, eligibility is 200% FPL and regular Medicaid is 100% FPL, so how does that interact with what you are mentioning here? Staff stated that for SSI, the federal benefit rate applies but when you convert that to the federal poverty level, it's about 74%. For the low-income families and children, their income limits are 133% FPL.
- For a family of four with one disabled child and one that is not, what would be the gross income? Staff stated that that it would be $3,219 per month… and the 300% would be $6,438.
- If the state went to 300%, would they have to maintain the exclusions? Staff stated that CMS is silent on the 300% if it is gross or net. We would have to work with CMS on this. There is a chance CMS might deny it.
- Does the state have flexibility on setting the premium? The speaker stated that she believed that they do.
- We know there are a large number of people who are eligible who are not buying in. Staff stated that the estimate was based off uninsured children, and those numbers have grown.
- Do you know if Navigate Life has examples? (Here is the link to Navigate Life).
- Is there a person to whom we can send people to discuss this? There is no specific phone number, but 211 would be a good place to try.
- There was a presentation to the IDD subcommittee, and it was decided that Medicaid Buy-in 101 would be helpful. There are questions about child income and other issues. There are nuances that have to be addressed.

7. Presentation: Texas Autism Council. Dr. Dotson, Chair of the Council, made the presentation. Unless continued through rule by the Executive Commissioner, this advisory council will no longer exist. They have been extended through December 2020 in order to enable the Commission to determine the path the Committee should take.

The Texas Autism Council advises and makes recommendations to the HHSC executive commissioner to ensure that the needs of persons of all ages with autism spectrum disorder and their families are addressed and that all available resources are coordinated to meet those needs. The council was established September 1, 2016.

The Texas Autism Council performs the following functions:

- Makes recommendations to HHSC through regularly scheduled meetings and HHSC staff assigned to the council; and
- Handles tasks consistent with its purpose that are requested by the executive commissioner.

Texas Autism Council recommendations were presented to the Executive Council at their last meeting in February**.** The following recommendations were made from the Committee.

Recommendation #1: Increase identification of and services to young children with autism to increase proportion of children with autism receiving services at younger ages.

Recommendation #2: Increase transition services and adult programming in anticipation of impact of increasing prevalence rates on adult population of individuals with autism.

Recommendation #3: Increase number of service providers across all programs by increasing reimbursement rates and decreasing barriers to collaboration and creativity.

Recommendation #4: Increase family and professional awareness of all programs and reduce barriers to enrollment and participation for families and individuals.

Dr. Dotson presented from their report. Charge of the Council: The Texas Autism Council has been charged to summarize and make recommendations to the Commissioner of the Texas Health and Human Services Commission about issues related to autism and the provision of services to people with autism and their families. The goal of the report is to provide a brief summary of the services available to individuals with autism and their families across Texas, to identify areas of success within those services, and to provide a vision for ways in which those services can best be structured and funded within the state to maximize the benefit to the most people with autism and their families as possible.

Due to the increasing prevalence of ASD, the recent reorganization of HHSC, and the diverse number and type of services provided by HHSC, it is important that the Texas Autism Counsel carefully consider the unique and cumulative impact of those changes and services on people with ASD across the state. The goal is to identify where this diversity of services and models is working best while also identifying ways that efficiencies can be found to better maximize the impact of the available resources.

Autism Spectrum Disorder is a neurodevelopmental disability characterized by impairments in social communication and social interaction across multiple contexts and the presence of restricted, repetitive, and stereotyped patterns of behavior, interests and activities. Autism is the fastest growing disability in the country and in Texas. The prevalence of autism is currently 1 in 592, and is increasing, with 2.79% of children nationally and 1.54% of children in Texas

receiving an autism diagnosis in 2016-17. Conservative estimates suggest there are at least 250,000 individuals with autism in Texas. From early childhood intervention through to adult services, individuals with autism are requiring more supports and resources than ever before. The most dramatic example is within Texas Vocational Rehabilitation (VR) services, where the number of individuals with autism receiving services has doubled from 3000 to 6000 customers from 2010-2017. In the most recent state total, 18.75% of VR customers are identified as having autism. Students identified as eligible for Special Education (SPED) services with autism in Texas have increased in number and proportion. 13.5% of students receiving SPED services in 2018-2019 received an autism label (71,951 total) –up from 9.3% of students in 2012-2013 (41,206 total with Autism). The percentage of Early Childhood Intervention clients qualifying for services with an Autism identification has increased to 6.4% in 2018, up from 5.8% in 2016. The smaller increase in ECI, and the overall lower proportion of individuals with an Autism diagnosis in ECI services, is likely due to the difficulty of securing a formal autism diagnosis before the age of 3 for the majority of families in Texas.

Prevalence of ASD by Age Groups	Estimated Numbers
Children with ASD in Texas Birth to 3	26,129 *[6,16]
Children with ASD in Texas in K-12 Education	71,951[5]
Adults with ASD in Texas	125,000**[5]
Overall Number of Individuals with ASD in TX	223,080-250,000+

**Most recent numbers from 2017-2018*

***No comprehensive estimate is available. Prevalence is likely underestimated and is based on a rough estimate from 20 years of exit data from special education services.*

The increasing number of people with autism has put a strain on state resources, while also providing a unique opportunity to explore ways to better serve a growing population through HHSC services. HHSC provides a number of powerful and important supports and services to individuals with autism and their families. Those supports are listed below. Programs which most directly serve autism are included, but many HHSC services influence the quality of care of individuals with autism.

The most successful services were those that allowed for flexibility in the service design. The services are also best when they are interdisciplinary.

The recommendations from the Council appear in the shaded box above.

There is discussion about ending the Autism Council and having it transition into another council, or they can recommend being a standalone council. There is concern about rolling services into Medicaid, because many of those children would not qualify for Medicaid.

Questions and Comments

- There is a significant wait for services because of the absence of service providers.

- There are two separate things going on: medical diagnosis and the identification of Autism during the educational process.
- There is a high prevalence of children removed from their family home because of Autism.
- There is an IDD strategic plan under way, and we have tried to get prevalence data for people with IDD and comorbidity of Autism.
- It is a complex problem and so there has been discussion about getting an add-on rate for people with Autism.
- Ms. Tucker stated she supports the continuation of the Autism Council.
- There has to be an integrated lifespan focus.
- There could be a standing committee or subject matter on each agenda for Autism.

MOTION: *Recommendation from this Council that the Autism Council continue and that a person be appointed to this committee representing Autism Services. Due to a quorum not being present, this was tabled for another meeting. A workgroup would work on drafting the letter of support*.

8. Workgroup presentations of proposed recommendations:

Workgroup 1: Transition Clinics for Adults and Complex Care clinics
Recommendation: Expand Transition (pediatric and adult) and Complex (Comprehensive) Care Clinic. Apparently, there are only few transition clinics in Texas, one is at Texas Children's Hospital and another is Transition Clinic at Baylor College of Medicine in Houston (Dr. Cynthia Peacock). There are several complex care clinics across Texas, however, not all complex care clinic has both pediatric and adult line of service for children with complex needs. DSRIP funding is going away, eliminating this source for the clinics. Therefore, funding options should include to explore to expand these clinics to meet the need of this population.

Build the provider capacity and training to meet the need of the complex need of the children who transition to adult complex care clinic. There are no codes for Medicaid providers to offer co-consult visits of children with complex care needs who are transitioning from pediatric to adult care providers.

Questions and Comments

- A comment was made that we should try to get more clinics up and running in urban areas. We do not have to worry about the codes, because that is down in the weeds. Dr. Peacock had stated that it would be best implemented at major institutions around the state.
- A coordinator should be imbedded at the clinic from the MCO.
- There is an 1115 workgroup looking at all the 1115 projects that could look at placing these clinics in needed areas.
- Will this recommendation narrow down and focus on the transition clinics?

- The comprehensive care clinics are not funded under the DSRIP. It might be good to partner with an FQHC for the comprehensive care clinics.
- We need more than STAR Kids (Advisory) to advocate for this. It is also on the IDD Advisory LAR recommendations.
- Last year's report addressed this.
- There is only one clinic like this in the state and it is at risk.
- There was a study conducted at HHSC that showed hospital visits went down. (Dr. Peacock's clinic vs a matched group)

***CONSENSUS**: focus on the transition clinics expanding the clinic in Houston. (Recommendation to be crafted still with Dr. Peacock).*

Workgroup 2: Medicaid Buy-In for Children and Adults

Improve access to Medicaid State Plan services and/or lower cost waivers for children who meet an institutional level of care. Considerations include:

- Applying the Family Opportunity Act's family income limit of 300% Federal Poverty Level to the Texas Medicaid Buy-In for Children. This is a win/win.
- Bringing the Texas Home Living waiver's financial eligibility requirements in-line with the other Texas HCBS waivers so that families of children can access the lower tiered waiver in lieu of more comprehensive waivers. The only waiver that considers a family's income.
- Instituting a TEFRA option for children who meet an institutional level of care to prevent placement in a facility.

Under the Tax Equity and Fiscal Responsibility Act **(TEFRA)** of 1982 (PL No. 97-248, Section 134), states may provide Medicaid coverage to children with severe disabilities younger than 19 who require a level of care that could be reasonably provided in a hospital, skilled nursing facility, or an intermediate care facility for individuals with intellectual disabilities (ICF/IID), without using household income as an eligibility criterion.

When a child receives extended care in an institutional setting, Medicaid disregards family income as an eligibility requirement and makes the determination based solely on the child's income. The TEFRA/Katie Beckett State Plan Option makes it possible to do the same for a family whose child requires care at the level provided in an institution, but who can safely be cared for at home, as long as it is cost neutral to the state to do so. Currently, 18 states and the District of Columbia have chosen to implement the TEFRA/Katie Beckett State Plan Option. Because states vary widely in the availability of institutional care for children and in the clinical criteria they use for determining a child's level of care needs, the number of children and youth with disabilities who receive Medicaid benefits under this state option varies widely from state- to-state.

Workgroup 3: Reduce the Medicaid Waiver Interest List.
Recommendation Goal is stated to increase Medicaid Buy-in for Children and provide TEFRA options to reduce Medicaid interest list. This is already done in STAR+PLUS and has been recommended before.

Recommendation Goal: Changing overnight rule under Rider 28 to improve use and reduce abuse of the services under the rider. This is helpful for children transitioning out of a nursing facility. It makes no sense that an overnight stay is required. This puts children at risk and causes transportation issues.

Recommendation Goal: Promoting Independence:

- Fund and dedicate HCS waiver services for 25 to 35 young children with intellectual and developmental disabilities living in DFPS licensed General Residential Operations as part of the state's Promoting Independence Plan.
- Fund HCS waiver services for 20 medically complex children and young adults with developmental disabilities under the age of 21 to move from nursing facilities to families and HCS funding to divert the admission of children into facilities.

Workgroup 4: Crisis Intervention for Respite Services
Recommendation Goals:

- Improve access & availability of crisis intervention services to families (Behavioral crisis & Family crisis)
- Increase availability of crisis prevention services to reduce the severity of crisis when it occurs (Crisis prevention network)
- Extend the number of days of respite services provided to families based on individual need
- Improve access & availability of both in-home and out of home respite services for families. This would not be a budget change it would simply add hours of access.

There was discussion about adding a section on Autism. The Chair stated that they are a little behind the timeline for the report and indicated that this should be considered before adding an item.

Ms. Tucker suggested tying the LAR recommendations to the document. There was also discussion about going back and look at the previous mental recommendations.

9. Public comment.

10. Legislative Appropriation Request. The LAR recommendations were developed and were open for discussion. The Chair stated that there are recommendations across a number of areas including wait list numbers. The list below summarizes the recommendations.

- Ensure that children with co-occurring intellectual or developmental disabilities (IDD) have the support necessary to live with families instead of costly institutions.
- Reduce need for a more comprehensive community-based waiver by improving access to Medicaid State Plan and lowering cost waivers for children requiring institutional care.
- Fund Home and Community-Based Services (HCS) waiver services for up to 35 children with IDD living in DPFS-licensed General Residential Operations.
- Fund HCS waiver services for those with IDD under the age of 21 to support in-family living and avoid admission to institutions.
- LAR for development of incentives, for those with IDD in community settings using HCBS programs, to choose consumer-directed services.
- Ensure Texas' commitment to Texans with disabilities by providing integrated information, resources, and funding supports.
- LAR for a minimum wage of $15/hr for attendants assisting those with disabilities in community settings.
- HHSC should dedicate significant funds for the expansion of Applied Behavior Analysis for persons under 20 with a diagnosis of Autism Spectrum Disorder.
- Fully fund ECI services based on each child's need for services as opposed to funding based solely on available resources.
- Allocate sufficient funds for services for children on the Special Health Care Needs Services Program waitlist.
- Develop pay-for-performance initiatives for physicians to allocate longer appointment times for children and young adults with medically complex conditions.
- Increase availability of medical homes for youth transitioning to adult services by recruiting centers of excellence for transition across the state.
- Allow children and young adults with SSI, who meet the Medically Dependent Children Program eligibility criteria, entry into STAR Kids or STAR Health waiver services with no wait.
- Fund respite care for families who do not have access to Medicaid or Medicaid waivers.
- Provide flexible pool of funds on a limited basis for families in crisis situations.

Question/Comments

- Recommendation for respite be extended up to as much as 60 or 90 days (CLASS, TxHML, Deaf Blind, STAR+PLUS and other waivers).
- There is a need to make respite more flexible for families.
- Provide a cap up to 90 days for respite.
- Regarding expanding CDS, as they raise the rates in agencies, they should be raised for CDS as well.
- Make the recommendation for the base wage increase to be for all attendants.

MOTION: *Accept the recommendations with edits and suggestions - prevailed*.

11. Policy Discussion: Care for Minors. This discussion was tabled for the time-being. Ms. Tucker stated that only 7% are receiving personal care CFC services under STAR+PLUS. These children have a qualifying disability. There are not people abusing the system.

12. Next steps for developing the 2020 legislative report
Mr. Blanton made the presentation and in advance, announced that there was approval for candidates, and they will be contacted by HHSC.

Mr. Blanton stated that there has been good guidance from this group about proceeding with the report.

- **January:** workgroup calls to work on recommendations (completed)
- **February 28th:** Full Council Meeting: Each workgroup will present the work and first draft language they've completed over the past quarter. (Completed)
- **February to April:** Recommendation Template due for complete council. Complete council drafts legislative report and asks members for photos and stories. Workgroup calls conducted as needed.
- **April:** Workgroup calls complete, council completes the second draft of the report, will distribute before the meeting
- **May 1st:** Full council meeting: Committee Chair will present draft to the council for review and will update the report based on the council's feedback. CC will have a WG call with the Chairs for further discussion
- **Jun 15th:** Complete third draft.
- **July 1st:** Distribute report to the council and stakeholders for review of the draft report. Solicit stakeholders' comment letters.
- **August:** Report follow-up and format editing.
- **September 8:** Full Council Meeting: Approve final report. Comment letters from stakeholders are due. Discuss report education and follow-up.
- **September–October:** Report follow-up and format editing.
- **November 3:** Full Council Meeting: Final report due to the legislature.
- **December:** CC workgroup meets to discuss report education and follow-up.

Mr. Blanton stated that the next meeting is May 1st. And the recommendation language should be completed by then with the narrative developed.

13.Public comment. No public comment was offered.

14.Action items for staff or member follow-up.

- LAR language to be developed and included;
- A letter related to Autism Services developed; and
- Reports on the transition clinic will also be provided to people.

15, Adjourn. There being no further business, the meeting was adjourned.

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