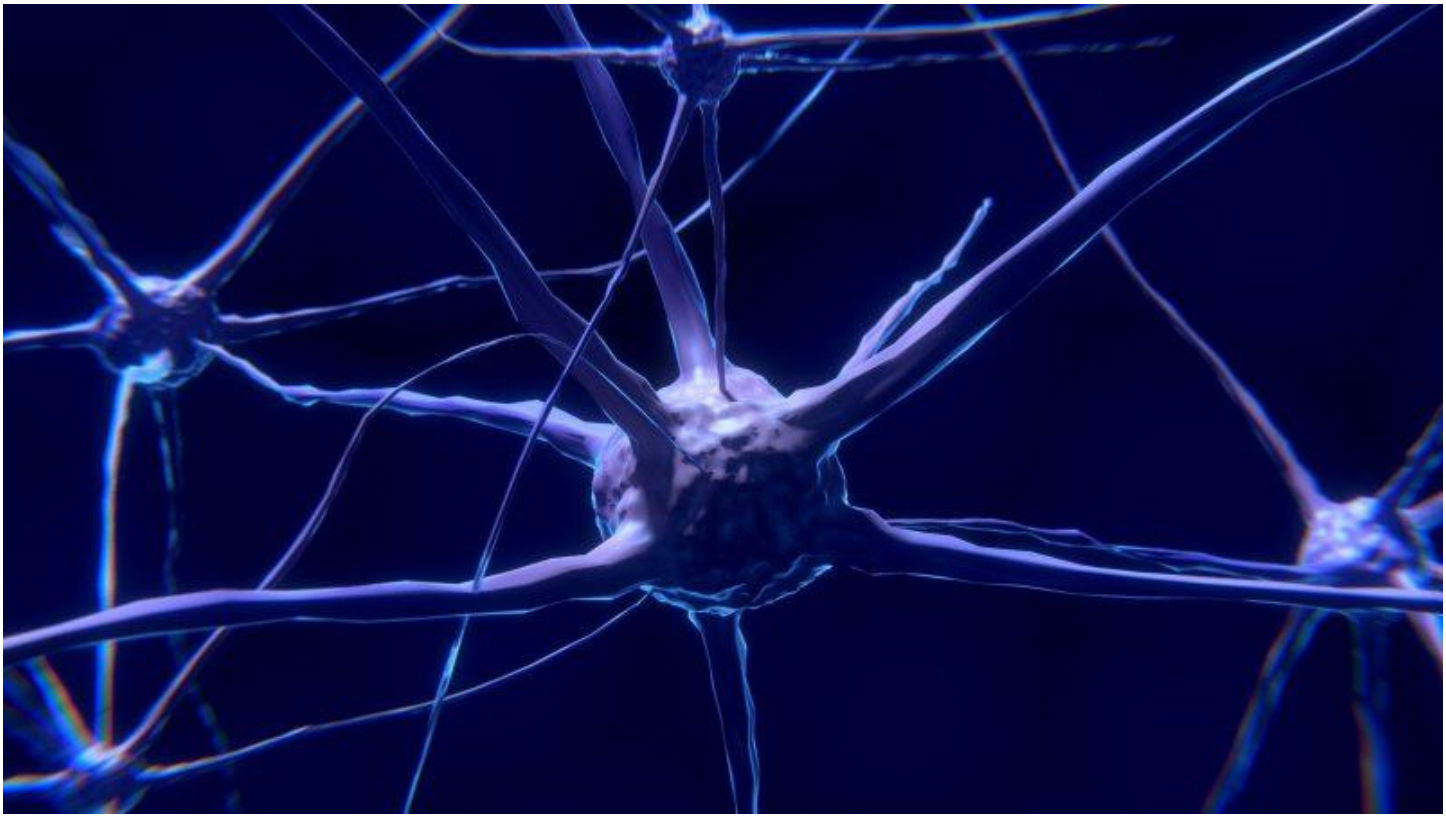

HHSC: Intellectual and Developmental Disability System Redesign Advisory Committee – June 29, 2021

Intellectual and Developmental Disability System Redesign Advisory Committee advises on the implementation of the acute care services and long-term services and supports system redesign for individuals with intellectual and developmental disabilities.

Recording and playback difficulties were encountered in producing this report impacting on the completeness of the report.

Welcome and introductions. The meeting was convened by the Chair, Carol Smith

Consideration of IDD-SRAC recommendations for the annual legislative report on the implementation of acute care and long-term service and supports for individuals with intellectual and developmental disabilities. (#2_IDD SRAC 2021 Leg Report Recs_Final DRAFT.pdf).

The above link will connect the reader to the DRAFT Report and Recommendations. The report will be voted out at the next meeting. Members discussed word smiting and clarification of the recommendations.

The chairs of the subcommittees laid out the recommendations by subject area. The items below are DRAFT and discussion was held on many of the items. In addition, some received comments from members in advance of the meeting. In one case a new recommendation was added and is noted. Some other edits and recommendations were made and will be reported in the subsequent reports. The final recommendations will be presented and voted on at the next meeting.

Identify Eligibility and Enrollment Criteria for the STAR+PLUS Pilot

1. HHSC should determine STAR+PLUS Pilot eligibility by needs-based criteria. To qualify for the pilot, a person must meet all of the following requirements:

    a. Be a Medicaid-eligible adult 21 years of age or older who is enrolled in STAR+PLUS
    b. Meet criteria for a target group (see recommendation #2 below)DRAFT
    c. Demonstrate a need for at least one pilot service d. Have substantial functional limitations in three or more areas of the following major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

2. Recommended target groups should include

Table 1. STAR+PLUS Pilot Target Groups

Target Group	Criteria
Group A	People who have a diagnosis: • Intellectual disability (ID) • Autism • TBI • Acquired brain injury (ABI) • On the Texas HHSC Approved Diagnostic Codes for Persons with Related Conditions List
Group B	People with "similar functional needs" as Group A, without regard to age of onset or diagnosis. HHSC should determine which individuals have similar functional needs based on eligibility for or use of state plan LTSS, including: • Personal assistance services • Day activity and health services • Community First Choice (CFC) services
Group C	People enrolled in STAR+PLUS HCBS with a diagnosis listed in Group A who could benefit from pilot services not available through STAR+PLUS HCBS

3. Enrollment should be open for a limited time to ensure a statistically viable and consistent population.

4. HHSC will automatically enroll STAR+PLUS Pilot eligible persons in the pilot but give them the ability to opt out.

5. HHSC should develop informational materials to help pilot participants make an informed choice to stay in the pilot or opt out.

6. HHSC should allow pilot participants to transition to a 1915(c) IDD waiver if their slots become available during pilot operation.

Identify Benefits for the STAR+PLUS Pilot

1. The SRAC recommended the following benefits be included in the STAR+PLUS Pilot. The services include current STAR+PLUS HCBS benefits, current STAR+PLUS State plan LTSS services and new services allowed under statute (Chapter 534, Sec. 534.104(a)(6) Government Code) and approved by the SRAC for considerations. These include the following:

Table 2: STAR+PLUS Pilot Benefits

Current State Plan LTSS Services - Reference Section: 1143.1.2 Long-term Services and Support Listing	• Day Activity & Health Services • Personal Attendant Services • Community First Choice (Personal Assistance Services;Emergency Response Services; Support Management;Habilitation

Current STAR+PLUS HCBSServices Reference Section:1143.2 Services Available to STAR+PLUSHome and Community Based Services Program Members	• Adaptive Aids & Medical Supplies • Adult Foster Care adding modification • Assisted Living • Audiology (Limited) • Auditory Integration Training/Auditory Enhancement Training • Cognitive Rehabilitation Therapy • Dental Treatment • Emergency Response (for MAO members) • Employment Assistance with modifications career planning • Financial Management Services • Home Delivered Meals • Minor Home Modifications • Nursing Services • Occupational Therapy • Personal Assistance Service (for MAO members) • Protective Supervision • Physical Therapy • Respite • Speech • Support Consultation () • Support Management (not available to MAO) • Supported Employment Services • Transition Assistance Services

New HCBS Services for STAR+PLUS Pilot referencedin statute	• Behavioral Support Services
	• Behavioral Health (BH) Crisis Intervention Service
	• Enhanced Behavioral Supports
	  ○ Enhanced In-Home Respite Services (EIHRS)
	  ○ Enhanced Out of Home Respite Services (EOHRS)
	  ○ Behavioral Support Specialty Services
	  ○ Individual/Family /Caregiver Coaching to includetraining, education and Peer Supports
	  ○ Peer Supports
	• IDD Enhanced Extended Substance Use Disorder Services(SUDS)
	• Community support transportation
	• Day Habilitation
	• Enhanced Medical Supports
	• Innovative Technology including remote monitoring

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New Recommendations allowed under statute andapproved by SRAC - HCBS Services	• Community Integrations Supports (CIS) • See Enhanced BH and SUDS above • Specialized Therapies – Massage; Recreational; Music; Art;Aquatic; Hippotherapy; Therapeutic Horseback Riding. • Dietary Services • Intervener/interpreter

Simplify Accessing Dental Services

1. For each HCBS waiver, include in the person's yearly plan of care the amount of services needed for dental for the year. Educate participants about the change.

2. For TxHmL and HCS, HHSC should expand the approved list of covered Adaptive Aids to include dentures and implants with prior approval from HHSC and reflect the benefit change in all waiver renewals.

3. As part of the development of the plan of care, HHSC will not ask for information on how much primary insurance will pay prior to services being rendered. However, once the claim has occurred, the dentist will include the amount paid by primary dental to assure there is no overpaid amount from Medicaid.

4. If using an anesthesiologist, the anesthesiologist and/or the facility will be paid by acute Medicaid or Medicaid managed care. The health plan must allow for an out of network (OON) anesthesiologist and facility to allow access to dental services. Clear guidance including coding for services is needed to describe facilities allowed to bill including the dental office, outpatient facilities, and inpatient facilities. Clear guidance is also needed when the dentist as part of the dentist's license applies anesthesiology services.

5. For any prior authorizations needed for dental services reviewed by HHSC, HHSC will provide a response within three business days of receipt of the treatment plan. Need follow-up from HHSC

6. If the dental procedure exceeds the approved amount in the initial budget for the individual, the excess amount will be reviewed and approved if determined medically necessary without requiring the individual receiving the services to return for another procedure under anesthesia. Need to educate providers.

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7. Some services related to a disability shall be deemed medically necessary/functional necessity, rather than cosmetic, such as chipped teeth in a person who bites, has feeding challenges or other complications related to the functional necessary dental procedures typically defined as cosmetic. Education is needed with dentist to clarify the policy.

8. HHSC should align policies across HCBS programs to allow for ease in access to dental services that promote access and not restrict access. The policies should be easily understandable for consumers and families.

9. HHSC and the IDD SRAC shall work to build access to services for this population by working with dental schools across Texas.

10. HHSC and IDD SRAC shall develop methods to address accessing services through sedation early for a child through such strategies as Practice without Pressure to save Medicaid future dollars and result in better outcomes for the member. Possible LAR recommendations. (flag for broader population)

11. Review impact of HB2658 or similar from the 87th Texas legislative session adding dental benefits for persons in STAR+PLUS. Determine change in policy and impact on wavier benefits. Included in impact is use of dental provider under state plan versus dental provider in wavier or private insurance.

Education on Transportation Benefits

1. Update current HHSC brochure that provides a clear understandable information to persons with IDD on how to access nonemergency medical transportation.

2. Provide information on how to access Non-Emergency Medical Transportation (NEMT) access within 48 hours. Allow same day access to NEMT mileage reimbursement benefits, which were allowed prior to June 1, 2021 by Logisticare and Modivcare.

3. Distribute the brochure to the public through websites, sharing with organizations to distribute to their members and through mailings. In addition, provide brochure at annual service planning meetings and contacts with service coordinators and case managers (completed, awaiting distribution).

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4. Monitor call center hold times for NEMT to assure access to Medicaid transportation benefit and report to HHSC. Consider longer times for access to call centers. Access to on-line scheduling and communication. Transportation system needs to be accessible as all information and scheduling needs to be in accessible format.

5. In the brochure:
a. Provide information on who to contact and their contact information;
b. Inform persons with disabilities on how to set up a ride;
c. Provide information on how to be reimbursed when using a personal car; and
d. Answer FAQs identified by the committee.

6. Standardize NEMT applications for Individual Transportation Participants (ITP), who provide mileage-reimbursement transportation services to Medicaid recipients. The applications and requirements for ITPs should be the same across all Medicaid programs and MCOs to reduce barriers for Medicaid recipients who use NEMT mileage reimbursement benefits.

7. Require TMHP and MCOs to automatically transfer NEMT data for ITP drivers when Medicaid recipients change MCOs or switch to or from an MCO to Traditional Medicaid to avoid delays in access to NEMP mileage reimbursement services for Medicaid recipients. ITP drivers should not be required to complete new ITP applications if they have already been approved as ITP drivers by another MCO or by Traditional Medicaid, to reduce barriers for Medicaid recipients who use NEMT mileage reimbursement benefits.

Monitor Quality on Acute and LTSS Benefits

1. Create a system that is public and data-informed by developing mechanisms for recurring data collection and review of acute and LTSS data, what is used, what is needed, gaps, and implement evaluation of the data. Data must include aggregate information such as:

- Review plans of care based on individual identified needs and desires.
- Compare what was on plan, provided or not provided and why and overall service utilization.
- Identify services provided by one or more than one or different providers, such as behavior supports, PT, OT, which may be provided by non-licensed individuals that reinforce therapy according to the plan of care.
- Within the IDD system including ICF-IID, 1915(c) waivers and the STAR+PLUS waiver publish deficiencies of the results of the survey results, complaints and resolutions, similar to the quality reporting system on a quarterly basis. Examine other states for meaningful measures.

2. Incorporating the pilot program performance measures or other quality measures identified in the pilot.

3. HHSC shall coordinate and consult with SRAC on a study for regulatory requirements for residential group homes and other residential settings where individuals with IDD receive services.

4. Identify people with private insurance coverage and dual Medicaid/Medicare through electronic means. Reports shall differentiate satisfaction and outcomes between those with other coverage and those solely with Medicaid only coverage through the EQRO annual survey. Since Texas does not allow Medicaid recipients with private insurance to "opt out" of MCO enrollment, require changes to survey design to allow respondents to provide separate responses for satisfaction and outcomes for members with private insurance or Medicaid/Medicare coverage vs Medicaid coverage.

5. Establish and publish a dashboard to track data elements on the HHSC website

- Implement recurring data collection, assessment, review, action plan, and public reporting of results and expenditures related to publicly funded services in coordination with the IDD Strategic Plan development and implementation.
- Ensure that state leaders have accurate, reliable data to use in development of policy and critical decisions that impact people with IDD.

6. Establish IDD population tracking codes within managed care.

7. Continue to seek and monitor IDD data on acute care, targeted case management/service coordination and LTSS quality measures using encounter data from Medicaid managed care organizations and other entities providing targeted case management/service coordination and LTSS using state data and National Core Indicators to obtain participant experience. In addition to NCI–AD, measures should include sufficient NCI IDD measures.

8. Evaluate and consider OPTUM recommendations for measurements and Utilization Management Review team information/data.

9. Ensure the committee will receive and review the results quarterly with HHSC to determine if the data are valid and can be used as baseline data for the future. The committee will continue to work with HHSC to refine the measures; and determine targeted case management/service coordination and LTSS measures that should be added and used to identify and address

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opportunities for improvement assessment and evaluation processes for people with IDD. The system should:

a. Determine people's satisfaction and the flexibility of the system to meet their changing needs;
b. Increase frequency of reviews throughout the year to ensure progress toward desired outcomes and preferences of the people using services and flexibility to make changes as needed;
c. Increase number of people who choose or help decide their daily schedule;
d. Increase number of people who use self-directed supports and participate in how to use supports budget, hiring, and services;
e. Increase number of people and families who report high quality services;
f. Increase number of people and families who report a high quality of life; and
g. Decrease the number of people experiencing transitions to higher levels of care due to unmet needs (e.g., ER, hospitals, jails, NF, SSLCs and other institutions).

Identify and Develop Health Initiatives

1. Expand quality-based outcome and process measures to include health care concerns impacting individuals with IDD such as obesity (due to medications), recovery based mental health services for individuals with IDD and co- occurring mental illness, diabetes, respiratory disorders, early onset Alzheimer's/dementia, heart disease, health literacy for self-care and decision making.

2. Improve access to preventive health services and access to timely and accurate psychiatric diagnoses and appropriate treatments.

3. Expand MCO provider networks to include both private and non-profit providers to prevent MCO members from having to go outside Medicaid to get health care services covered by Medicaid, and create a mechanism to collect claims and health care outcomes data from outside Medicaid when the individual uses non-Medicaid health care due to lack of access or due to coverage by primary insurance or Medicare benefits.

4. Ensure that SB 1207 regarding coordination of benefits, which was passed in the 2019 Legislative session, is implemented as written to allow Medicaid members to access Medicaid benefits for in network and out of network provider for copays, coinsurance and deductibles. Ensure that Medicaid members are informed or educated about the revised coordination of benefits policy.

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5. When Medicaid is the secondary insurer, ensure that Medicaid covers what the primary insurance does not cover, such as co-pays. Implement education and outreach to ensure Medicaid beneficiaries are aware to changes to be implemented due to recent legislation, including people on the Health Insurance Premium Payment (HIPP) Program who need coordination of benefits.

6. Encourage additional enrollments of private health care systems and private providers into Medicaid and Medicaid managed care to expand MCO provider networks.

7. To encourage health and wellness that may result in reduction of obesity rates, which are not always due to low physical activity levels, develop and implement easily understandable, targeted health promotion policies and practices that focus on nutrition, healthy lifestyle and diet.

8. Analyze data and, if needed, expand data collection to include access, availability, experience, utilization, and the results of health care activities (outcomes) and patient perception of care including use of NCI health and wellness data for individuals with ASD, ID and other developmental disabilities in order to identify health care initiatives. Provide separate results for persons with private insurance and those with dual Medicaid/Medicare coverage.

9. Use MCO encounters and other HHSC data regarding hospitalizations, ER visits and other physical and behavioral health related factors that may lead to institutionalization in nursing facilities, ICF/IID, SSLCs, State Hospitals and other long-term care institutions information to identify and address health initiatives to prevent admissions and facilitate returning to the community for individuals with IDD.

10. Track and report quarterly to SRAC the number and type and health related reasons for admissions, the number of discharges of individuals with IDD, including where they were admitted from, whether they had access to health care or community services by program, length of stay and where they were discharged to by program.

11. Implement certain innovative practices learned during the COVID public health emergency that increased timely access to services and are agreed to by the individual. Survey individuals and families to understand the impact of COVID and COVID policies during the public health emergency.

12. Services defined during the pilot program benefit design process should be incorporated into current waivers.

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13. Consider use of focused telemedicine for urgent care and behavioral health needs for persons with IDD performed by physicians experienced with the population.

Develop and Implement a Regional Partnership

1. Develop and implement a regional partnership throughout Texas for LIDDA, Medicaid MCOs, TEA, TWC, comprehensive providers and persons with IDD, and families to better coordinate services and supports for persons with IDD, to develop local solutions, and to develop strong partnerships resulting in better outcomes for persons with IDD.

2. Explore options for leadership roles to develop and operationalize regional partnerships.

3. Initiate regional partnerships prior to the STAR+PLUS Pilot Program to best support the goals of the pilot.

4. Increase coordination and collaboration between MCOs, local providers and state agencies (e.g. TEA, HHSC, DSHS, LIDDAs, TWC, and DFPS) to ensure appropriate and timely transition to adult services including competitive and integrated employment.

5. Pursue public-private partnerships to develop cross-system collaborations and innovative funding options to offer people with disabilities meaningful access to the same opportunities as their peers without disabilities.

6. Increase use of the regional education service centers' statewide networks to develop and provide innovative leadership development, training, and support for education for both professionals and families.

7. Increase regional and statewide resources and personnel to develop and implement inclusive competitive and integrated employment programs for students.

Improve the IDD Assessment Process

1. Implement person-centered, individualized and comprehensive training and assessments;
• Support comprehensive and accurate assessment of functional, medical, psychiatric, behavioral, physical, and aging needs in all settings and that results in receiving appropriate services regardless of settings.

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- Allow and encourage using a variety of evidence-based, empirically- valid tools as necessary to accurately identify needs.

2. Expand or enhance assessment tools and resource algorithms that account for high support needs and changes in conditions across the life continuum of the individual, whether physical, medical, or behavioral;
- Ensure high quality services that align resources with assessed needs and preferences (adjust rates that support quality)

3. Across programs and settings, develop and implement flexibility in service planning and resource allocation based on assessed needs, including for, but not limited to, individuals transitioning to community settings from institutional settings who may need higher levels of support during periods of transition.

4. Ensure continuity and integrity of services for transitions across programs, settings and changes in needs.

5. Acknowledgment of the important role an individual's natural supports can play and a willingness to Provide justified family support services, such as additional respite or in-home supports, at the level necessary to support an individual to remain at home.

6. Ensure individuals receive the amount, type and duration of services needed without requiring natural supports beyond those voluntarily provided.

7. Increase and improve training for assessment personnel to ensure assessments and staff appropriately address cultural, language, communication, learning differences, and needs of children and adults and their families.

8. Increase access to board certified behavior analysts to identify and provide timely and appropriate functional behavior assessments and behavior intervention plans.

9. Increase and enhance mental health screening to obtain baseline information and identify needs.

10. During any system redesign that implements new or modified assessments, ensure people maintain their services with no significant reductions.

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11. Maintain continuity and level of care when an individual moves across service or geographic areas.

12. Coordinate with and include joint recommendations from the pilot program workgroup for assessment recommendations to be utilized in the pilot.

Additionally, the SRAC recommends HHSC take the following actions to address immediate issues with the current assessment process:

1. Modify ICAP scoring requirements to allow for assignment of LON 9 to individuals without a behavior management plan in place if other evidence justifies assignment of LON 9 for a period of 12 months.

2. Automatically assign at least an LON 6 for a period of at least 12 months to all individuals transitioning from institutional settings (already in place for individuals transitioning from SSLCs, but not in place for individuals transitioning from Nursing Facilities and other settings) and aging out from CCP skilled nursing.

3. Adjust the ICAP and other assessment tools to better account for high support needs, including physical, behavioral, and medical needs that enable the assignment of an appropriate LON, including LON 9 for medical and physical needs, not just behavioral.

4. Review adequacy and accuracy of current assessment processes for STAR+PLUS HCBS, CLASS and DBMD.

5. Streamline Determination of Intellectual Disability and ID/RC and Related Conditions processes and study how other states complete this determination, such as not requiring repeating the DID or ID/RC at the current frequency unless requested by the individual or LAR.

6. Allow telehealth and telemedicine and other technology, unless contraindicated and when agreed to by the individual and LAR, to prevent delays in enrollment, prior authorizations, reassessments and renewal of IPCs.

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Identify Employment and/or Meaningful Day Goals

1. Require a person-centered plan for all individuals that addresses competitive, integrated employment and other meaningful day activity goals.

a. Include self-advocates in the discovery process by the development of a Peer Support Model benefit to assist individuals in identifying their meaningful day.
i. People planning together- Learning Community
ii. Opportunities for individual and group learning
iii. Exploring how to support families and friends to understand the value and possibilities of employment.
b. Review and develop recommendations to ensure that assessment and service planning questions are meaningful to individuals.
c. The service planning discovery tool currently in development should include a specific module on employment.

2. Require that ALL Long-term Services and Supports (LTSS) providers including case managers, service coordinators, day habilitation providers and direct service agencies (DSAs) complete training in the principles of Employment First (EF), employment services, steps to become an Employment Services Provider (ESP) with Texas Workforce Commission (TWC), the development and implementation of an Employment Plan, work incentives and other resources to maintain benefits while working and the transition of services from TWC to LTSS/waivers.

a. Improve electronic communication channels between TWC and LTSS providers and MCOs.
b. Require HHSC staff and LTSS providers to be trained in the implementation of what is required from TWC-VRS to obtain employment services to ensure it is never a barrier to pursuing employment goals.
c. Provide training that is affordable, accessible and available across Texas for all IDD LTSS providers and day habilitation providers to become successful Employment Services Providers (as the ESPs in TWC) in order to have a "pool" of providers for EA and SE services and to easily transition employment services from TWC to the waiver services.
d. Require TWC staff to notify HHSC staff when there is an ESP (Employment Service Provider) contract open enrollment period. HHSC will inform TWC who their contact person is. HHSC staff then will distribute this information to all LTSS providers and encourage them to enroll as ESPs.
e. Encourage HHSC staff and LTSS providers to register to receive notifications on TWC website to be informed of information related to vocational rehab.

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f. Allow ESPs contract open enrollment to be available year-round.

g. Examine the current state contracts for training providers of EA and SE to reduce the overall time required for them to qualify as a credentialed provider.

3. For individuals desiring to seek or maintain employment, include TWC Employment Service Providers in the service planning to ensure participants have an Employment plan coordinated with TWC or other employment supports and include this plan in the participants individual plan of care in their waiver. This recommendation is included in My Life Plan.

4. Promote awareness of employment supports through all means: case management, service coordination, person-centered planning, assessments, reviews, etc.

5. Require all TWC Vocational Rehab counselors to receive training from HHSC regarding Employment first principles, waiver employment program services and the process to transition employment services from TWC to long term services and supports/waivers.

6. Explore HHSC regulatory staff reviewing for compliance to Department of Labor standards for all sheltered based employment services paying less than minimum wages.

7. Explore additional strategies to increase competitive integrated employment as per the Texas Employment First policy including utilization of transitioning from the use of 14c waiver certificates.

8. Increase additional strategies that lead to skill development to increase competitive employment.

Increase Utilization of Employment Services

1. Require all LTSS providers to contract with a network of Employment Assistance (EA) and Supported Employment (SE) providers who meet quality standards to provide (SE) and (EA) services in order to meet the needs of the participants, including Employment Service Providers (ESPs.) The recommended Quality Standards include:

- The Employment Service Provider must have a discovery process in place that supports the individual to identify their employment capacities, abilities and preferences. Employment Assistance services used for discovery must reflect one-on-one interaction, business exploration and job training. EA service results in the person transitioning to Supported Employment Services.

2. For all individuals receiving employment assistance services, individual employment plans must be reviewed by the service planning team every 6 months to discuss and remove any barriers to competitive, integrated employment.

3. The Employment Service Provider must have a Supported Employment plan in place that includes employment placement, systematic instruction, fading of direct employment supports at the job site and long-term services.

4. Supported Employment services matches the individual to a job that reflects their employment capacities, abilities and preferences to a full or part-time job in the community paying minimum wage or better.

5. Develop and facilitate regularly scheduled regional and/or local collaboration on employment issues, including state agencies that provide employment services [MCOs, Local Intellectual and Developmental Disability Authorities (LIDDAs), Direct Service Agencies (DSAs), TWC, Texas Education Agency (TEA) and Health and Human Services Commission (HHSC)] which will develop (1) a joint plan for identification of federal and state funding and resources to promote competitive integrated employment, (2) a joint phase- out plan that transitions individuals with disabilities out of subminimum wage and segregated work environments, (3) annual goals for increasing the numbers of persons with disabilities employed in competitive integrated employment and (4) a requirement for each agency to develop a system for collecting and aggregating data that follows Workforce Innovation and Opportunity Act (WIOA) requirements and is reported to the HHSC Employment First designated staff annually (this recommendation also requires TEA and TWC participation).

6. Require contractors and subcontractors to comply with Employment First policies by ensuring the primary goal is competitive integrated employment as outlined in the Government Code, 531.02447.

7. Expand the definition of Employment Assistance services to include providing a person-centered, comprehensive employment plan with support services needed. This could be similar to the Employment Plan used by TWC. This service would provide assistance for waiver program participants to obtain or advance in competitive employment or self-employment. It is a focused, time limited service engaging a participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state's minimum wage. Include transportation between the participant's place of residence and the site where career planning is delivered as a component part of career planning services. The cost of this transportation is

included in the rate paid to providers of career planning services and the state would include a statement to that effect in the service definition.

8. Establish a centralized source of resources for employment related services and supports including information regarding continued Medicaid eligibility.

9. HHSC to measure employment outcomes to support the implementation of Employment First initiatives.

10. Promote competitive, integrated employment by developing and expanding existing educational campaigns and other initiatives to increase awareness of work incentives and provide accurate employment information for pilot participants.

11. Add Social Security (SSA) benefits counseling as a service in all LTSS waivers to promote competitive, integrated employment by not only increasing awareness of work incentives and providing accurate information, but by also assisting with, applying for and implementing work incentives that allow individuals who work to continue their Medicaid eligibility. The SSA benefits counseling will be provided by certified social security benefits counselors or those who are Work Incentive Practitioner-Credentialed. This will ensure participants understand that their Medicaid waiver pilot benefits will be preserved after obtaining employment.
a. Increase the number of certified social security benefits counselors by providing the necessary training in SS benefits. Currently there are less than 30 state certified benefits counselors in Texas.

12. Require and allow billing in the IDD waivers for EA providers to be present with an individual when a SE staff is being trained to ensure the transition from EA to SE is successful.

13. Establish a higher EA and SE reimbursement rate, in all waivers, for participants who have higher support needs, such as medical and/or behavioral supports, who require staff to have a higher skill set of training.

14. Establish a transportation benefit to allow flexibility to include the use of taxis, bus passes and ride shares and allow this to be billable through EA and SE services when it is employment related transportation.

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Improve Community Access through Home and Community Based Services Regulations

1. Pilot or phase in an hourly community integration service available to individuals regardless of their residential arrangement.

2. Develop and promote pooling of day services dollars to participate in shared interests in the community for up to three individuals to provide staff and transportation.

3. Provide funds to incentivize or reward creative service models that increase flexibility and support individualized, person- centered, lifespan goals to assist the state to come into compliance with HCBS requirements. (For instance: competitive/integrated employment, integrated retirement, community recreation, volunteering, or other activities identified as meaningful by the individual).

4. Incentivize waiver providers (DSAs-direct service providers) and day habilitation providers to become employment providers (such as ESPs in TWC).

5. Seek input from stakeholders in various settings with varying services to increase awareness of barriers to community inclusion.

6. Fully implement the services proposed by the IDD SRAC supported workgroups to allow for choice of meaningful day providers and day activities across settings in order to comply with the federal HCBS regulations.

7. Allow for flexibility of transportation services to support community participation activities.

8. Individuals in residential services should have increased flexibility and options for how they spend their daytime hours.

9. Develop an emergency/disaster plan to include stakeholder input in the event of disruption of services. Include post disaster emergency response evaluation data.

Access to Services

1. Fully fund 10 percent interest list reduction per year. The committee recognizes this does not fully address reasonable promptness or timely access to Medicaid home and community-based waiver services. The committee recommends using additional available federal funding initiatives, as initiatives become available, to better address reasonable promptness.

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2. Fully fund sufficient slots for the Promoting Independence Plan as related to transition and diversion waivers for children and adults, ensuring that the Texas Promoting Independence Plan is comprehensive, effective, and timely in meeting demands. Ensure inclusion of initiatives benefiting children, including waivers to support children being diverted or moved from nursing facilities and other institutional settings to community settings.

3. Provide outreach and training on how to access waivers, including the various attrition waiver slots, to the IDD population (persons and families) and those implementing the processes for accessing attrition slots. As LTSS services are carved into managed care over the next decade, eliminate the LTSS interest list for SSI recipients who qualify for IDD waiver programs. Consider HCBS waivers under Section 1915(c), 1915(k), or 1915(i) of the federal Social Security Act (42 U.S.C. Section 1396n(c) in addition to 1115 waivers which may be used to provide HCBS services to persons with IDD who meet eligibility criteria.

4. Implement a no-interest-list policy for eligible MDCP recipients who receive SSI and are enrolled in STAR Kids or STAR Health managed care programs.

5. Continue the "bridge to the appropriate waiver" policy. When a person comes to the top of an interest list and is found to be ineligible for that specific waiver program, based on disability or medical necessity criteria, the person's name is moved to the appropriate waiver interest list(s) consistent with their disability or medical necessity criteria. The placement date on the new waiver interest list is the original date that the person was placed on the waiver interest list(s) for which they have been determined to be ineligible. MCOs, LIDDAs, service coordinators and case managers should inform persons of the policy and assist with the process to get onto the appropriate interest list(s).

6. Implement the strategies outlined in HHSC Article II, Rider 19 and Rider 41, HB3720, HB2658, and SB1648, 87th Regular Session, Legislature requirements regarding Medicaid Waiver Interest lists, to include strategies recommended by the SRAC in coordination and consultation with HHSC.

Strengthen Support for People with More Complex Needs, Including Behavior Supports

1. Address barriers for persons with high needs that result in difficulty accessing or maintaining stability in home and community-based programs and services. For example, ensure that provider payments are both justified and sufficient and allow for billing for critical services such as nursing and supervision of non-licensed staff.

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2. Establish clear expectations and ensure compliance for providers who delay or deny services to persons with complex or high needs by providing technical assistance and resources for successful services, and by tracking delays and denials.

3. Continue to expand the behavioral, medical, and psychiatric regional teams to serve all waiver programs. Expand the use of evidence-based programs by supporting Local IDD Authorities delivering evidence- based programs to provide training, technical assistance, and ongoing support to other Local IDD Authorities 13.

4. Establish a Regional Collaborative with participation by IDD provider agencies, managed care organizations, Local IDD Authorities , community stakeholders, and advocates to develop and implement strategies to better serve persons with complex or high medical, behavioral, physical or psychiatric needs. Implement processes for participating entities to collaborate to identify unmet needs that may lead to crises and identify services to prevent crises.

5. For new HCS waiver enrollments, accept the initial proposed Level of Need (LON) from the Local IDD Authority for the first 12 months unless the LON is appealed based on the persons' needs exceeding the LON by the Local IDD Authority.

6. Enhance capacity of crisis respite and long-term stabilization as a measure to prevent hospitalization and/or institutionalization across all waiver programs and in non-waiver services for all persons with IDD.

7. Ensure access to protective supervision /personal assistance services across all waiver programs. Reinstate access to protective supervision in the HCS waiver.

8. Expand due process rights to appeal an LON determination, currently afforded to providers only, to persons and their representatives.

9. Implement a one-year presumption of LON 6 or LON 9 for persons 10.enrolling from all institutional settings or aging out from the
Comprehensive Care Program (CCP) skilled nursing, not limited to SSLC transitions. Maintain, at a minimum, the LON of a person transitioning from another waiver or other IDD program for one year.

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11. Improve and streamline the SSLC transition process and create successful and timely continuity of necessary supports and services.

12. Modify LON 9 to address the need for 1:1 staff, beyond aggressive behavior supports and supervision, to include any behavior, or medical or physical need that is life threatening or puts a person at risk of physical harm and requires the same high level of supervision and intervention.

13. Create high needs services, such as enhanced behavior supports and enhanced case management, that support advanced direct service professional training, supervision and compensation when supporting persons with high medical, behavioral, physical or psychiatric needs.

14. Create an add-on level or "bump" in Community First Choice services and payment for persons with more complex needs. Consider a rate structure equivalent to that of Residential and Day Habilitation in the HCS Medicaid waiver program. Support a higher rate for persons with higher needs. Note: Currently a person with a LON 6 receives a higher rate for the residential and day habilitation services. However, in Community First Choice (CFC), the rate is the same regardless of the person's LON. A flat rate that does not recognize individual needs limits the individual/ family's options to obtain services that best meet their needs.

15. Add higher level of services with higher total cost allowance for persons with the most complex needs in Medicaid, including in managed care and the STAR+PLUS Pilot program. For example, add a LON 9 for medical needs in the HCS waiver. The increased level may include enhanced rates for Direct Service Workers.

16. Streamline access to General Revenue funds for those who exceed the cost cap for Medicaid waivers, including in managed care and the IDD Pilot Program.

17. Consider recommendations by the SRAC, in coordination and consultation with HHSC, to meet the requirements of Article II, HHSC Rider 38, 87th Regular Session Legislature regarding a study on the Home and Community- based Services waiver program.

Create Housing Transition Specialist as a Medicaid Waiver Benefit

1. Create a Housing Transition Specialist benefit to assist persons with IDD to transition to the most integrated, appropriate housing for the person.

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2. Approve funding for Housing Transition Specialist as a Medicaid waiver benefit

3. Address barriers for persons with high needs that result in difficulty accessing and maintaining housing.

4. Explore opportunities to establish funding for security deposits and basic furniture/household items for those without resources.

5. Consider creating a Housing Supplement for people seeking to live on their own, but unable to do so due to the cost of living. Explore options for roommate assistance, rental assistance and assistance with resource management. Consider a capped monthly amount to use to cover the difference between the person's benefits and the cost of rent and living expenses. Note: The cost would be less than institutionalization. HHSC could pilot the Housing Supplement initially to evaluate the costs/benefits.

6. Remove barriers created by policies preventing HCS and TxHmL waiver caregivers from residing with individuals in the same household. Ensure policies are clearly communicated to participants.

Navigation Across the Entire IDD Service System

System reform must assist persons with IDD to live full, healthy and participatory lives in the community. Specifically, the system reform must address the needs of persons and families to navigate the IDD and Home and Community Based Services (HCBS) systems successfully. In addition, the system must be designed to support and implement person-centered practices, consumer choice and consumer direction. Persons with IDD and families should receive the assistance they need to effectively support and advocate on behalf of themselves and other persons with disabilities. The system must be accessible, easily understood and transparent for persons, including information about rights and obligations as well as steps to access needed services.
The Health and Human Services Commission should identify and obtain data needed to fully evaluate the migration/transition of persons with IDD across systems, including the reasons and number of transitions, and provide recommendations on the delivery of services to facilitate timely access to the services most appropriate to a person's needs. HHSC should coordinate and consult with the SRAC on the following strategies:

1. Provide comprehensive data at least quarterly to the SRAC and the public regarding the requests for waivers, and enrollments by slot type, and the, interest lists by waiver type. In addition,

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provide data on institutional census, admission and discharge of persons with IDD including State Supported Living Centers (SSLCs), Intermediate Care Facilities (ICFs), General Residential Operations (GROs) and Nursing Facilities (NFs). Data should include the numbers of persons active and inactive by waiver type on the interest lists, and the numbers of persons inactivated by quarter.

2. Improve Interest List data and tracking across programs, including STAR+PLUS, serving persons with IDD, including the number of persons on the interest list who are receiving institutional services by institutional type and waiver interest list.

3. Provide choice of the most appropriate waiver when a person in an SSLC or other institutional setting is transitioning to the community and would qualify for the Deaf Blind Multiple Disabilities (DBMD) or Home and Community Based Services (HCS) waiver.

4. Participate in the development of the five-year IDD Strategic Plan, and encourage broad stakeholder input.

5. Continue to contribute to the development, implementation and recommendations of the STAR+PLUS Pilot program for persons with IDD and similar functional needs. Continue to collaborate with the STAR+PLUS Pilot Program Workgroup.

6. In conjunction and coordination with Regional Collaboratives, implement a well-coordinated transition and referral process when persons experience a transition in care. The transition processes should identify problems and explore options through local, state and Medicaid resources. Transitions in care may include changes in caregivers, MCOs, provider agencies or care settings.

7. Fully assess a person with IDD at the time the person applies for assistance to determine all appropriate services for the person under the Medicaid medical assistance program, including both waiver and non- waiver services. In the selection of a standardized assessment, consider adoption of an assessment, or screening tool, that identifies current needs and imminent risks of individuals. Practical options are to modify Form 8577, develop an assessment tool, adopt a fully vetted IDD assessment tool, and/or incorporate existing health and risk assessments used by MCOs.

8. Continue processes to allow a person with a suspected of having an intellectual or developmental disability to register for IDD Interest Lists.

9. Ensuring procedures are operationalized for obtaining authorization for IDD Medicaid waiver services and other non-waiver services under the Medicaid medical assistance program, including procedures for appealing denials of service that take into account physical, intellectual, behavioral and sensory barriers and providing feedback on development of the new Independent Review Organization, including outreach and education.

10. Continue use of HCBS waivers and other alternative programs to meet the support and service needs of persons on Interest Lists for IDD comprehensive waivers.
Consider waivers under Section 1915 (c), 1915(k) or 1915(i) of the federal Social Security Act (42 U.S.C. Section 1396n(c) in addition to 1115 waivers which may be used to provide HCBS services to people with IDD who meet eligibility criteria. Access funds through all available federal initiatives, to include Money Follows the Person and the 10% increase in the Home and Community Based Services Federal Medical Assistance Percentage (FMAP).

11. Implement consistent processes to assist individuals seeking placement on Interest Lists to receive information about alternate community resources during the routine Interest List contacts. Process should include training requirements for entities responsible for completing the Interest List contacts. In addition, process should require the provision of written information about critical resources, to include Medicaid eligibility, Community First Choice, Texas Home Living program, Money Follows the Person, diversion for at risk individuals, and local community resources.

12. Ensure compliance with policies that require that a child or youth receiving Medicaid services has access to the most appropriate, comprehensive
waiver service as adults, based on that person's needs and preferences, when the person ages out of and loses eligibility for Medicaid State Plan or Medicaid waiver services for children. In addition, processes should ensure that families have access to education and resource information to successfully support their family member transitioning to adult services.

13. Establish the family support necessary to maintain a person's living arrangement with a family for children and, if desired, for adults with ID.

14. Ensure that eligibility requirements, assessments for service needs, and other components of service delivery are comprehensive, accurate, and designed to be fair and equitable for all families, including families with parents who work outside the home, parents who volunteer and parents who are not employed.

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15. Provide for a broad array of integrated community service options and a reasonable choice of service providers, consistent with home and community- based service settings requirements. Improve use and flexibility of consumer directed services options and training for self-advocates to direct their own services when desired.

16. Ensure that the array of integrated community service options allows persons with IDD to experience a "meaningful day" Consider the following definition for "meaningful day".

Meaningful Day (See And Yet More selection of the Idea Book for It's Official: The Unabridged 3/1/06 Measurable Definition of a Meaningful Day): Meaningful Day means individualized access for individuals with developmental disabilities to support their participation in activities and function of community life that are desired and chosen by the general population. The term "day" does not exclusively denote activities that happen between 9:00 a.m. to 5:00 p.m. on weekdays. This includes: purposeful and meaningful work; substantial and sustained opportunity for optimal health, self-empowerment and personalized relationships; skill development and/or maintenance; and social, educational and community inclusion activities that are directly linked to the vision, goals, and desired personal outcomes documented in the individual's Person-centered Support Plan. Successful Meaningful Day supports are measured by whether or not the individual achieves his/her desired outcomes as identified in the individual's
Person-centered Support Plan, as documented in daily schedules and progress notes. Meaningful Day activity should help move the individual closer to a specified outcome identified in his/her (Person-centered Support Plan).

17. Evaluate the quality and effectiveness of services for persons with IDD, including persons with high support needs. The evaluation should address whether access to crisis services prevented or could have prevented the need to migrate to a more restrictive setting or a different Medicaid waiver.

18. Coordinate, or combine, statutorily required IDD-specific reports to allow for a broad view of the systems' strengths and weaknesses and a more accurate assessment of barriers and gaps to services. Note: There are numerous IDD- specific reports that identify barriers to community, including reports on referrals, provider capacity, affordable community housing, and other services and supports needed to ensure community stability. The data from these various reports needs to be coordinated in a focused assessment of barriers and gaps to services.

19. Monitor the implementation and impact of managed care, new policies and initiatives required by the 87th Texas Legislature.

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20. Identifying state agency staff to assist persons to understand, maintain, and manage their Medicaid benefits. Implement improvements to ensure a streamlined process for Medicaid eligibility for IDD Waiver applicants.

Increase Community First Choice Utilization and Improve Coordination

1. Increase awareness of CFC through a concerted, statewide outreach effort. Require HHSC to create a brochure and website content that describes CFC in a meaningful and, accessible way, to include eligibility requirements for the benefit and information on who to contact to request services. Distribute education material to all persons served, providers and advocates of persons with IDD and MCOs.
Require MCOs and LIDDAs to discuss CFC services at annual assessments to ensure persons with IDD are aware of CFC and are routinely screened for eligibility and interest in the benefit. Ensure schools provide information to students with disabilities who may qualify for CFC services.

2. Enhance the CFC service array by adding transportation and respite services to the benefit.

3. Set sustainable CFC rates that allow for hiring and retention of direct service workers with skills and abilities in teaching habilitation. Set rates for CFC services across all programs, including rates paid by MCOs, to attract and retain direct service workers. Rates for direct service workers who support persons with IDD must take into account the lifelong needs of persons with IDD and the distinct skills and abilities required to teach persons to perform tasks independently.

4. Require HHSC to track and report compliance data on timeliness to include periods of time from the date of request or determination for the need of assessment for CFC services until the date the services are rendered or denied. Require HHSC to report data on declines to include reasons for decline.

5. Establish a clear and streamlined funding mechanism and payment rate for the LIDDAs to perform eligibility determinations and CFC functional assessments for persons with IDD. This includes funding mechanisms and rates for CFC eligibility and/or assessments for persons with IDD who receive CFC in non-waiver programs such as STAR+PLUS, STAR Kids and STAR Health.

6. Require HHSC to provide strong oversight and training to MCOs, LIDDAs, providers and CDS employers on the CFC benefit. This includes when to provide, how to report and how to bill for services. Training must include information on how to provide habilitation for persons with IDD, as

well as additional resources. Habilitation providers, as members of the Service Planning Team, must contribute to the development of outcomes, implement strategies to achieve habilitation goals, and report progress on a regular basis.

7. Allow flexibility within the CFC benefit, utilization policies, and person- centered planning such as:

- The ability to access CFC habilitation services from one provider to more than one person at the same time taking into account appropriate rates.
- Allowing, through the amendment to the HCS and TxHmL waiver, individuals living in the household of the waiver recipient to provide CFC if they meet the qualifications and want to be the provider.
- Ease in changing service delivery models. The system should not pressure families to use natural supports further overburdening families caring for their family member. This includes any tools requiring use of natural supports.

8. Use data-driven decision-making to commit to ongoing evaluation and improvement in CFC. Request HHSC to work in concert with the MCOs and LIDDAs to allow for identification and tracking of CFC utilization data for specific populations (i.e. persons with IDD Analyze the utilization data to address network adequacy and to determine additional training needs and process improvement.

9. Request HHSC to work with MCOs and LIDDAs to identify and address issues related to the sharing of information such as referrals, eligibility determinations and the authorization processes that slow down or impede enrollment. Streamline and create less administratively burdensome processes.

10. Require HHSC to recognize that a person remains eligible when eligibility was determined by a Determination of Intellectual Disability (DID) assessment completed after age 18. The requirement for a DID update every 5 years should only apply to a person whose eligibility was determined by a DID completed prior to the 18th birthday.

11. **NEW**: Request HHSC to consult and coordinate with the SRAC on the improvement, revision and further development of the CFC assessment tool and processes. In addition, consider revisions to the instructions and directions to assessors, to include training requirements for assessors on the use of the tool and technical assistance on the development of justification for identified services.

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Impact of COVID-19

Recommendations to Gain Efficiencies in the Medicaid and CHIP Programs

1. Allow qualified individuals living in the same household as a person receiving waiver services to be providers of Community First Choice services. NOTE: Currently, this is not allowed in TxHmL and HCS programs. This change would keep individuals safe by limiting the number of people coming into the home as well as assist with the recruitment and retention of direct service providers. Parents of minor children and spouses are not eligible providers.

2. Allow for individuals in different waivers to share attendants when deemed appropriate in accordance with the person-centered plan and ensure flexibility in rates when an attendant is supporting more than one person.

3. Add Personal Protective Equipment (PPE) as a reimbursable Medicaid benefit for all recipients including those using Consumer Directed Services.

4. Streamline the Medicaid provider enrollment process by combining and using one vendor for Medicaid managed care credentialing verification and HHSC Medicaid provider enrollment. HHSC relaxed some of the requirements for becoming a Medicaid provider during COVID-19. NOTE: This was crucial in allowing providers to enroll to provide telehealth services. However, prior to the crisis, becoming a Medicaid provider had become a long complex process often taking many months to complete. Once completed, the provider must become credentialed by Medicaid managed care health plans. The health plans simplified the process by use of one entity to assist providers for all the Medicaid managed care plans. The same changes are needed to the burdensome Medicaid enrollment process.

5. Permanently remove the 30-day spell of illness limitation for hospitalizations for adults in the STAR+PLUS and fee-for-service programs. This has been a concern during this COVID crisis for Medicaid recipients who have exceeded the 30-day length of stay for COVID 19.

6. Allow the use of social determinants of health to develop value-added services. During this crisis, health plans have been asked to support food, housing, PPEs and other social determinants of health services. Additionally, HHSC should issue a list of Social Determinants of Health supports that health plans can provide as optional enhanced services.

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7. Amend the Medically Dependent Children Program (MDCP) to create a nursing facility diversion target group for children with medical fragility who are at imminent risk of nursing facility admission. NOTE: Currently it is the only program that requires institutionalization through a nursing facility to

access crisis diversion slots through Medicaid. Requiring that this population be exposed to additional risks by staying in a nursing facility for up to 30 days puts the medically fragile child at risk.

8. Explore opportunities for Direct Service Workers to work remotely, virtually or off-site to the extent allowed by federal regulations. Consider options for Day Habilitation, habilitation activities and Supported Employment.

9. Develop televisit options for the provision of some attendant and habilitation services for persons with IDD. NOTE: There are some services that attendants can provide during a crisis such as teaching and verbally prompting a person through the completion of tasks such as doing the laundry or making a meal.

Recommendations to Guide Future Disaster Response

1. During an emergency or disaster, allow Consumer Directed Services (CDS) employers of record to be the providers of CFC services, unless the individual is their own CDS employer of record. Currently this is not allowed in the CDS option. This change would keep individuals safe by limiting the number of people coming into the home as well as assist with the recruitment and retention of direct service providers. Parents of minor children and spouses are not eligible providers.

2. To hasten the employment process in both of the instances addressed above as Recommendations 1 and 2 to Gain Efficiencies, defer the new employee training requirements for family members of the individuals receiving services during an emergency or disaster. These would be the same deferments in place for all programs in regard to the crisis.

3. Include IDD providers and CDS employers on the list of essential providers who need PPE to ensure they get the PPE needed during COVID-19 and any other public health emergencies.

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4. Include a communication plan within the person-centered plan that explains how a person communicates their needs in the event that the person is separated from their primary care provider due to hospitalization or other circumstance.

5. Extend all Medicaid waiver plans of care, level of care assessments, and CFC assessments expiring during the pandemic by one year as allowed by the state's CMS approved Appendix K submissions. This will allow Medicaid recipients in waiver programs to continue to receive services while protecting them from unnecessary exposure from waiver or assessment providers.

6. Require Medicaid managed care health plans to expand their emergency disaster plans to include situations such as a pandemic rather than only natural disasters such as hurricanes.

7. Screen for early detection and identification of abuse and neglect during times of crisis.

8. Allow the use of on-line CPR training and certification such as the training offered by the American Heart Association during and beyond the COVID-19 public health emergency. HHSC should allow for modifications to CPR training and certification requirements in all Medicaid waivers to allow for easier onboarding of new employees and easier recertification of existing employees during a public health emergency.

9. Disallow the reduction in waiver eligibilities, services or budgets if persons are temporarily under-utilizing the services in their plans due to emergencies or pandemics like COVID-19.

10. Increase and expedite access to and enrollment in IDD 1915 (c) waivers, MDCP and STAR+PLUS Home and Community Based Services (HCBS) to avoid admission to and provide transition from institutions during local, regional, or statewide disasters.

MOTION: To approve the recommendations with edits that were discussed today failed due to the absence of a quorum.

Public comment. No public comment was offered.

Review of action items and agenda items for next meeting July 29th.

- Election of Vice Chair
- Edits to Bylaws
- SB 1207

- EVV Migration
- Legislative update
- Vote on Recommendations

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

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