BIP FUNDING RECOMMENDATIONS OFFERED FOR CONSIDERATION – 10/26/12

Infrastructure and Information Technology

#	Stakeholder Recommendation	BIP Requirement(s)	Additional Stakeholder Comments
1	Implement electronic person centered life records (including health records) for individuals with intellectual and developmental disabilities (IDD).	Access to community long term services and supports (LTSS)	This recommendation would help ensure that appropriate community living options and services are provided.
2	Establish statewide, coordinated Aging and Disability Resource Center (ADRC) coverage.	No wrong door/single entry point (NWD/SEP)	Currently, Texas has 14 ADRCs (with at least one in each HHS region except Region 5). This recommendation would allow DADS to fund additional ADRCs and expand some existing ADRC service areas to ensure a statewide NWD/SEP system (a BIP requirement).
3	Implement required IT enhancements to establish a fully coordinated No Wrong Door/Single Entry Point system.	NWD/SEP	An evaluation of required IT enhancements is underway. In general, required enhancements will include changes to current automation infrastructure and related financial and functional eligibility processes; enhanced information collection and sharing across systems; development of a statewide 811 system; development of a basic screening tool; and some changes to current assessment instruments.
4	Develop a multi-agency website for children with special health care needs, their families and providers.	Access to community LTSS	Funding would allow development of a single portal for families of children with special needs to address the lack of access to easy-to-find, updated, inclusive and quality information. SB 1824 (81st Texas Legislature, Regular Session, 2009) created the Task Force for Children with Special Needs to develop and implement a five year plan to improve coordination, quality and efficiency of services for children with special needs. This is one of the Task Force's recommendations.
5	Increase self-service for seniors and individuals with disabilities (via website, call center, online chat).	NWD/SEP	This recommendation would simplify navigation to ensure that seniors and individuals with disabilities can easily find what they need and manage their services. Questions re: eligibility, available programs; and required documentation should be user friendly (like Turbo Tax questions). An integrated set of customer service options (e.g., website, call center, online chat) would rely on simple questions. All options would be connected so the individual does not have to provide the same information twice. With the individual's approval, the system could pull information from other government systems. Ultimately, the system would proactively collect data and trigger outreach to individuals at risk of institutionalization.

#	Stakeholder Recommendation	BIP Requirement(s)	Additional Stakeholder Comments
6	Develop a secure web-based portal for service providers and DADS staff or contracted case management staff to upload and download necessary documents.	Access to community LTSS	In many programs, service providers and DADS staff or contracted case management agencies send and receive documents by fax or mail. DADS conducted an Electronic Document Submission pilot from December 2011 to May 2012 to test the feasibility of sending and receiving documents via email between service providers and DADS regional case managers. Pilot participants experienced problems receiving and opening documents sent via encrypted email because their encryption and operating software varied widely. Often, the DADS system did not recognize the service provider's encryption software or operating software, creating access issues and service authorization delays. In some cases sending and receiving documents via email actually required an additional step because scanned documents had to be saved as Word or PDF documents, then emailed to the receiver (versus faxing a document or sending through regular mail with no additional steps required). The portal would obviate the need for encryption software, as the sender would upload the documents to a secure website. The portal would include secure folders specific to each contracted agency and each DADS office for easy access by providers and DADS staff, and authorized users could access the folder and download documents. A portal would also expedite service authorization because the DADS case manager or contracted staff could access the provider's documents directly from the appropriate portal folder, eliminating the need for staff to collect and distribute the documents.
7	Enhance the Your Texas Benefits self-service portal to include information about benefits and work incentives.	NWD/SEP; Access to community LTSS	The economy benefits from more individuals being in the workforce and fewer individuals relying on public assistance. Would-be employees benefit as well. However, many people with disabilities choose to not work because they lack reliable, accessible information about the effect of earned income on federal and state benefits and fear they will lose critical benefits, such as Medicaid if they go to work. When people with disabilities have access to accurate information about earned income and benefits, they will more likely choose to work rather than rely on public programs such as SNAP and public housing. Washington State's Pathways to Employment website allows people with disabilities to make informed decisions on whether to work by providing: a benefits estimator, an online resume builder, video success stories of people with disabilities who have started or returned to work successfully, information on how, when and if a person should disclose disability to an employer/potential employer, and access to an "employer proximity locator" which enables people to obtain information on businesses located near their home. The coding and platform for this site is available to Texas at no cost. However, funding would be needed for a contractor to incorporate the information into the existing Your Texas Benefits self portal.
8	Develop one website dedicated to: LTSS programs offered through the state and local areas, eligibility requirements to receive services, limitations on availability, services, and funding, how to apply or get on an interest list, and providers.	NWD/SEP	Currently there are many points of entry and people have to guess which one is correct for what they need (DADS regional office; AAA's; ADRC's; ILC's; Authorities). Each has its own silo of services offered to a particular population. People may not even know about the various doors, or they may need services from several doors. Also, emphasis has been on a "place" where people can come. However, that "place" is often not convenient or accessible to most people. ADRCs are making some inroads here. This would be helpful for people to "pre-screen" themselves for eligibility and usefulness of services in meeting their needs. It would also be available for other local resources (hospital discharge planners or other care providers or care managers) so they can assist clients in identifying sources of needed services. The website should be searchable by service type needed, income, age or type of disability if that is a limitation in receiving certain services or determining the primary door to access.

#	Stakeholder Recommendation	BIP Requirement(s)	Additional Stakeholder Comments
9	Fully automate Texas Medicaid Buy-In in TIERS.	NWD/SEP; Access to community LTSS	The Balanced Budget Act of 1997 created an optional Medicaid group to incentivize work for individuals with disabilities, enabling them to earn enough income to become economically self-sufficient and ultimately less dependent on state and federal benefit programs. In September 2006, HHSC implemented this option by establishing the Medicaid Buy-In (MBI) as required by SB 566 (79th Legislature, Regular Session, 2005). MBI offers people with disabilities the opportunity to make a living wage and retain critical health services through the purchase of Medicaid health insurance. Despite considerable efforts, Texas has the lowest MBI enrollment rate in the country, with 259 participants as of June 2012. The MBI application/re-determination process is largely manual and is not cost-efficient or participant-friendly. In 2006, MBI was slated for automation in in TIERS, but it was never fully automated. The Medicaid for Elderly and People with Disabilities (MEPD) staff who process all MBI applications complete much of the process by hand, which is time consuming and subject to human error. Texas's low MBI enrollment rate is due in part to the laborious application process which can take up to eight months to complete. Full automation in TIERS would increase the number of people with disabilities who have access to MBI. This population's healthcare needs will be timely met rather than allowing a condition to worsen until they are forced to quit working and/or utilize costly emergency room services. The state will also see a savings in reduced staff overtime. Additionally, if data from other states holds true, Texas will see a decrease in usage of Medicaid services by the MBI population.
10	Rather than forcing everyone through one single door, thus potentially creating a bottleneck to receive services, it is important for persons to enter through any of the doors (they will most likely choose the one that best fits their primary needs). However, they should not have to go to each door that has any of their services. All services should be coordinated through the one primary door.	NWD/SEP	Currently there are many points of entry and people have to guess which one is correct for whatever it is that they need. (DADS regional office; AAA's; ADRC's; ILC's; Authorities) Each has its own silo of services that they offer to a particular population. People may not even know about the various doors, or they may need services from several doors. ADRCs are making some inroads here. Persons seeking services could have all services coordinated through one door, and would not have to have multiple applications, assessments, case managers, etc. Should also eliminate duplication among entities.

#	Stakeholder Recommendation	BIP Requirement(s)	Additional Stakeholder Comments
11	Provide each ADRC with one additional FTE to focus on managed care needs of individuals who are aging, individuals with disabilities and their family.	Conflict free case management; Access to LTSS	Medicaid managed care has reshaped the delivery of Texas's LTSS. Although it promises more integrated acute and LTSS, it creates challenges for clients who must learn new processes to access services. In addition, it focuses only on integration of Medicaid-funded services. HMO service coordinators do not identify and arrange non-Medicaid services (e.g., non-medical transportation, money management) that promote wellness and community inclusion. For Medicaid managed care to operate effectively, clients must understand their rights and responsibilities and have access to impartial advocates in the event that their needs are not being addressed. In addition, HMO service coordinators must recognize the importance of non-Medicaid services and know how to access them as needed. We propose an expansion of ADRCs to increase supports for managed care consumers and providers, with ADRC options counselors performing the following the functions: • Provide HHSC assistance with outreach, especially as managed care is introduced in a fee-for-service area; • Educate clients during enrollment about how managed care affects access to providers and provide objective advice about choosing a managed care provider; • Educate clients about appealing care decisions; • Provide disenrollment counseling, as needed; • Advocate clients with complaints about managed care services or needs beyond the scope of managed care programs; • Develop training for managed care service coordinators on non-Medicaid supports and access procedures.

#	Stakeholder Recommendation	BIP Requirement(s)	Additional Stakeholder Comments
12	• 1 FTE to oversee BIP implementation. • 1 FTE for ADRC Outreach & Marketing to include website content management. • 2 FTEs for ADRC Access & Intake to respond to increased calls and walk ins. • 2 FTEs to serve as ADRC options counselors for clients in the community. • 2 FTEs to support ADRC options counselors. Employed by and housed at hospitals and would assist clients being discharged home or to a NF. • 1 AAA FTE to support ADRC Service Coordinator & Consumer Advocate by acting as a liaison with MCOs. • 1 ILC FTE to support ADRC MFP Options Counselor by supporting Medicaid and Non-Medicaid relocation services. • 1 Local Authority FTE designated as an INTERACT II Intervention Coach among NFs to prevent avoidable hospital admissions from NFs and provide access to Behavioral Health services. • 1 AAA FTE to support ADRC Consumer Directed Options Counselor for DADS LTSS, Veterans Programs, and to train clients in various private pay models and legal requirements. • 1 FTE for ADRC Evidence-Based Programs and Schmeiding Caregiver Education & Training (family and para-professional) to expand direct care workforce. • HHSC FTEs at the ADRC to support streamlined eligibility determinations. • 1 FTE to support ADRC staff designated administrative support.	NWD/SEP; Access to community LTSS	Finding the right services can be daunting for individuals and their family. The LTSS system involves numerous funding streams and is administered by multiple federal, state and local agencies using complex, fragmented and often duplicative intake, eligibility, and assessment processes. Individuals who may be vulnerable or in crisis are confronted with a maze of agencies, organizations and bureaucratic requirements. These issues frequently lead to the most expensive care, including NF care or an extended hospital stay, and can cause a person to quickly exhaust their resources without appropriate decision support. Public education, including education of healthcare providers is essential to inform them that the ADRC can help them access the right services. However, there is an urgent need for resources to support the ADRC capacity to serve people of all ages, disabilities and income levels, including people interested in planning for or being able to pay for their service needs and not rely on public assistance. Due to a lack of resources, some ADRCs must use "Options Counseling" as an approach to support consumer's decision making but does not have resources to support staff officially designated as "Options Counselors." There is also a need for MCOs to partner with the ADRC as they become another "door for access." The ADRC can provide added value to MCOs to: support consumer assessment; improve service coordination; provide ombudsman type consumer advocacy relations; provide education and training to family caregivers (Schmeiding Method of Caregiver Training); and provide access to evidence-based health and wellness programs. Also, to negate the fragmentation for accessing public services that only state agency staff can authorize through the financial eligibility process, the State Medicaid Agency should assign financial eligibility staff to the ADRC. Lastly, the ADRC needs to strengthen its relationship with healthcare systems by having necessary resources to support embedding ADRC Options Counselors within the discharge planning and social work departments along with the Care Transition Team to help prevent avoidable hospital readmissions and unnecessary NF placements. This type of ADRC and Hospital alignment can serve as a model to assist Texas to transform the healthcare/community-based LTSS system into a more a fully integrated comprehensive system.

#	Stakeholder Recommendation	BIP Requirement(s)	Additional Stakeholder Comments
13	• Support new ADRCs and expand existing ADRCs to ensure statewide coverage. • Give ADRCs read-only access to the Medicaid database to help clients determine application status. • Give ADRC partners read-only access to a shared consumer database to eliminate duplication of gathering and entering basic data. • Use ADRCs to promote online Medicaid enrollment using YourTexasBenefits.com. • Fund ADRCs to provide cross-agency training so DADS front door staff and managed care service coordinators are familiar with non-Medicaid LTSS. • Fund ADRCs to provide service navigation to help Medicaid clients of all ages access Medicaid and non-Medicaid LTSS. • 1 Program Manager to oversee day to day operations, provide back up during high volume and vacancies, and build the critical work flows with each key partner. • 2 System Navigators to provide options counseling, benefits counseling, assistance with Medicaid applications and information and referral calls. • 1 Marketing/Outreach Coordinator to provide community education and training to clients, family, and service organizations, and continue developing local community resources. • 1 part time clerical support to assist with work flow and assist ADRC staff with job duties. • Pay 25% of current Project Director balancing this role with other job duties of the Lead Agency. • Provide operations sufficient to cover ADRC costs (e.g., 70% personnel and 30% operations). • Additional 10% Indirect of ADRC costs to fund the Lead Agency's operational costs.	NWD/SEP; Access to community LTSS	Medicaid clients in need of LTSS face a dizzying array of programs and providers, with segmentation on the basis of variables such as age and diagnosis type. DADS' three front doors—DADS Community Services, Local Authorities for persons with IDD, and AAAs—utilize different eligibility criteria and are limited in information flow to each other. The introduction of Medicaid managed care has added to the complexity of the LTSS network as well as the inclusion of Local Mental Health Authorities as added in the BIP application. Further, the separation of Medicaid program eligibility—determined by DADS or its contractors—and financial eligibility—determined by HHSC—creates challenges in inter-agency coordination. As a result, individuals with multiple, complex needs often have difficulty accessing the full range of available LTSS. Frequently they are referred from one agency to another, undergoing lengthy and sometimes duplicative assessments. At worst, they are deemed eligible for waiver services but are placed on interest lists and provided little or no immediate assistance. DADS has realized significant progress streamlining eligibility for Medicaid services by supporting ADRC development, which covers large portions of the state. However, ADRC services are not available statewide, and ADRCs are at different stages of development and ability to integrate LTSS. Using real costs projections, core funding equates to $350,000 per ADRC. This will provide the solid platform that can be built upon for further ADRC initiatives. Using this funding formula and adding $100,000 for new ADRCs (10) and $50,000 for the expanding ADRCs (5), it is estimated that the total core functioning for ADRCs in the robust role the BIP envisions = $9,650,000. This would leave 80% to 90% of the remaining BIP funds to address state level needs, IT needs, and other special projects. This is a good investment to create the new front door for screening, eligibility, LTSS and monitoring described in the BIP application.

#	Stakeholder Recommendation	BIP Requirement(s)	Additional Stakeholder Comments
14	We propose and volunteer to work on (with other stakeholders) an assessment of Texas ADRCs related to their ability to ensure that each Texas ADRC has necessary cross-age and cross-disability expertise and resources – including materials, volunteers and staff. We believe standards should be set and met related to full functionality for both aging and disability access and information and would like to provide input on those standards prior to ADRCs' expansion. We would like this implemented in collaboration with the ADRC advisory committee, but not limited to advisory committee members. We insist that all new technology related to a self-service portal or screening tools for use by the public, agency staff and contractors be fully accessible to individuals with disabilities, including individuals with physical, mental and cognitive disabilities.	NWD/SEP	The BIP application relies heavily on the ADRCs as the NWD/SEP and emphasizes expansion of ADRCs' number and functionality to achieve statewide coverage. If the ADRCs are going to be Texas' NWD/SEP for all Texans and are going to be "fully functional," we need to ensure each ADRC has cross-age (including children) and cross-disability expertise. Currently ADRC expertise is for people who are aging. Amend BIP application to ensure statewide, coordinated ADRC coverage across all ages and disabilities. Recent experience with the Electronic Visit Verification system shows much improvement is needed regarding accessibility of technology for agencies, their contractors and the public.

Mental and Behavioral Health

#	Stakeholder Recommendation	BIP Requirement(s)	Additional Stakeholder Comments
15	Establish Regional Crisis Intervention Teams to provide in home crisis intervention and triage; training to family and staff; behavioral supports; and nursing assessments.	Access to community LTSS	Crisis Intervention Teams would include a psychologist or behavior analyst, social worker, registered nurse, and specialized direct support staff. This recommendation would help individuals with challenging behaviors and mental illness avoid institutional placement.
16	Support individuals with challenging behaviors who are in the community or are transitioning from institutional settings to the community by training caregivers and direct service staff and delivering comprehensive behavioral treatment and crisis response and intervention services.	Access to community LTSS	This proposal includes Recommendation #15 in addition to training and comprehensive behavioral treatment. Unlike Rec. #15, which is limited to crisis response, this rec. would provide stabilization training and support for caregivers to empower them to continue helping individuals with challenging behavioral needs, as well as evidence-based treatment services for individuals with IDD who exhibit challenging behaviors. By providing training, treatment and crisis intervention, individuals transitioning from an institution (e.g., a SSLC, psychiatric hospital, or NF) back into the community or those at risk of losing community placement, can receive more support and structure and will have a higher opportunity for success. Re-admissions will decrease and more individuals with challenging behavioral needs will be able to be able to receive needed services while remaining in their homes. The proposed services are based on models that have proven effective in both helping people avoid a crisis that would result in alternative placement, as well as cutting costs associated with institutionalization, hospitalization, incarceration, and an array of waiver services which may no longer be necessary due to preventative skills teaching and education initiatives. Incorporating preventative services will likely drive down the need for crisis response services, and therefore the high costs associated with it.
17	Implement a basic online mental health (MH) and substance abuse (SA) screening tool in the statewide coordinated LTSS assessment system.	NWD/SEP; Access to community LTSS	Currently, LTSS intake does not include standardized, basic screening for MH/SA conditions or referral within the state's MHSA and Medicaid system. MH/SA conditions are prevalent in individuals served by the LTSS system and they impact the individual's ability to perform ADLs, impair cognitive functioning and increase the probability of an extended stay in a NF, acute care hospital, or institution for mental disease. These conditions also increase community LTSS costs for supports such as personal assistance services. This recommendation would be accomplished by providing external partners access to an internet-based, basic screening and referral component of the DSHS Clinical Management System for Behavioral Health Services (CMBHS). Referring external partners (e.g., ADRCs) would conduct a brief screen with the client and document it in CMBHS. Positive screens would trigger a referral to the appropriate managing authority within the state's MHSA or Medicaid system to initiate assessment and referral for treatment.
18	Regional crisis intervention teams to help individuals with IDD and a co-occurring mental illness avoid institutionalization should be available to all individuals regardless of disability.	Access to community LTSS	A significant number of individuals with complex behavioral support needs do not have co-occurring mental illness. Pursue service enhancements to provide enhanced community based services for individuals with significant and/or complex needs (e.g., hospital level of care in existing programs or in a new program). Expand and supplement MFP when needed so individuals of all ages in NFs and ICFs of all sizes can use funds allocated for their services in the most integrated setting. Allow individuals, not just providers closing the ICF, to use MFP as requested. Community program eligibility must be at least 300% SSI for all programs, including TxHmL. Provide flexible family supports.

#	Stakeholder Recommendation	BIP Requirement(s)	Additional Stakeholder Comments
19	Create a Community Transition training curriculum for peer support specialists and recovery coaches to prepare them to support individuals transitioning from institutional settings and stabilize them in community settings. Provide appropriate training for key executive and management staff of community organizations.	Access to community LTSS	Texas lacks a well-trained workforce to support individuals with MH/SA disorders to transition from institutional settings and adapt to the demands of community living. A well-trained workforce would include peer support specialists and recovery coaches trained to provide the unique supports needed for transition and stabilization in the community. The workforce also includes key executive and management staff in community organizations (e.g., Medicaid HMOs, Local Mental Health Authorities (LMHAs), SA providers) who must be educated about resources and activities required to support community transitions for persons with MH/SA disorders. Building on existing infrastructure (e.g., current basic training for peer support specialists and recovery coaches provided by state-approved contractors), this proposal would create advanced training and deliver it to peers interested in working with individuals with MH/SA disorders wanting to transition from institutional settings. The curriculum would draw on evidenced-based practices (e.g., Cognitive Adaptation Training, Illness Management and Recovery, Wellness Recovery Action Planning) as well as what has been learned in the MFP MHSA pilot to create practical skills for this workforce. Trainings would be held regionally to ensure easy access and participation and provide statewide coverage for these services.
20	Develop a health information network with an initial focus on facilitating information exchange between state hospitals and the community mental health centers to improve coordination of services between state institutions and community-based services and supports.	NWD/SEP; Access to community LTSS	Currently, no automated system exists for data exchange between the state hospitals (and SSLCs) and local community centers or for exchange between the state hospitals and external primary care providers. The lack of an automated system impacts care coordination between elements of the behavioral health system of care and limits the ability to coordinate care between the state facilities and external primary care providers. The lack of electronic information exchange can contribute to unnecessary duplication of services, repetitive questions to clients, development of inaccurate or inappropriate care plans, increased costs of care delivery and increased institutional utilization due to the inability to effectively coordinate care. This network could also serve as a connection point between the state's public behavioral health delivery system and the locally-managed regional health information organizations (RHIOs), creating a platform to coordinate the delivery of primary and behavioral health services at the community level, enhancing access to community-based LTSS for primary care needs. Because the state psychiatric hospitals share a common electronic health information system with the SSLCs, this same framework may also serve as a foundation in information exchange between the SSLCs and their external partners.
21	Instead of DADS developing a six-bed ICF behavioral intervention model to provide specialized interventions to individuals with IDD and extensive behavioral health needs, direct DADS to develop these supports in a four bed HCS residential program.	Access to community LTSS	Individuals with significant behavioral health needs are better served in smaller settings where fewer behavioral triggers exist and where they can receive more focused, one-on-one care. Instead of developing the behavioral intervention model around six-bed ICFs, DADS should develop these supports in the four-bed HCS program. DADS could develop a time-limited service with restricted access, and establish a rate structure to accommodate needed behavioral interventions, taking vacancies into account. Developing community based behavioral services in the HCS model would allow DADS to address an important need in the community, reduce the intersection of persons with IDD with the criminal justice system and emergency departments, save money by reducing reliance on the SSLC system, and allow the state to blend MFP funds for this worthy purpose.

#	Stakeholder Recommendation	BIP Requirement(s)	Additional Stakeholder Comments
22	Provide funding to local partners (e.g., LMHAs, MH services providers, NorthSTAR MCO) to offset the cost of modifying their electronic health records (EHR) and IT systems to accommodate the new assessment instruments in the Uniform Assessment process. Provide training and competency evaluation (certification) for persons who will administer the new uniform assessment tools.	Core standardized assessment	In FY 2012, a steering committee of LMHAs, consumers, advocates and providers, in partnership with DSHS, identified the need to move from current state-developed assessment tools to nationally-validated, standardized assessment instruments for adults and children (i.e., Child and Adolescent Needs and Strengths assessment (CANS); Adult Needs and Strengths Assessment (ANSA)). Unlike the current Uniform Assessment, the CANS and ANSA can inform eligibility, appropriateness for specific levels of care, and treatment plans. The new instruments provide more detailed information in a number of domains re: effectively coordinating with and accessing services from other agencies/systems. These domains include medical issues, functioning (ADLs, cognitive functioning, behavior concerns), hospitalization and criminal justice involvement. In order to implement these standardized assessment tools as part of the Uniform Assessment for MH services, local EHR and IT systems must be updated, which requires a financial investment by local partners. This requirement could impede statewide adoption by 2014. Additionally, local partners will need to be trained and demonstrate competency using the tools. The developer of the CANS and ANSA would provide face to face training (one week for each tool). A third party would contract with DSHS to provide an online certification process for providers. Funding to help local partners facilitate system updates and training in using the tools will enable successful statewide adoption of CANS and ANSA by 2014.
23	Provide seed money to establish Recovery Support Centers (RSCs) in two pilot areas and develop and administer training to RSC affiliated peers in an effort to increase access to peer supports for LTSS clients in recovery from substance abuse, increase positive community engagement, and improve health and social outcomes.	Access to community LTSS	Untreated substance abuse disorders result in substantial costs to Medicaid LTSS and acute care systems (e.g., due to increased NF bed days, increased medical costs and inpatient recidivism). RSCs, which provide peer services to support substance abuse recovery, are recognized by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) as a promising practice to improve health and recovery outcomes. Due in large part to a lack of resources, Texas has few RSCs and RSC affiliated peers receive no training to address the specialized needs of older adults and people with disabilities. Eligible communities for funding must have an active Recovery Oriented System of Care (ROSC) stakeholder group recognized by DSHS. Funding would help communities establish a RSC and could help lease or purchase space; make the space physically accessible to elderly and disabled individuals; recruit and train staff and peers; establish data systems and reporting capabilities; develop connections to local LTSS providers and Medicaid HMOs; and develop/implement sustainability plans to finance their activities after BIP funding ends. These sites would in turn provide technical assistance to similar organizations as they seek to increase access for LTSS clients. DSHS would contract to develop and administer training to RSCs in LTSS related substance abuse interventions. The pilot programs would coordinate their activities with ADRCs, CTTs, Medicaid LTSS providers and managed care plans. These sites would serve as models for expanded access and provide support to similar organizations in the State.

Nursing Facility Diversion

#	Stakeholder Recommendation	BIP Requirement(s)	Additional Stakeholder Comments
24	Establish a nursing facility diversion program in each ADRC.	Access to community LTSS	This program would be modeled after the Central Texas and Tarrant County Community Living Programs. Through partnerships between the ADRC and local hospital systems, these programs identify individuals who are not Medicaid eligible but are at imminent risk of NF placement and provide service options to help them live independently in their homes and communities. Average cost savings attributed to the Community Living Program - $4 for each dollar spent (compared with NF care).
25	Include hospital discharge planners as an extension of the "front door" in the BIP infrastructure design (possibly coupled with presumptive eligibility).	NWD/SEP; Access to community LTSS	Often, NF admission is precipitated by a hospitalization, and the hospital effectively becomes the 'front door" to LTSS. Hospital discharge planners should help set an individual up with in home care or develop a transition plan from short term convalescent NF care to home care instead of hastily placing the individual in a NF.
26	Fund a pilot to educate healthcare and social services professionals to promote referrals (from hospitals) to both public and privately funded in-home services and supports for people at 300% of SSI for private community based services.	Access to community LTSS	Often, people are discharged from hospitals to NFs even though they may be able to function in the community with HCBS. Hospital discharge planners and general social service providers continue to refer clients with support needs who are above Medicaid income eligibility to expensive NFs. This recommendation would promote available in-home services and supports while preventing immediate NF personal income spend-down. Emergency room and discharge planning staff need education incentives to promote any personal income available to be spent in the home prior to NF spend-down. This initiative would prolong potential Medicaid rolls from growing while individuals needing services and supports would not be displaced from their residence.

#	Stakeholder Recommendation	BIP Requirement(s)	Additional Stakeholder Comments
27	Attach at least one options counselor with every ADRC to meet with Medicaid clients who are hospital in-patients and whose doctors have identified NF placement; discuss clients' needs, preferences and desires for post-hospital care; discuss available Medicaid and non-Medicaid LTSS; coordinate with ombudsman to identify facilities that accept payer sources and have demonstrated higher quality care.	Access to community LTSS	Hospitals serve as a frequent entry point to NFs. According to the CDC, ~58% of NF residents are admitted directly from hospitals. Hospital to NF transfers are usually initiated by physicians with limited knowledge of community services, institutional biases, and little understanding of clients' wishes, needs, and preferences. While some hospitals excel at educating clients and involving them in decision-making, others arrange placements without their consent and without discussing alternatives to institutional care. Clients discharged to NFs without their fully informed consent receive care in more restrictive environments, at significant cost to Medicaid and other payer sources. Clients discharged from hospitals to lower-quality NFs face heightened risk of re-hospitalization, greater lengths of stay, and greater morbidity and mortality rates, compared to consumers discharged to higher-quality NFs. For example, in 2006, Medicare made payments of $301 million for Texas clients readmitted to hospitals from skilled nursing facilities within 30 days of hospital discharge. Texas was the third highest state in the amount of payments Medicare made. ADRC options counselors provide individuals of all ages and all payer sources objective information about LTSS. Through the MFP/ADRC options counseling grant, they have targeted NF residents who wish to relocate, in addition to NF social workers who provide discharge planning. By broadening their primary target audience to include hospital discharge planners, options counselors can provide a valuable service to hospital staff and individuals at imminent risk of NF placement. Options counselors will have the following responsibilities: • Timely meet with Medicaid clients who are hospital in-patients, and whose doctors have identified need for NF placement. Discuss clients' needs, preferences, and desires for post-hospital care; • For clients who express interest in receiving community care, discuss Medicaid and non-Medicaid LTSS, including services through the Veterans Administration and Area Agencies on Aging. • For clients interested in receiving NF care, coordinate with the long-term care ombudsman to identify NFs that accept their payer sources and have demonstrated higher quality care, as determined by the Centers for Medicare and Medicaid Services, Texas Long-term Care Regulatory Services, and regional ombudsman program.

Direct Care Workforce

#	Stakeholder Recommendation	BIP Requirement(s)	Additional Stakeholder Comments
28	Establish a health insurance buy-in pilot for uninsured personal attendants.	Access to community LTSS	Personal attendants typically lift, transfer and provide personal care services to individuals with disabilities. This work is physically demanding and exposes attendants to illness and injury. The direct care workforce is aging and the need for health care is increasing. Texas is one of four states with the highest proportions of uninsured direct care workers in the nation. A major barrier is that health insurance is costly for both the providers and personal attendants. The Affordable Care Act will soon require home health agencies to provide health benefits for their attendants. Unfortunately, home health agencies will likely drop attendants' hours to 29 hours per week to exclude the agency from having to provide health benefits. The personal attendant will then be required to purchase health insurance and with current wages, this will be unattainable.
29	Direct HHSC to collect data on the attendant workforce (e.g., age, gender, race/ethnicity, full/part-time status, benefits, whether they receive any public benefits, access to transportation (car, bus)).		Texas has ~ 275,000 personal attendants working in HCBS programs. Information about this workforce is national and anecdotal at best. Data about Texas's personal attendant workforce will better inform state policymakers planning and implementing future LTSS policies impacting personal attendants and people they serve.

Conflict Free Case Management

#	Stakeholder Recommendation	BIP Requirement(s)	Additional Stakeholder Comments
30	Remove Local Authorities' ability to provide direct services to be consistent with CMS's intent and with other current models. It may be necessary to grandfather in Local Authorities' current caseload if this is perceived as a transition issue.	Conflict free case management	Currently DADS performs case management in PHC, CAS, and CBA and this is considered independent since DADS does not provide direct services. Private entities contract with DADS to provide independent case management for CLASS, and those entities are prohibited from providing direct services to CLASS recipients. The Local Authorities perform case management for HCS and TxHmL clents. However, they also provide direct services with some limitations—this is not conflict free case management, even though the case management is provided through a different division from the direct services.
31	Stronger focus on conflict free case management beyond "firewalls" (e.g., expanding CDS to include case management/service coordination)	Conflict free case management	Review case management/care coordination systems across HHSC and DADS and eliminate or minimize decisions based on income or convenience vs. person centered quality of life outcomes. BIP is an opportunity to expand CDS to include case management/service coordination. Adding choice is even better than a firewall. This would require defining conflict free and qualifications for case managers and case management organizations. We continue to be concerned with MCO care coordination and want to identify and evaluate a conflict free option in managed care as part of the BIP. Require case managers/care coordinators to be employed by an agency that does not have a conflict between a private interest and the official or professional responsibilities of a person (e.g., providing other direct services to participant, being participant's guardian, having a familial or financial relationship with participant). Establish protocols for conflicts of interest when they arise. Create choice of case management/service coordination through consumer direction.

Medicaid Reform

#	Stakeholder Recommendation	BIP Requirement(s)	Additional Stakeholder Comments
32	Strengthen the community based network.	Access to community LTSS	• Augment waivers to support individuals with complex medical needs. • Create cost neutral or Hospital Level of Care. • Implement CBA and MDCP Waiver renewal recommendations. • Fund safety net services. Add State Plan Services to support individuals in the community, such as services and supports for individuals with traumatic brain injury; targeted case management accessible to individuals in the Community Based Alternatives waiver program; and personal attendant services and habilitation • Add services to waivers so the menu of services is equitable across programs, including employment services; behavior supports; transition assistance; independent advocacy; independent "discovery process" and "person centered plan development" service options.
33	Ensure payment that supports transformation.	Access to community LTSS	• Expand MFP to ICF's of all sizes, state and non-state operated. • Ensure client and family user friendly education on community services. • Ensure plans of care are based on needs and medical necessity, not available/ limited funding. • Remove incentives to over- or under-utilize services through rate establishment, rate methodology, or administration or design of services o Increase CLASS Support Family rates. Due to the rate, the service is not usable o CLASS supported employment rates are not adequate to purchase supported employment services o Direct service workers pay rates prevent attendant recruitment and retention o Career ladders should support increased expertise and responsibilities o Expand consumer directed services and self-determination

Miscellaneous

#	Stakeholder Recommendation	BIP Requirement(s)	Additional Stakeholder Comments
34	Ensure ongoing stakeholder input into design and testing of new LTSS systems, including assessments.	Core Standardized Assessment	Significant gaps exist in the state's system of standardized assessments. Many are not person centered or strengths-based and do not fully assess the complexity and intensity of the individual's needs. We see the potential benefit of having a single modular assessment for individuals of all ages and disabilities, but know this is a substantial undertaking requiring significant stakeholder input. If BIP primary stakeholder input is delegated to an existing committee/advisory group, we recommend forming a BIP subcommittee to increase focus and effort on BIP. We foresee development of a modular assessment used cross-ages and disabilities as a substantial undertaking that should be set up with a <u>new</u> overarching committee/ advisory group to establish assessment subcommittees with additional stakeholders related to key components of the assessment (e.g., policy workgroup, experienced assessor workgroup, technology committee). The new overarching committee should have broad stakeholder representation and a broad scope of considerations to include in the assessment modules (e.g., Quality of Life, Employment, Housing, Social Integration) with a charge to identify issues with current assessment processes and goals. Other states' assessments should be reviewed and a person centered approach should provide the foundation to the assessment process.
35	Continue to make funds available to counsel non-Medicaid NF residents about their options for services in the community.	Access to LTSS	NF residents who wish to return to the community often confront barriers to independent living, including limited incomes, need for assistance with ADLs, co-occurring physical and mental disabilities, limited informal support, and lack of appropriate housing. Such issues may become insurmountable in the absence of advocacy and intense case management. Texas leads the nation in its NF relocation activity due to strong state level leadership, effective interagency coordination, and a comprehensive package of LTSS. Yet, until DADS created its options counseling program in 2011, NF relocation services were beyond the reach of non-Medicaid-eligible residents. As such, these residents had less access to relocation supports and were often left to negotiate a complex system of LTSS on their own. Restricting relocation services to Medicaid NF residents leaves critical gaps in Promoting Independence services. For example, a homeless person with a disability may enter a NF to access community-based housing and LTSS. If he does not have Medicaid, he must wait at least 30 days before receiving relocation services. If deemed eligible for Medicaid, each day's delay comes with a cost—in foregone independence and Medicaid outlays. Options counseling services bridge the gap for residents awaiting Medicaid eligibility determination. In addition, options counseling services bridge the gap for NF residents pursuing relocation but who lose Medicaid eligibility. Such individuals require intense case management to re-establish benefits and fulfill their independent living plans. Finally, options counseling services are vital to NF residents who do not wish to qualify for Medicaid but require assistance finding and arranging quality community-based LTSS. Residents without Medicaid may have relocation needs that are as complex—if not more so—than Medicaid beneficiaries. For example, residents who have no payer source require intense case management to meet their basic needs—within or beyond the facility.