TEXAS DEPARTMENT OF HOUSING AND COMMUNITY AFFAIRS

HOUSING AND HEALTH SERVICES COORDINATION COUNCIL MEETING

Stephen F. Austin Building
Room 1104A
1700 Congress Avenue
Austin, Texas

July 12, 2017
10:05 a.m.

COUNCIL MEMBERS PRESENT:

TIMOTHY IRVINE, Chair
DONI GREEN, Vice Chair
BRADLEY BARRETT
REV. KENNETH DARDEN
ERICA GONZALES (for SUZANNE BARNARD)
VERONICA NEVILLE
MICHAEL WILT

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I N D E X

P R O C E E D I N G S

MR. IRVINE: Why don't we go ahead and kick it off. Hello. Everybody on the line, if you'll please identify yourselves, we're getting ready to start.

MS. SYLVESTER: Megan Sylvester with TDHCA.

MR. DAVID: David Burkley, Rainbow Housing

MR. IRVINE: Up here we've got Michael Wilt from the State Affordable Housing Corporation, we've got Rev. Darden, we've got Bradley Barrett from the Veterans Commission, we've got Doni Green here, and a roomful of interested participants.

We are not having an official meeting because we do not have a quorum; therefore, we cannot take any actions. I'm very appreciative of those who did show up to contribute to the attempt at a quorum. We are preparing some additional communications to try to galvanize people to fill out the full complement of board members, but sometimes government doesn't work as quickly as it ought.

Let's see, is Jay Todd here? Jay, you want to come on up here where everybody can hear you. Just everybody who's here attending, since this isn't a formal meeting, you're welcome to participate as much or as little as you want. Also, since it's not a formal meeting and I'm not, therefore, required actually to preside, I

may take off a little early since this is the day before a critical tax credit Board meeting.

Anyway, we want to hear what Jay has to say.

MR. TODD: Well, thank you for inviting me. Terri had actually invited me before she skipped off into the land of retirement. My name is Jay Todd and I am with HHSC and I am the acting director for Behavioral Health Program Innovation. In your packet you should have some slides here for my presentation, but this is really informal so stop me if you have questions.

What Terri wanted met to talk to you about today is a project that we have that's called Certified Community Behavioral Health Clinics, or as you'll hear me talk about it today, CCBHC. CCBHCs came up as a part of a SAMHSA grant, Substance Abuse and Mental Health Services Administration. They were working with Centers for Medicare and Medicaid Services, CMS, and the focus was on looking at ways for integration of behavioral health, so both the mental health side and the substance abuse side, with acute care services as a way of providing more seamless services to clients, as well as putting together a set bucket of services that clients would always receive, no matter who the funding stream was that was paying for the services that client received.

Currently there are many multiple funding

streams and each of them have a little bit different type of requirement, different benefits, a client may be under one funding stream for a while, those benefits run out, they get put onto someone else's, and under our current silo kind of system, what that client can expect, even if they're with the same agent receiving services, suddenly it feels very different for the client. And so the CCBHC concept is that client has no concept -- or they may know who's paying for their services but it doesn't feel different depending on that.

Our participation was actually dictated during the last legislative session that HHSC would apply to be part of this national planning grant.

It targeted adults with serious mental illness, children with severe emotional disturbance, individuals with long-term and serious substance use disorders, so those were the key buckets that we were dealing with. And it had two phases to it, so there was a planning grant phase, so during that planning grant year we were working to identify potential pilot sites, we were working to develop a payment system for this, as well as writing a national grant to be part of their national demonstration project that would pick up after the planning grant was over.

We were not selected for the national planning

grant demonstration, however, we are continuing on in Texas because both HHSC and the agencies we've been working with have identified that this is a model that has potential, we know that both CMS and SAMHSA have already started making administrative changes to support this model, so Texas wants to go ahead, start piloting it, finding out what we need to make changes to do, and be positioned for when this becomes an actual national model.

So CCBHC, the model serves as a stepping stone to integrating behavioral health in primary care, so it focuses on care coordination, that's one of the big pieces, so all the agencies are having to really focus and look at what care coordination looks like. And a lot of times when folks have case managers there may be referrals that are given or some other way that they're hooked up with services. In care coordination those are all warm handoff, so if I'm taking care of a client, I'm actually making connections for that client, whether that be with another agency that can provide services, someone else in my own agency, or with some community referral.

And so the care coordination is an essential piece, it's shown that it helps keep clients in services which in turn then prevents them going to emergency rooms when they need service, they instead call who their care coordinator is. It also helps them have better outcomes.

They are able to establish housing, they're able to maintain jobs when they stay in services, and so that care coordination is really designed for that so that ultimately there are those improved client outcomes.

It also emphasizes focusing on efficiencies, so we identified eight agencies that we're working with, and I'll talk about them in a moment. Those agencies have rebuilt their policies and procedures and their entire client flow from the ground up during our planning year because they realized that they were structured around those silos of funding rather than being structured around what the client needed, and so that's been a major change for those. It also focuses on building relationships with other partners in the community, talking about ways that they can share data and information, as well as trying to minimize wait lists to get clients into services quicker, and this aligns with what the HHSC IDD/BH strategic plan wants is clients being able to receive the right service at the right time.

So again, we weren't selected as a national site, we are still doing our state-run pilot that will start September 1. And if we had been selected as a national site, we would have had additional funding from CMS. These sites have seen the value of moving to this model and so they're moving forward with these changes

with no additional funding, and this is for our partner sites a totally voluntary process for them. And so it's really led to some great community-state partnership through this because everyone is involved in it because they see that it's going to have positive outcomes. They're not in it because of the additional funding that they'll get because there is no additional funding.

We are exploring funding strategies because we want to encourage agencies to start moving to an integrated model, and so through this pilot we'll be tracking costs and seeing what the actual impact is on client outcomes, we'll be able to then have discussions with managed care organizations about how they reimburse agencies that are served as a community behavioral health center as well as looking at are there funding incentives through Medicaid or other programs that we have that reflect the better outcomes and efficiencies that are gained through a coordinated system.

We do have a CCBHC website and that link is at the back of this presentation for you that will give you a lot more information, and as we move forward, tracking outcomes and what the process looks like, you'll be able to track that.

As a CCBHC there are nine services that they have to make available to any clients. They don't have to

provide them because a client may not need them all, but they've got to make them available. So they have to have crisis mental health services, including 24-hour mobile teams, they have to provide screening assessment and diagnosis, patient-centered treatment planning, outpatient mental health and substance use services, outpatient clinic primary care screening and monitoring for key health indicators. A lot of times our clients have co-morbid conditions so it's not just a behavioral health condition, there's also additional health pieces, diabetes, hypertension that can impact both the medication they receive as well as their overall treatment and engagement in treatment.

They have to provide targeted case management, psychiatric rehab services, peer support and counselor services, as well as if they are serving veterans they need to have intensive community-based health care for members of armed forces and veterans, and especially in the rural areas.

So those are the nine services. To be certified they have to be able to show that they would be able to provide all those and that they had a clear plan for being able to do that.

Initially when we were doing this as a national model, CMS required that there be a monthly payment that

is provided to the sites that covers everything a Medicaid client would need for that month if they came in for services. And so what that meant was that we had to have all of our managed care companies on board for this because unlike our current managed care structure where managed care companies get to negotiate rates with the providers they contract with, the state was actually going to be dictating to the managed care companies what they would pay in an integrated health facility.

So as a result, a lot of our sites, when we selected them we had to select based on managed care area because we had to make sure that all the managed care companies in that particular setting were on board with paying it. There were a couple of places where managed care companies were like I want to see it first, and so we didn't select sites in those particular areas.

Our project sites that we selected. We have StarCare which is operating out of the Lubbock area. We have Tarrant MHMR which is out of Fort Worth. We have Helen Farabee centers which operates in North Texas; their headquarters is in Wichita Falls but they have these 17 northern counties that they cover; they're the most rural of any of the sites that we have and they do a whole lot of services through telemedicine and telehelp. We have Burke Center which is probably our next most rural

setting; Burke is located in Lufkin and it has kind of that corridor from north of Lufkin over to Livingston, that part of Texas.

We have Montrose Center which operates out of Houston. Most of the sites that we work with are local mental health authorities, Montrose Center is not. They are a nonprofit organization and they are one of the few nonprofits that came forward that wanted to participate in this, but for our local mental health authorities, our LMHAs, it's been really eye-opening to have someone that's an LMHA part of the project because they've learned from each other in terms of different ways of operating.

We have Integral Care which is here in Austin-Travis County. We have Bluebonnet Trails which operates out of Round Rock and they've got essentially the counties that form kind of a crescent around Travis County, so Williamson down to Bexar County. And then we have Tropical Texas which operates in South Texas; they have sites in Brownsville, McAllen, and surrounding areas.

And each of these sites has approached providing mental health and substance use differently in the past. One of the pieces that the CCBHC model is doing is bringing consistency, so if I was a client at Integral Care here in Austin and then I moved north into Williamson County and suddenly I became a client at Bluebonnet

Trails, my experience should start being the same because they're all following the same type of model for care. It's the same integration, and that's one of the bigger hallmarks of this is that there's some consistency, which also means that if people are following that model, we should start seeing consistent outcomes for those sites.

There is here just a picture of our web page. If the site links don't work, then we're buried down underneath a page that says Doing Business with HHSC, but that's where we're at. But that gives you some real in-depth profiles of each of the sites that we work with, talks about some of the outcomes that we're going to be looking at, and ultimately, as HHSC looks at additional options for integrated care, this page will evolve beyond just being CCBHC and will focus on all integrated care initiatives.

So for instance, from two legislative sessions ago there was Senate Bill 58 that focused on behavioral health homes. The commission is just starting to work on those behavioral health homes and they're selecting some of the CCBHC sites to serve as behavioral health homes. So we're really trying to minimize a proliferation of a variety of models of what integrated care looks like and really streamline what outcomes would look like, streamline contracting around integrated care, and really

focus on some of those best practices.

I had mentioned that one of the pieces that CMS had had requirements for us was developing a monthly payment rate and that was called a PPS system, and it was basically a different payment rate for different populations, and so all the sites had to go through a really labored cost report process where they had to look at their costs, again, regardless of who the funding source was. It was interesting, when we started talking to them we could say, So what does it cost to do case management? And they're like, Well, it depends on who the payer is. We're like, No, that's what you're being reimbursed, what does it cost you?

And so really moving to this cost-based model for a lot of them was eye-opening because, one, it gives them better negotiating power because they can say here's what my true costs of service is. It lets them compare how they're doing with others in their area, are their costs out of control, do they need to do things to be more efficient, and it, again, removes the siloed mentality when you're just talking about here's what my cost of care is.

The way that we put it into effect was we were going to have seven different payment rates for them, it was going to be based off of client diagnosis. So there

was a rate for mental health only diagnosis for adults and then one for kids, one for substance use only for adults and then for kids, one for those with co-occurring mental health and substance use for adults and kids. And then we had what we were calling our standard rate because if this is a monthly rate but a client came in for services on the last day of the month, we didn't want to pay for a full month of services, and so an agency would receive that standard rate if it was the last day of the month or if they were putting that client into inpatient care because at that point they wouldn't be providing additional outpatient services. It also then served as kind of a way of preventing this perverse incentive of everyone trying to get people in on the last day of the month and getting this full payment.

Now since we don't have the additional CMS money for this, our focus is on building a sustainable program, so our goal is within the next six-seven months, using current funds to still move to a monthly payment rate for the sites. For now they'll continue to get reimbursed on a per-service basis like they currently are, but our goal is to move to that monthly payment rate, using current funding and being able to identify where savings are, to be able to enhance the funding for those doing integrated pieces.

So that's a very high level of our project, and I'll also introduce Melissa Martinez who is the program specialist and she answers a lot of the questions that come in, so there's a mailbox for the project as well as our website, and Melissa will handle all of those.

Any questions from folks?

MS. GREY: I'm Dianna Grey and I'm actually a consultant to supportive housing and health care and have worked with some of the LMHAs as well as housing providers. And so one of my questions is, and you may have covered this, but presumably some of the people who come into the LMHAs or the nonprofits would not yet be enrolled in Medicaid. Is that accurate?

MR. TODD: Correct.

MS. GREY: So is what we're saying that then we're looking for sources of funding that would provide for that care unless or until they are enrolled in the Star Plus Program?

MR. TODD: So most of the LMHAs receive both state general revenue for indigent care and Medicaid services. The PPS rate is only for Medicaid services. What we've done, though, is these agencies now that operate under a CCBHC model, they're not stratifying between are you a Medicaid client or are you receiving indigent care. So if someone comes in, they get the

package of services no matter what.

MS. GREY: And then the next question is as we are looking at potential funding sources, acknowledging that the status of the 1115 waiver is not entirely certain, is that one of the sources of funding that's being considered?

MR. TODD: It actually is. So the 1115 waiver project has for the last six years funded specific projects around the state, and agencies were tied to those projects that they had to stick with that. The new focus for this waiver, which really is getting those folks that can't qualify for Medicaid into services, the focus now is focus on agencies achieving specific outcomes, and so all of the CCBHC outcome measures are now 1115 measures, so our sites will be able to get 1115 dollars based off of meeting their CCBHC outcome measures.

MS. GREY: Thank you.

MR. WILT: I have three questions. The sources of funding, I imagine there's some local sources of funding for indigent care, too, right, for these sites?

MR. TODD: So for all the LMHAs, they have to provide a local match into that. They may also get funding from other sources, but the primary sources they get are the state indigent care dollars through Behavioral Health Services or the Medicaid dollars, and as local

authorities, they have to put in money as well.

MR. WILT: The nine services they provide, four of them have to be provided by the clinic and the next five you can collaborate with an organization. Can you give me an example of an organization?

MR. TODD: Sure. So for instance, Burke Center, which is in East Texas, so there is another organization that does most of the substance use counseling in that are, and so Burke Center is partnering with them and that care coordination piece is for them to be able to have the same type of treatment plan, share information. It may be, for instance, Montrose Center partners with one of the FQHCs to provide the primary care services and then that FQHC will share back the client's information with them so that then when they're doing their prescribing on the mental health or substance use side, they know what the clients already receiving at the FQHC, and then they share that information back and forth.

So under the national model, they would have had to set up an oversight contract with each of these collaborating partners. We're not requiring that for the Texas model, but they do have to set up MOUs that assure that there is that data sharing and communication.

MR. WILT: And then the seven populations that receive PPS, do you have a breakdown, and I'm curious

about the percentage of the population that's co-occurring mental health and substance use.

MR. TODD: So really varied from site to site. So for instance, if we were to look at Integral Care, it's a higher co-occurring percentage, and none of them really exceeded 20 to 30 percent, I would say, but we have some where co-occurring was as low as 5 to 10 percent. So it really kind of depended on the part of the state that we were working with.

MR. WILT: And then lastly, this is all outpatient substance use. Are they coming from inpatient and going into outpatient?

MR. TODD: So we've got clients that enter either through crisis services, just entering into outpatient themselves, or part of what they've got to do as part of their coordination is to coordinate that movement from inpatient into outpatient services. That's actually one of their outcome measures is how quickly they get someone enrolled coming from inpatient services into outpatient followup care.

MR. WILT: And if they're indigent, how are they paying for inpatient?

MR. TODD: Again, through their state beds that cover some of the inpatient care, so there's a whole general revenue stream that funds through Behavioral

Health Services, and the LMHAs get those funds, the state hospitals get those funds, and they have to have arrangements for state beds that are held. And some of them, for instance, StarCare, has its own inpatient facility and so they can use their indigent care for that.

MR. BARRETT: I'm curious, who's responsible for certifying the veteran aspect of services?

MR. TODD: So for all of them there is a series of -- while veterans is like one of the nine, for certification there were actually 250 points, specific pieces that they had to meet and that's where all the detail came from, and all of that came from the federal level in terms of here's everything you've got to show that you are doing. It included having not just knowing where they are but the had to have agreements with any of the veteran services in their area. So for instance, Helen Farabee in the Wichita Falls area, because of where they're actually cross into four different VISNs, and so they have to have agreements working with each of them.

They also have to identify specific military cultural competency trainings that their staff go through, and that has to be part of both their original orientation, as well as an ongoing piece. And then, like I said, there's a whole other series of pieces, including trauma-informed care and some other pieces that they have

to. We worked with also some of the folks who are part of the HHSC Behavioral Health Coordinating Council and really got kind of the concept, as well, that a lot of these services, I'm not necessarily doing counseling differently if someone is a veteran or not a veteran but I'm asking some additional questions and I'm making sure I'm asking questions. So I'm asking suicide risk questions and those sorts of things and being more direct and open in that.

They also had to be able to provide those services even if someone was eligible to go to the VA that if they didn't want to, providing those services.

MR. BARRETT: So they are checking if they're eligible for additional services?

MR. TODD: Yes.

MS. GREY: But no VA reimbursement is coming to them currently?

MR. TODD: So there are some pieces where they coordinate and they can get it but a lot of them have seen that even if they get approval for the VA for that client to stay with them that that payment is slow to nonexistent if it does come. So they're still looking for ways to cover that but they are pursuing it but they're just not necessarily getting it.

MS. GREY: I have one question. Since this council has focused particularly on the intersection of

housing and health care, I'm interested in whether typically turning case management or even the state sort of package for more higher need clients has allowed for both case management and supportive housing services, and so I'm wondering what we're seeing in terms of what the LMHAS or participants are doing, and also, if at least conceptually an LMHA could subcontract with a local entity that is specialized in providing case management and case management that's linked to housing.

MR. TODD: So yes, for these sites they're all providing supportive housing.

MS. GREY: On the service side, not necessarily the housing itself.

MR. TODD: Some of them actually have pieces. Montrose actually, because they have some different funding streams so they do actually help provide housing and they actually just told us because they've got a large veteran population that they work with and a large aging population, and so they're actually working on a housing community now that they've gotten funding for, and the City of Houston ceded land to them to be able to build that, so that's a big initiative.

So it varies from place to place. There are some that are actually helping to not just find but do a little bit more, but they could definitely contract out

for those types of services.

MS. YEVICH: Any other questions?

(No response.)

MR. TODD: All right. Well, thank you all very much.

MR. IRVINE: Thank you. Thanks for the printed materials too.

Quick run-through of the first part of the 85th Legislature because the second part hasn't started yet, so Michael Lyttle is here from our external affairs shop to what happened this session to impact HHSC issues as relates to TDHCA.

MR. LYTTLE: Well, I think the biggest and most significant issues were budgetary with the council. As a result of the 4 percent general revenue reduction that all agencies had to take, the council, along with other entities that we fund had to see a reduction in funding, approximately $320,000, exactly $328,069 over the biennium. That pretty much wipes out most of the funding for the council outside of staff support funding and travel money for council members, that's still in place. There were a lot of very grueling, difficult choices for the agency to make, and that certainly was one of them, but those changes are reflected in the budget in Senate Bill 1.

The other thing to mention that did occur in the budget of interest is that TDHCA was added to the Statewide Behavioral Health Coordinating Council, which is something that Jay referred to a few times in his presentation. So the agency will start participating in that council effective September 1, and I think there's clearly, it seems like, a lot of similar type approaches that they may be looking at as well as the council here, so there's going to be some similar type work going on, no doubt, there.

I did visit with the TDA's governmental affairs person and they indicated that there wasn't anything that they knew of that related from their perspective to the council. I was not able to get anybody from HHSC or the Veterans Commission to coordinate with them to try to get some information, so I can't speak to those two agencies.

So that sort of summarizes my report, unless, Tim, you had something you wanted to add.

MR. IRVINE: I'll circle back to that. Have you got anything?

MR. BARRETT: Nothing that I can think of that directly affects the council or related entities.

MR. IRVINE: HHSC, anything? No?

The only other thing I would mention, and it may or may not be relevant, but a lot of the time we're

talking about mental health care issues but when you get into the world of health care issues in general, there are some things that are in Senate Bill 1 that are absolutely worth reading. We came across in Article 9 prohibiting the use of appropriated resources to anyone who is or is affiliated with any provider of abortion services that aren't in compliance with the state requirements. So I really do think that even though it's kind of dry, everybody really should read not only their own bill pattern but you should read Article 9. There's a lot of very pointed and useful stuff in there.

MS. GREY: Tim, would that prohibit an FQHC, for example, that might be providing some of the services, because some of them do, from receiving any state funds?

MR. IRVINE: If they are a provider or affiliated with a provider of those services and they aren't qualified services under state law, no state dollars or federal dollars can go to them. Because don't forget that even though you get federal dollars to expend, they are covered in the appropriations process.

MS. GREY: Are there no Medicaid funds?

MR. IRVINE: I can't get into a legal discussion, sorry, of what all that really entails. I just point you to Article 9, Section 6.25.

MS. GREY: Thank you.

MR. IRVINE: The only other thing I would mention, and it's not legislated but it's rule-making related, and since we're not having a formal meeting, we're not constrained to the agenda, and that is we are undergoing a process with the development community trying to strengthen our definition of supportive housing to really focus on providers that have established a substantive track record of providing supportive housing services and make it so that it's not something where you can basically claim a point item as supportive housing if you aren't in fact providing meaningful substantive services.

MS. GREEN: And I really think that case management piece is so critical.

MR. IRVINE: Not only case management, but frankly, around the clock staffing to deal with the issues that come up in any household but especially a household where one or more members have got some medical or substance abuse type issues or mental health issues where those aren't things that can wait for an emergency responder.

MR. IRVINE: You're next, Elizabeth.

MS. YEVICH: I am next. If you look in your handouts, you've got one that's called major activities, and really, we don't need to go over it line by line, but

like with what Michael was referencing, we're not going to have any more extra funding to do work. With Terri leaving, with other changes, especially with HHSC now being HHS and DARS and DADS and a lot of representatives here and a lot of changes, we will have new members, we thought it was a good idea just to put together all the activities since the inception of this council back in 2009. So that's what this is as a handout.

The one I sent to you yesterday actually has links on it, hyperlinks. It looked a bit messy when just printing it out, so this one doesn't have the hyperlinks, but you will have in the email the version with the hyperlinks if you're interested.

So this is everything up to date, and if you have any questions, let me know, but I think it speaks for itself on everything that is going on right up to, of course, as you know, we continued on with contracting with CSH for Housing and Services Partnership Academy, and they are coming up with some trainings with the groups the end of this summer. They haven't set the dates, in fact, they have just started working on the flyers and I'm working with them on that, but I will certainly send out some emails once they have some dates pinned down. And if they're in your area, it would be great to go to some of these further trainings they're going to have before that

contract runs out on August 31. So that's the update there.

And I think next up is Mr. Spencer. Well, we did the 811 handout here that speaks for itself as well?

MR. DURAN: Yes. I'll be happy to answer any questions, but this council has been interested in the 811 program in the past. I didn't want to do a big formal presentation but just kind of give a snapshot of its current status.

MR. IRVINE: People are getting housed.

MS. YEVICH: There we go.

And then Veronica, and welcome, and she was briefly going to talk about the IAP. Do I have the acronym right? There we go, another acronym.

MS. NEVILLE: Hi. So I'm with HHSC in the Medicaid/CHIP Policy Program division, and HHS just recently applied for a CMS innovation accelerator program application, and Terri just asked that I give a little update.

So we applied in June, and TSAHC actually is on the core team as well, and this particular IAP is focused on Medicaid housing agency partnerships and promoting community integration through long-term services and supports. The IAP programs, in general, if you're no familiar with them, they provide technical assistance,

tool development, learning collaborative type support. And this one particular opportunity, CMS partnered with HUD, USICH, the Office of the Assistant Secretary for Planning and Evaluation, and SAMHSA.

And this one will provide TA in developing public and private partnerships between state Medicaid agency and state and local housing agencies -- or I should say systems, and also create an action plan for fostering additional community living opportunities for Medicaid beneficiaries.

The proposal is for nine months of TA which start in August through April '18. CMS is going to select eight states, we're still waiting to hear, and the selected states will be assigned a two-person coaching team comprised of a housing expert and a services expert. They'll have regular calls and then also an on site, and then the core team goes up to D.C. for a kickoff meeting.

We're pretty excited about the team that we proposed, it's got a lot of high level, decision-making type staff. So the team is Emily Zalkovsky, she's the deputy associate commissioner for Policy and Program in Medicaid and CHIP at HHS. The core team is comprised of: Dena Stoner, who is a senior policy advisor with HHS -- probably a lot of people are familiar with her; Jennie Costilow, she's my manager and she's a manager in Policy

and Program Development; Robin Strickland, who is a manager of Adult Mental Health Program Services; and them Michael Wilt, as well. And TSAHC is a new partner for us so we're pretty excited to have them on board, and with them, of course, they're going to bring new partners and resources. So we're hoping, fingers crossed, that we will get selected.

And then in addition to that, a lot of people were really interested, and so volunteered or agreed to participate to be additional team members. So within Medicaid we've got: Joyce Pohlman, who works on MFP; Jessie Aric, who is the Money Follows the Person Behavioral Health pilot program manager; Emily Sentilles is from the 1115 team; Joy Kearney is the IDD specialist; I'm on it, I'm the nursing facility specialist; and then Carissa Dougherty, who is also the Senior Adult Mental Health Policy analyst.

Additionally, we've got two MCOs that agreed to participate: Caren Zysk, who is from Molina and she's the director of healthcare services; and Kim Nettleton from United, who is the community and state product director.

We stated that our goals were basically to build upon the information that we learned in the last housing IAP we participated in in 2016 which was a webinar series. This one will be much more intensive, focused on

our other two goals for this round which would be to actually really extend and expand the relationships that we have with local and state housing providers, including looking at coordination between MCOs and housing providers and things like that. And also then, really develop an action plan that is tailored to the State of Texas, given we're a huge state, we're a managed care state, and looking what housing and supportive services are available and what are the gaps. So those are our main goals.

And we stated our target populations were: Medicaid beneficiaries with disabilities exiting institutions; Medicaid beneficiaries with complex high needs, receiving LTSS and living in the community who are at risk of housing instability or homelessness; Medicaid beneficiaries receiving behavioral health LTSS life services and living in the community; and then also, youth aging out of foster care in need of supports to be able to live independently.

So that's in a nutshell our application we submitted in June. We had a call on June 19, I wasn't there but I did hear that it went really well and we had great turnout, much of the team came in person. So we'll see. CMS emailed us the beginning of this week that they'd let us know this week.

MR. IRVINE: Very nice. Glad to hear it.

MS. YEVICH: A couple of other housekeeping. To our visitors, if you haven't signed in at the desk, please sign in there, and then TDA really requires you to sign in on their little tablet, it's finicky, Dianna has it, if you could also sign in on that.

And then the next meeting.

MR. IRVINE: When is it?

MS. YEVICH: October 11 here.

MS. GREEN: Can I ask a question for funding about Project Access? Any changes in the budget?

MR. IRVINE: I'm not aware of anything else in our bill pattern.

MR. LYTTLE: Nothing strikes me immediately on that. Let me double check.

MS. SYLVESTER: This is Megan, I'm on the phone. We temporarily, because we've not received our 2017 ACC contract from HUD, we temporarily for a while stopped issuing Project Access, but we continue to put folks on our waiting list. And my understanding, from talking to Andre, last week is he was getting ready to issue some vouchers off that waiting list.

MS. GREEN: Okay. Do you have any idea what the wait is for vouchers right now?

MS. SYLVESTER: I really don't; sorry. I know that for a while we got down to about 20, and I think it's

up higher than that now.

MR. LYTTLE: Doni, I'd be happy to find out from our viewpoint and will get back to you on that on both of those questions.

MS. GREEN: Thank you.

MR. IRVINE: That's all I've got. Since we never convened, we're not adjourned.

MS. YEVICH: Thanks, everybody.

(Whereupon, at 10:56 a.m., the meeting was concluded.)

C E R T I F I C A T E

MEETING OF: Housing & Health Services Coordination Council

LOCATION: Austin, Texas

DATE: July 12, 2017

I do hereby certify that the foregoing pages, numbers 1 through 34, inclusive, are the true, accurate, and complete transcript prepared from the verbal recording made by electronic recording by Nancy H. King before the Housing & Health Services Coordination Council.

7/19/2017
(Transcriber) (Date)

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