Promoting Independence
Advisory Committee
Stakeholder Report
2016

Submitted to
Charles Smith, Executive Commissioner,
Texas Health and Human Services Commission

by the
Promoting Independence Advisory Committee

November 2016
This 2016 Promoting Independence Advisory Committee Stakeholder Report reflects the views and opinions of a majority of the Committee’s membership.¹ The Committee, for purposes of this report, refers only to those members named to the Committee by the Health and Human Services Commission’s (HHSC) Executive Commissioner and does not include agency representatives. Unless otherwise noted, the views and opinions expressed in these recommendations do not necessarily reflect the policy of HHSC, the Department of Aging and Disability Services (DADS), or any state agency represented on the Committee.

This report and the Committee’s recommendations for agency legislative appropriations request (LAR) exceptional items reflect the positions of a majority of Committee members. Committee membership represents a number of different perspectives and policy interests and not all statements in this report reflect each member’s official position. The Committee discussed the contents of this report and all members voted on each recommendation independently.

Recommendations were passed by a simple majority and each vote is illustrated in the report in order of members who voted yay, members who voted nay, and members who abstained.

¹ See Appendix A for a detailed listing of the Committee membership.
INTRODUCTION

The non-agency stakeholders of the Promoting Independence Advisory Committee (Committee) respectfully submit the following recommendations to the HHSC Executive Commissioner, as required by Section 531.02441, Subchapter B, Chapter 531, Government Code, to be considered for inclusion in the 2016 Promoting Independence Plan.

Texas has made significant strides and investments to ensure individuals have the ability and right to live in the most integrated setting as required by the Americans with Disabilities Act and upheld by the U.S. Supreme Court’s Olmstead decision in June 1999. Through Executive Orders GWB 99-2 and RP-13, Texas made a strong commitment to provide community-based services to individuals and ordered the development of a Texas Olmstead plan. Since the development of the Texas Promoting Independence Plan in 2001, over 44,000 Texans with disabilities, both old and young, have moved from institutions to the community, where services on average cost significantly less than in institutions.

While Texas has achieved remarkable progress implementing the Texas Promoting Independence Plan and rebalancing the long-term service and supports (LTSS) system, significant challenges persist for those remaining in facilities and those at risk of institutionalization who wish to remain in the community. Legislative appropriations have consistently provided resources for expansion of home and community-based services; however, extensive interest lists remain for these programs.

Texas continues to participate in the Money Follows the Person Demonstration (MFPD) awarded in 2008, providing enhanced federal match for eligible populations transitioned from nursing facilities (NF) and large and medium sized intermediate care facilities for individuals with intellectual disabilities or related conditions (ICFs/IID), including individuals in state-supported living centers (SSLCs) who have interest in returning to the community. Administrative grants available through MFPD allowed the state to make system changes necessary to support people to live in the community. The authorization for the MFPD expires in 2016, with supplemental funding available through 2020. The state, under Promoting Independence, will continue to transition individuals to the community after the MFPD grant ends and must continue to offer the critical support services developed and initiated with MFPD administrative grant funds to ensure transitions are successful.

In addition, effective June 1, 2015, Texas implemented the Community First Choice (CFC) option in the Medicaid State Plan, allowing the state to claim an additional six percent in federal match for some attendant-like services. Operated under the authority of 1915(k) of the Social Security Act, CFC offers attendant care, habilitation, emergency response services, and support management, in lieu of services in an institutional setting for Medicaid-eligible Texans with disabilities who meet an institutional level of care. Although there is not enough data available to evaluate the cost effectiveness of this program, it holds promise as a means to support people in the community and avoid the need for services in an institutional setting.
Utilizing a 1915(i) state plan amendment, Texas is also in the early stages of implementing a Home and Community Based Services – Adult Mental Health (HCBS-AMH) program to provide comprehensive services for individuals with a diagnosis of serious mental illness who have an extended tenure (three or more cumulative years) in an inpatient psychiatric hospital during the five years prior to enrollment. The program holds promise to provide a community-based alternative for people who are at substantial risk of spending many years residing in an institutional setting.

The PIAC advocates for a more comprehensive system of long term services and supports (LTSS) responding to individual needs, regardless of age or diagnosis, and commends the Department of Aging and Disability Services (DADS) and HHSC for making policy changes supporting this goal, such as allowing children who qualify medically for nursing home care to access Home and Community-Based Services (HCS) nursing facility diversion slots.

This report includes 33 recommendations, which are not prioritized, and are organized into nine categories. The categories include:

- Community-Based Services
- Children’s Initiatives
- Managed Care Initiatives
- Mental and Behavioral Health
- Relocation Services
- Housing
- Employment
- Workforce and Provider Stabilization
- Miscellaneous
RECOMMENDATIONS

SECTION I: COMMUNITY-BASED SERVICES

Recommendation 1: Allow children with developmental disabilities and/or related conditions who are at risk of nursing facility admission to be a part of the Preadmission Screening and Resident Review (PASRR) nursing facility diversion group.

Children are not included in the group of individuals who are being diverted from nursing facility admission. For a child to access the out-of-home support offered in a Home and Community-based Services (HCS) waiver host home setting, the child has to be placed in a nursing facility. The child must remain in the facility, often far away from family, for months before the child can gain eligibility for the HCS waiver slot and the host home services they need.

Children with developmental disabilities who meet nursing facility admission criteria and are in a crisis do not have immediate access to Medicaid waivers that could divert their admission. They are one of the only groups of individuals who do not have a rapid mechanism to access a waiver when they are at imminent risk of institutionalization.

Texas has created reserved capacity groups in the HCS waiver to support individuals to remain living in the community when they are in a crisis and need out-of-home placement.

1. Adults and children have access to the HCS waiver as a diversion to admission to a State Supported Living Center.
2. Adults 21 and older have access to the HCS waiver as a diversion to admission to a nursing facility.
3. Historically, the state has set aside Community Based Alternatives (CBA)/STAR+PLUS waiver slots for adults at risk of nursing facility admission.

The HCS waiver has a reserve capacity group for individuals with level of care I or VIII at risk of admission to a nursing facility. Neither the waiver nor 40 Texas Administrative Code 9.155 specifies the individual has to be 21 or above to qualify as a member of this reserve group. However, DADS has a nursing facility diversion protocol which lists as an eligibility criteria the person must be at least 21 years of age. Amend the nursing facility diversion protocol to allow children younger than 21 who are at imminent risk of nursing facility admission to qualify for one of the set aside waivers and make sure the number of appropriated waivers is sufficient to serve this additional group.

Vote 12-0-0

Note: After the member vote on this recommendation, DADS updated the local individual with developmental disability authority (LIDDA) protocol for nursing facility diversion requests to remove the age limitation of “21 years of age or older.” LIDDAs may now request a nursing facility diversion for individuals of any age who meet all other criteria described in the protocol.
While this is a wonderful move by DADS to ensure children at risk of institutionalization have access to services to remain living in families, one of the criteria described in the protocol is problematic. The criteria that requires a child who is in need of out-of-home placement to first attempt to obtain community-based services in a 6-bed ICF is contradictory to state law. Section 531.152 of Texas Government Code requires the state to “...ensure that each child receives the benefits of being part of a successful permanent family as soon as possible.” Children who need out-of-home placement should not be required to move to a facility, but should be offered HCS host home services that allow them to live in families.

The updated protocol and Form 1047 are posted on the DADS Website at: https://hhs.texas.gov/laws-regulations/handbooks/local-intellectual-and-developmental-disability-authority-handbook See “Request for Targeted Waiver Slot” in the left column and choose “Request for Nursing Facility Diversion.”

Recommendation 2: Modify all Medicaid waivers to include access to:
- Direct support workers who are paid a rate that promotes retention and specialized skills
- Two direct support workers when needed
- Intensive service coordination including RN coordination
- Higher individual cost cap or level of need (LON) for individuals when needed
- Crisis intervention teams and crisis respite

Both DADS and HHSC have been working on several initiatives to better support individuals with complex needs in the community, including development of changes to the HCS waiver for individuals with high medical or behavioral health needs, as well as the development of a hospital level of care waiver. Funding to implement the initiatives is needed.

Vote 9-0-3 (Kevin Warren, Texas Health Care Association; Cindy Adams, Superior HealthPlan; and Danette Castle, Texas Council of Community Centers abstaining)

Recommendation 3: DADS should design a form saying a CFC option has been offered to the individual and this service has been refused for reasons specified on the form. The individual should sign the form.

A large number of people on HCS and CLASS waiting lists are turning down CFC. When an individual eligible for CFC turns down a CFC service that would meet the individual's functional need safely, DADS should have a face-to-face meeting to ascertain the reason(s) a needed service is refused. DADS should design a form to document that the CFC option has been offered to the individual and specify reasons the service was refused.

Vote 7-3-2 (Kevin Warren, Texas Health Care Association; Cindy Adams, Superior HealthPlan; and Kyle Piccola; The Arc of Texas, opposing. Elizabeth Tucker, EveryChild, Inc.; and Danette Castle, Texas Council of Community Centers, abstaining)
Recommendation 4: Request funding in the Legislative Appropriations Request for Department of Labor overtime/travel rules.

As a result of the Department of Labor's (DOL) home care rule, effective October 13, 2015, most home care workers, including those employed by Medicaid recipients who use the Consumer Directed Services (CDS) option, will be entitled to receive at least the federal minimum wage for all hours worked and overtime compensation—one and a half times the worker’s regular hourly rate of pay—for all hours worked over 40 in a workweek. Lack of funding for overtime and travel harms people who use over 40 hours per week, who are the people most in jeopardy of going into a nursing facility institution.

*Vote 11-0-1* (Kevin Warren, Texas Health Care Association, abstaining)

Recommendation 5: PIAC supports inclusion of Promoting Independence funding in the budget. HHSC should analyze use of Promoting Independence funds in the current biennium to determine the level of request as the CFC option may have (or not) reduced the demand for Promoting Independence.

People with disabilities encounter situations where they are at immediate risk of institutionalization. For example, critical informal supports may be lost, due to death or other loss of availability of a caregiver. These individuals may be on a wait list for a community waiver or they may be receiving some services. In either case, the community services are inadequate. Promoting Independence slots allow persons not at the top of the waiver wait list to access services and avoid institutionalization.

*Vote 9-1-3* (Kyle Piccola, The Arc of Texas, opposing. Kevin Warren, Texas Health Care Association; Carole Smith, Private Providers Association of Texas; Doni Green, Texas Association of Area Agencies on Aging; and Danette Castle, Texas Council of Community Centers, abstaining)

Recommendation 6: Pay respite at the current hourly rate for the corresponding attendant service for home and community support services agencies.

Respite is also significantly underfunded. During the past two legislative sessions, the Legislature appropriated funding to support the attendant wage floor, which also applies to respite services. Currently, respite rates are paid a 24-hour reimbursement rate of $238.60. Providers can only bill for the number of hours respite is provided, not the entire 24-hour period, which breaks down to $9.94 an hour. Because agencies cannot pay attendants less than the current mandated wage floor of $8 per hour, the current rate is now unworkable. They report often relying on grandparents, aunts, uncles, or others who do not live in the home but have a relationship with the client in order to fulfill the need for respite care. In some cases, family caregivers may not be able to access respite at all.

*Vote 7-0-5* (Dennis Borel, Coalition of Texans with Disabilities; Kevin Warren, Texas Health Care Association; Carole Smith, Private Providers Association of Texas; Jean Langendorf,
Recommendation 7: The state should develop the capability to electronically maintain health and life records for all clients served in LTSS programs that are interoperable with related systems.

Currently, the system used by the state for billing and payment, service coordination, and critical incident reporting is either outdated (e.g., the HCS waiver CARE system) or paper-based (e.g., the CLASS waiver). Therefore, substantial administrative time is spent by DADS, service coordinators, and providers in the exchange of information that should be seamlessly shared electronically. Systems currently operated in fee-for-service programs are also not interoperable with managed care organization systems, creating barriers to the vision of a more streamlined acute and long-term care service delivery system.

With the transition to managed care, managed care organizations (MCOs) would benefit from more seamless data sharing. It was incredibly burdensome on waiver providers when individuals with intellectual and developmental disabilities (IDD) transitioned their acute care services to STAR+PLUS because MCOs requested lots of documentation on current medications and services, but there was no streamlined way to share information.

Vote 12-0-0

Recommendation 8: Develop operating standards for day habilitation services that aim to ensure they are fully compliant with home and community-based settings requirements and certification/regulatory oversight protocols, establish reasonable rates for implementation of day habilitation programs meeting operating standards and certification requirements, and incentivize innovative models for day habilitation programs, including models promoting and supporting competitive, integrated employment opportunities and offer flexibility with how an individual can use their resources to individualize their day habilitation services.

Day habilitation programs for people with disabilities play an important role helping them be as independent as possible and increase meaningful involvement in their community.

As identified in the DADS Sunset agency report, there are no statewide certification or licensing standards for day habilitation services, resulting in substantial variation in the quality of services across the state.

The current rates paid to providers of day habilitation services in waiver programs would need to be adjusted to cover the cost of services or facilitate delivery of quality services.

Vote 10-0-2 (Rachel Hammon, Texas Association for Home Care and Hospice; and Kevin Warren, Texas Health Care Association, abstaining)
Recommendation 9: Reduce the interest list by at least 20 percent.

Medicaid community-based waiver services in the setting of the individual's choice are a lifeline for individuals with disabilities to receive the services they need and deserve to be healthy and meaningfully participate in their life choices.

Waiver interest lists mean individuals who need community services are either not receiving services or receiving services that will not meet long-term needs. Waiting for services can result in ongoing deterioration of medical and functional wellbeing and being institutionalized. Community services, on average, are significantly less expensive than institutional services. While there is progress in reducing interest lists for individuals who would otherwise enter institutional care, the state should continue to increase access and ensure the interest list moves at a reasonable pace. Individuals with IDD continue to wait as long as 12 years for services.

As of February 2016, the interest list is 204,547, representing 106,604 unduplicated individuals needing critical services. Parents and self-advocates tell the Arc of Texas daily about the routine challenges they face while waiting on the interest list for services. Many of them fear by the time a slot opens for them, their child or loved one will be severely behind in socialization, behavior and independent living skills, employment readiness, and finding independent housing, and the gains made through school will be lost. Texas needs to prioritize funding more waiver slots to meet the increasing needs of people with IDD.

Vote 11-0-1 (Kevin Warren, Texas Health Care Association, abstaining)

Recommendation 10: PIAC supports consolidation, which includes closure of the state supported living centers (SSLC) system in Texas. Monies saved should be dedicated to community services for people with disabilities.

Despite a plummeting 75 percent decrease in its census, 13 SSLCs exist: the same number deemed sufficient in the mid-1990s. Approximately 3,100 residents remain in March 2016. These are among the factors pushing annual costs to over $312,000 per resident per year (www.hhsc.state.tx.us/Rad/long-term-svcs/downloads/2015-09-icf-rates.pdf).

In the most recent Independent Ombudsman Report, there were 1,617 “unusual incidents” documented between June and December 2015. An unusual incident is defined by DADS as “an event or situation that seriously threatens the health, safety, or life of individuals.” This rate averages out to nine “unusual incidents” per day. Additionally, monitoring as part of the state’s settlement of the Department of Justice lawsuit reveals all SSLCs remain out of compliance with the settlement goals.

Meanwhile, the interest list for the HCS program, the likely community Medicaid waiver for relocated SSLC residents, has a wait as long as 12 years. The state has a plan for LTSS based on Senate Bill 7, 83rd Legislature, Regular Session, 2013, that excludes SSLCs. A bipartisan plan came forward during the 2015 legislative session to address many of the concerns and should be considered again during the 2017 legislative session. The legislature should direct the closure of at least four SSLCs with residents meeting the Olmstead criteria assisted in relocating to the
most integrated community setting. The legislature must act to address the looming health and safety issues experienced by residents in SSLCs, and develop a plan that includes consolidation and closure to more efficiently utilize important state money to support the needs of people with disabilities. This ultimately will better serve those who choose to live in an SSLC and those still waiting for much needed services on an interest list. Further, the legislature should direct any savings realized from their efforts, including consolidation and closure, to be transferred to cost-effective community services and direct HHSC to develop a complete state plan for LTSS to include strategies for continuing right sizing of the SSLC system.

In the current day, a person with an IDD who qualifies for institutionalization faces a choice: (a) immediate entry in an SSLC, or (b) adding their name to the interest list for a community waiver, up to 12 years of wait. They should have a real choice. Given the capacity of the SSLC network, closure of SSLCs would not impact immediate entry into the institution.

**Vote 8-2-2 (Danette Castle, Texas Council of Community Centers; and Carole Smith, Private Providers Association of Texas, opposing. Rachel Hammon, Texas Association for Home Care and Hospice; and Kevin Warren, Texas Health Care Association abstaining)**

**Recommendation 11: Restore the In-Home and Family Support Program benefit to $3,600 annually, in addition to maintaining service levels. Request incremental funding to support a 20 percent reduction of the interest list.**

In Home & Family Support (IHFS) is an important independent living tool, but was unfortunately gutted by funding cuts. IHFS is used by 6,000 Texans, designed to be flexible for individual needs. Once $300/month, IHFS was cut to $100 or less several biennia ago.

**Vote 10-0-2 (Robert Ham, D&S Community Services, and Kevin Warren, Texas Health Care Association, abstaining)**

**Recommendation 12: Require tracking of all children and youth with IDD who are in the custody of the state and living in Residential Treatment Facilities for more than 12 months.**

- Include the data in the Department of Family and Protective Services’ (DFPS) quarterly report to HHSC’s Promoting Independence Advisory Committee.
- Include children and youth with IDD who are in the custody of the state and who have resided in a DFPS licensed Residential Treatment Facility for more than one year as a priority population in the Promoting Independence Plan.
- Provide these children the same expedited access to community waiver services as children residing in other long term care facilities, such as SSLCs and ICFs/IID.
- Request and appropriate funding for 20 to 25 children and youth with IDD who are in the custody of the state and living in Residential Treatment Facilities for more than 12 months to receive the HCS waiver per biennium.

**Vote 11-0-1 (Kevin Warren, Texas Health Care Association, abstaining)**
Recommendation 13: Request funds to support individuals to move from facilities, as well as to support individuals who are at imminent risk of institutionalization to remain in the community. Request the funds based on historical trends and projected future need. The following groups represent those who have received Promoting Independence funding and those who have been left out of the Promoting Independence funding request and need support to prevent institutionalization.

Group 1
- Those who received funds from the 84th Texas Legislature, specifically, HCS waiver services for:
  - 500 individuals to move from large or medium ICFs/IID
  - 216 children aging out of DFPS foster care
  - 400 individuals at risk of admission to SSCLCs
  - 25 children with IDD living in DFPS General Residential Operations
  - 120 individuals to move from state hospitals;
  - 700 individuals transitioning from a nursing facility to comply with PASRR; and
  - 600 individuals at imminent risk of admission to a nursing facility to comply with PASRR
- Money Follows the Person funding for individuals to move from nursing facilities with the support of STAR + PLUS, CLASS, MDCP, and DBMD.

Group 2
- Those who need Promoting Independence funding and have historically been left out of the Promoting Independence request.
- STAR+PLUS waiver services for individuals at imminent risk of nursing facility admission
- MDCP waiver services for children at imminent risk of nursing facility admission
- CLASS waiver services for individuals at imminent risk of institutionalization

The Texas Legislature has funded waiver slots to support individuals to move from facilities and to divert people from facility admission as part of its commitment to Olmstead and the Texas Promoting Independence Plan. Access to community-based waivers has allowed individuals to live the lives they want in the community, has often saved the state money, and has contributed to rebalancing the Texas LTSS system. This work should continue and be expanded to those who have not yet been included.

*Vote 11-0-1 (Kevin Warren, Texas Health Care Association, abstaining)*
SECTION II: CHILDREN’S INITIATIVES

Recommendation 14: Request adequate funding to allow statewide access to Youth Empowerment Services (YES) waiver services, and to support intensive residential treatment (diversion funding) in order to prevent child relinquishment to the state.

Children with serious emotional disturbance throughout the state of Texas need intensive community mental health services in order to prevent institutionalization. The Youth Empowerment Services (YES) waiver is one of the mechanisms the state uses to provide those services. The Centers for Medicare & Medicaid (CMS) has recently approved statewide expansion of this waiver.

Receiving CMS approval for statewide expansion of the YES waiver opens the door to making intensive and comprehensive mental health services available to children in Texas. The state needs to ensure the funding needed to ensure access to these services across the state is included in the legislative appropriations request. Additionally, the state currently has funds set aside to prevent relinquishment to the state of children with serious emotional disturbance who may require temporary residential treatment. These two initiatives should continue to work together to provide children and their families the support they need to achieve recovery.

Vote 12-0-1 (Kevin Warren, Texas Health Care Association, abstaining)
SECTION III: MANAGED CARE INITIATIVES

Recommendation 15: Allow all children and young adults who receive Social Security Income (SSI) and meet the eligibility criteria for the MDCP waiver to automatically receive waiver level services in STAR Kids with no wait.

The MDCP waiver offers several core services which are invaluable to families, including respite and minor home modifications. Respite is a well-recognized critical service for families of children with disabilities. The ARCH National Respite Network and Research Center states, "the goal of respite care is to provide family caregivers a break from continual care giving responsibilities and to improve their well-being and the well-being of the entire family." The provision of minor home modifications allows families to continue caring for their children safely in their home as opposed to having to seek out-of-home placement in a nursing facility.

As of January 31, 2016, 18,615 children and young adults were waiting for the MDCP waiver. The wait for services is approximately four to five years. The implementation of STAR Kids in November 2016 provides Texas an opportunity to significantly reduce the MDCP interest list by allowing all children and young adults who receive SSI and meet waiver eligibility to automatically receive services with no wait. Texas did this for adults when the STAR+PLUS waiver rolled out and thereby significantly reduced the interest list.

Vote 11-0-1 (Kevin Warren, Texas Health Care Association, abstaining)

Recommendation 16: Coordinate and conduct a webinar for MCOs, relocation specialists, and other stakeholders on the limits of surrogate decision-making.

MCOs and other stakeholders in the relocation process (e.g., relocation specialists) may encounter push-back from family members who believe they have authority to make placement decisions, even if they have not been designated as guardian of the person. Such resistance has the potential to derail the relocation process.

Surrogate decision-makers (e.g., those who’ve been designated as powers of attorney for business or health care decisions) often fail to understand the limitations of their authority. Although MCO service coordinators and relocation specialists are generally well educated on surrogate decision-making, they may benefit from more detailed information on limits of powers of attorney and changes in guardianship law promoting supported decision-making. This would help guide their efforts when a family member who is not a guardian opposes relocation efforts and asks a case be closed.

Vote 9-2-1 (Kyle Piccola, The Arc of Texas; and Jean Langendorf, Accessible Housing Austin!, opposing. Kevin Warren, Texas Health Care Association, abstaining)
SECTION IV: MENTAL AND BEHAVIORAL HEALTH

Recommendation 17: Include comprehensive behavioral health services in the Texas Medicaid State Plan.

This would ensure behavioral health supports and services are available when individuals and families need them and create a licensure process for Board Certified Behavior Analysts (BCBA). PIAC should study innovative ways to expand access to behavioral health services in Texas. For example, Oregon offers this service through CFC.

Vote 10-0-2 (Kevin Warren, Texas Health Care Association, and Danette Castle, Texas Council of Community Centers, abstaining)

Recommendation 18: Improve access to mental health services for individuals with IDD receiving publicly funded physical health care, mental health care, and/or LTSS.

This recommendation could be implemented in the following ways:
• Develop comprehensive initiatives to meet the behavioral health needs of people with IDD.
• Increase awareness and focus on recovery.
• Include comprehensive mental health and behavior support services as a waiver service.
• Build workforce capacity.
• Require trauma-informed care throughout the public IDD system.
• Develop provider training and consultation services.
• Continue and expand the technical assistance teams to include technical assistance and support for all individuals transitioning from all facilities.
• Increase crisis intervention, including crisis respite services.
• Increase access to appropriate level of need determinations and add-on rates to ensure providers can effectively support complex medical and behavioral health needs of people with IDD in community waiver services.
• Ensure regional behavioral health hubs and other crisis intervention teams around the state are trained to recognize and handle mental health crises involving individuals with IDD.
• Create a cross-discipline unit (MH and IDD) at the consolidated HHSC to oversee initiatives to improve services across programs.
• Develop MCO contract requirements to ensure network adequacy of mental health providers willing to provide services to individuals with IDD.
• Collect data on prevalence, treatment, and recovery outcomes for individuals with IDD.

Vote 10-0-2 (Rachel Hammon, Texas Association for Home Care and Hospice; and Kevin Warren, Texas Health Care Association, abstaining)
Recommendation 19: Reinstate Money Follows the Person (MFP) funding for medical, behavioral and psychiatric technical assistance teams. Change name of funding strategy to “technical assistance teams for individuals with IDD needing complex medical and/or mental health support.” Teams should be available to work with all IDD and mental health providers of services.

Currently, the MFP Demonstration Program funding proposal for individuals in nursing facilities with complex medical and/or behavioral health needs includes a reduction of $12,534,765. Individuals with complex support needs continue to face barriers when trying to move from facilities to community settings. Many of these barriers are caused by the lack of expertise of providers, managed care organizations, direct support workers, and the system as a whole. Additionally, individuals with IDD living in community settings often experience mental health conditions that require specialized care.

Vote 9-0-3 (Jean Langendorf, Accessible Housing Austin!, Inc.; Rachel Hammon, Texas Association for Home Care and Hospice; and Kevin Warren, Texas Health Care Association, abstaining)

Recommendation 20: HHSC should develop a pilot for self-directed mental health services in the integrated managed care system. The pilot should be developed with the goal of maximizing consumer choice and personal responsibility for achieving recovery.

Self-directed services (SDS), sometimes referred to as consumer-directed services, is an alternative approach to the traditional delivery of community services for individuals with mental health conditions. Mental health treatment has traditionally been grounded in a medical model which primarily considers an individual’s illness and accompanying debilities with treatment designed to eliminate their symptoms. With this model, participants receive services based on a limited menu of treatment options, services, and supports with limited choice and control over their treatment plan. Self-directed services shift attention from eliminating symptoms to a focus on goals using an individual’s strengths to achieve recovery.

The SDS model used in a Texas pilot is based on four core values:
1. Participant control
2. Participant responsibility
3. Participant choice
4. Avoidance of conflict of interest.

In an SDS delivery model, a person-centered planning process helps an individual identify recovery goals and the specific services and supports needed to accomplish those goals.

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After the treatment plan is developed, participants develop a budget for the purchase of goods and services to meet their goals. A self-directed individualized budget is typically a predetermined amount calculated based on an average cost of care and the individual’s assessed level of need. A portion of the individual’s budget must be used on traditional treatment and services with a specified percentage available for non-traditional services identified in the recovery plan. This allows flexibility to purchase goods and services the individual needs to reach their recovery goals (see example below). It also allows for consumers to select providers to whom they can therapeutically connect, rather than having to settle for the provider to whom they are assigned. Purchased services and goods must be directly related to recovery plan goals. The individualized budget cannot exceed the amount that would have been spent in the traditional service delivery model.

Texas currently offers a consumer-directed service delivery model in all the physical disability/developmental disability waivers administered by DADS, as well as in Medicaid managed care programs providing LTSS. Consumer-directed service delivery is available statewide in these programs. In the Texas mental health services system, the only self-directed service provision available is through a pilot implemented in 2005 in NorthSTAR, a carve-out managed care delivery system in seven north Texas counties. This will likely be going away with the termination of NorthSTAR. Although the pilot has achieved significant positive results, the state has not expanded self-direction in mental health services and has not tested the self-directed services option in the current integrated managed care system. This denies many individuals with serious mental illness access to treatment, goods, and services to help them meet their recovery goals.

**Vote 11-0-1 (Rachel Hammon, Texas Association for Health Care and Hospice, abstaining)**

**Recommendation 21:** Texas Clubhouses are a proven successful, cost-effective, community-based peer program for persons with serious mental illness. Community integration, peer support, employment support, and resources for accessing housing and other services are among the components. PIAC supports $2.5 M in the budget for Texas Clubhouses.

Texas Clubhouses are part of an international recovery and human rights movement for people diagnosed with serious mental illness. By participating in all of the tasks necessary to operate the Clubhouse, members develop confidence and skills in independent living and return to employment. The Clubhouse model has a nearly 70-year history and is an evidence-based practice recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA). A similar exceptional item was proposed in 2015, with funding approved at $1.25 million.

**Vote 8-0-4 (Kevin Warren, Texas Health Care Association; Robert Ham, D&S Community Services; Rachel Hammon, Texas Association of Home Care and Hospice; and Jean Langendorf, Accessible Housing Austin!, Inc. abstaining)**
SECTION V: RELOCATION SERVICES

Recommendation 22: Require MCOs to assess all members who are receiving ventilator care in nursing facilities for interest in returning to the community. As members express interest, require MCOs to develop and implement transition plans.

- If there are barriers to transition, contract with individuals who have expertise in arranging community-based services for persons who require ventilator care. This includes individuals who utilize ventilators and/or their family members.
- Provide training to MCOs and relocation specialists on relocating individuals who require ventilator care. Focus on those who serve areas in which facilities providing ventilator care are located.

Establish metrics to determine the degree of success relocation contractors and managed care service coordinators have placing individuals on ventilators in the community. The state needs to establish a public dashboard to be transparent and share the data.

People in nursing homes who are on ventilators are often not able to obtain the support necessary to live successfully at home.

Persons on ventilator assistance have few options for community services and an elevated incidence of living in nursing homes. People with ventilator assistance should have maximum independent living.

Nursing home residents who require ventilator care face unique barriers in returning to the community. Although relocation specialists are asked to target nursing home residents with complex needs, they have not been provided training specific to working with this population.

Vote 11-1-0 (Kevin Warren, Texas Health Care Association, opposing)
SECTION VI: HOUSING

Recommendation 23: Support a staff position at either HHSC or Texas Department of Housing and Community Affairs (TDHCA) to reach out to Public Housing Authorities (PHAs) and encourage them to establish preferences for Money Follows the Person (MFP).

The primary barrier to community living among long-term nursing home residents is lack of affordable, accessible, and integrated housing.

The TDHCA Project Access Program is an invaluable resource for obtaining vouchers but cannot accommodate residents’ full demand.

DADS has had success in partnering with the Department of Housing and Urban Development to reach out to PHAs and encouraging them to set aside vouchers for MFP participants. This has significantly expanded housing options for nursing home residents.

Vote 10-1-2 (Jean Langendorf, Accessible Housing Austin! Inc., opposing. Kyle Piccola, The Arc of Texas; and Kevin Warren, Texas Health Care Association, abstaining)

Recommendation 24: Provide funding to replicate the current Department of State Health Services (DSHS) housing voucher program for individuals experiencing mental illness for persons with other disabilities.

Lack of housing assistance is preventing many individuals with disabilities from successfully living in the community.

Many individuals with disabilities have very low incomes that do not provide enough income to afford the rental amounts of most apartments. There are a very limited number of housing vouchers available in most communities in Texas. The current DSHS housing voucher program for individuals experiencing mental illness has been very effective at addressing the housing needs of those individuals. A similar housing voucher program for individuals with other disabilities could help address the lack of affordable housing options.

Vote 11-0-1 (Kevin Warren, Texas Health Care Association, abstaining)
SECTION VII: EMPLOYMENT

Recommendation 25: HHSC and the legislature should support policies that encourage, promote, and place individuals with disabilities in integrated, competitive employment.

This could be achieved by:

- Pursuing (with input and assistance from the Texas Education Agency and Texas Workforce Commission (TWC), as necessary) a Health and Human Services system-wide effort to implement the Employment First Policy adopted in Circular C-048. This policy should set clear goals for employing individuals with disabilities (including IDD) and define how the agency and partner agencies will meet those goals.

- Working with appropriate state agencies to end segregated employment and sub-minimum wage for people with disabilities, which includes working to end state support of employers which promote use of segregated and sub-minimum wage employment. It’s time for the state to take a stand against these discriminatory employment practices.

- Incentivizing day habilitation providers, community rehabilitation providers, and other interested programs/parties providing services in segregated work settings to reallocate resources to competitive, integrated employment.

- Eliminating barriers to Supported Employment/ Employment Assistance by:
  - Addressing transportation and workforce challenges and training needs.
  - Examining reasons why day habilitation utilization rates are significantly higher than employment assistance and supported employment.
  - Incentivizing state agencies and providers to increase these utilization rates.
  - Holding HHSC and partner agencies accountable to improve employment utilization rates.

During deliberations on Senate Bill (S.B.) 1226, 83rd Legislature, Regular Session, 2013 (the Employment First bill), national surveys showed the majority of persons with disabilities wanted to have a job in the community, yet their participation rate in the workforce was low. National Core Indicators survey data indicated 74 percent of individuals with IDD did not have a community job and 47 percent of those without a job wanted one. It was further noted many individuals with IDD who did work were often in segregated settings and paid sub-minimum wages.

S.B. 1226 was passed to address the need for competitive, integrated employment for all Texans with disabilities. To date, however, it has yet to be implemented with little to no change in the number of persons with disabilities participating in the workforce. The HCBS CMS settings rule also addresses the requirement for integrated services.

Service plan implementation lacks flexibility to support individual choices related to competitive, integrated employment, and volunteer and community exploration related to community jobs, in part due to the lack of providers of employment assistance and supported employment and transportation limitations. There needs to be a "pool" of trained service
providers for individuals to access the services of supported employment and employment assistance.

Vote 10-0-2 (Kevin Warren, Texas Health Care Association; and Rachel Hammon, Texas Association for Home Care and Hospice, abstaining)
SECTION VIII: WORKFORCE AND PROVIDER STABILIZATION

Recommendation 26: Increase the base wage to $13 per hour for direct support workers (DSWs), which include attendants providing personal assistance and habilitation services in all HCBS programs.

Increasing the base wage to $13 per hour must also be accompanied by:

- Establishing rate methodologies for DSWs consistent with the cost report data in all community-based services for persons with disabilities;
- Ensuring the Attendant Compensation Rate Enhancement program is available to all attendant programs affected by the wage floor; and
- Funding the Attendant Compensation Rate Enhancement program to equitably support all providers participating in the program.

Direct support workers are the foundation for successful HCBS. Shortages and high turnover of direct service workers directly impact continuity and quality of care for children and adults receiving or attempting to access services. Although numerous factors contribute to provider recruitment and retention challenges, the inability to offer competitive wages and benefits remains the biggest barrier. In addition to high turnover, a lack of a stable DSW workforce results in excessive overtime costs, staff burnout, low morale, and inadvertent, unwanted, and unsafe staff errors in service provision.

The recommendation to increase wages to $13 per hour as the wage floor for DSWs is based on market and benefits factors, and the historical erosion of direct support wages across all community-based programs for persons with disabilities. In TWC’s 2014 report, Fastest Growing Occupations by 2020, two categories of direct support workers, home health aides and personal care aides, ranked 1 and 2 with a need for an additional 107,000+ workers. Home health aides and personal care aides also exceeded the next 13 fastest growing occupations combined.

Whereas many occupations include benefits in their compensation packages, many direct support workers receive no paid sick leave, no paid vacation, no insurance, and no paid holidays. That means the hourly wage is the worker’s total compensation. This is a job where the wage has significantly eroded. In 1968, a direct support worker earned $1.60 per hour; adjusted for inflation, that equals $10.90 in 2015 dollars, a factual erosion of almost 30 percent.

An adjustment to a floor wage of $11 per hour would represent only a restoration of the historical wage. Considering the high demand for the service, the fact there are little to no paid benefits, and alternate jobs pay more (direct support workers’ pay ranked dead last per the May 2015 Bureau of Labor Statistics Texas Occupational Employment Statistics), a recommendation of $13 per hour is realistic.

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4 Texas Workforce Commission. Presentation to the Select Committee on Health Care Education and Training, August 28, 2014.
5 https://www.dol.gov/whd/minwage/chart.htm
6 http://www.bls.gov/oes/current/oes_tx.htm
Additionally, attendant care programs such as Personal Care Services (PCS) for children do not have access to the Attendant Compensation Rate Enhancement program, yet are equally affected by the attendant wage floor. Each time the wage floor is increased, this program has no ability to adjust and avoid wage compression issues. All attendant programs affected by the wage floor should have access to the Attendant Compensation Rate Enhancement program. Currently the Attendant Compensation Rate Enhancement programs are not funded at levels to support all providers who wish to participate.

Vote 10-0-2 (Kevin Warren, Texas Health Care Association; and Rachel Hammon, Texas Association of Home Care and Hospice, abstaining)

Recommendation 27: Bolster DSW recruitment and retention efforts to include reaching out to the younger demographic and developing strategies to enhance the value of the position.

As many in the current DSW workforce pool are aging, and as many young people only serve in this capacity for a short time, the need to reach out to a younger demographic to not only replace those aging, but to also enhance the value of serving as a direct support professional to attract a younger workforce is critical.

The CMS Informational Bulletin, Suggested Approaches for Strengthening and Stabilizing the Medicaid Home Care Workforce (August 3, 2016), highlights several opportunities states, providers, and others have to leverage CMS guidance (and funds) to address the needs of the Medicaid home care workforce.7 Noting recent rebalancing from institutional to community-based care, CMS identified, “a stable workforce, engaged in the delivery of services and supports that address the needs and preferences of beneficiaries, is a critical element to achieving continued progress.”

Potential solutions include:

- Establishing an "open registry" for the public to identify available qualified care workers, plus examining state criminal history exclusions to respect the beneficiaries’ right to choose a trusted family member or friend. Medicaid administrative funds are available for this activity.
- Establishing either professional care worker associations or unions.
- Providing training for unqualified workers to enter the workforce.

In addition, CMS noted several guidance documents have been issued to address access to services, wage rates, and wage thresholds important to "attract dedicated and engaged" workers. CMS encourages states and providers to be mindful of the relationship between wage sufficiency, workforce health, and access to care, and has provided guidelines on how states can better adjust compensation rates according to a variety of factors (including a tiered rate structure, tuition assistance, and performance-based compensation).

Vote 11-0-1 (Kevin Warren, Texas Health Care Association, abstaining)

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Recommendation 28: Fully fund the administrative/operational portion of the rate for community-based provider agencies.

With more than 10 years of no increase in this portion of the rate for most programs, a rate increase to fully fund the administrative/operational costs is essential. These functions support the stability of the provider network, ability of the provider and direct support worker to provide quality services in the community, and include costs to supervise direct support workers. In fact, the STAR+PLUS waiver has actually reduced the administrative/operational portion of the rate. The lack of adequate funds over the years to cover these costs has stretched community-based providers (including home and community support services agencies, financial management services agencies for consumer directed services, and providers of IDD waiver services) extremely thin, exposing the individuals they serve to inadequate services.

Although not all-inclusive, examples of administrative/operational pressures include: reduction of the administrative/operational portion of the rate in the STAR+PLUS waiver; the expansion of managed care, which has increased administrative/operational costs for community-based providers compared to fee-for-service (as reflected in the FY 2016-2017 Consolidated Budget); and implementation of initiatives such as Electronic Visit Verification (EVV), which have increased administrative and training costs.

Vote 9-0-3 (Kevin Warren, Texas Health Care Association; Cindy Adams, Superior HealthPlan; Jean Langendorf, Accessible Housing Austin! Inc., abstaining)
SECTION IX: MISCELLANEOUS

Recommendation 29: HHSC will establish reporting requirements for the MCOs to capture enrollment and utilization data for individuals receiving HCBS including, but not limited to, the CFC program, nursing facility transitions, STAR+PLUS waiver services, etc. HHSC will use encounter submissions, statistically valid Individual Service Plan audits, or other publicly reported data to avoid relying on self-reported data from the MCOs.

With the majority of adults LTSS consumers enrolled in and receiving their community-based services through the STAR+PLUS Medicaid managed care program, and the timeline for all remaining Medicaid waivers to transition into managed care, it is important HHSC establish measurable metrics on enrollment, utilization, quality, and individual choice and control. STAR+PLUS has now been in existence since 1998, however much of the performance data published still relies on MCO self-reported data, which does not allow clear comparison and insight for stakeholders.

Vote 12-0-0

Recommendation 30: The Legislature should direct HHSC to examine person-centered plans to ensure they were developed with clear, reachable goals, that the individual was included in developing the plan, and that the plan is truly written in the person-centered philosophy.

Texas has made great strides to implement policies encouraging state agencies, nursing facilities, ICFs/IID, group homes, SSLCs, day habilitation programs, and MCOs to use person-centered practices to guide the services they provide for consumers. There are many programs and facilities creating person-centered plans to improve the quality of their services and put the consumer first. We know from experience and data person-centered philosophies, when implemented correctly, have the potential to improve outcomes and meaningfully impact the quality of life for individuals with disabilities.

It is an ideal time to take a purposeful look at our efforts and audit a sample of the person-centered plans to ensure the plans are high quality, linked to clear, reachable goals and developed by the individual using the services. This could be implemented through the utilization review process. Another option would be to convene a workgroup with diverse stakeholders (Center for Person Centered Philosophies, advocacy organizations, and relevant stakeholders) to examine a sample. Ideally, the sample would include diverse levels of need and remove their identifying information. The audit should make recommendations to the legislature and HHSC with their findings.

This process could be at no or minimal cost to the state.

Vote 12-0-0
**Recommendation 31:** Include funding for a CDS marketing campaign in the DADS Legislative Appropriations Request (LAR) or split between DADS and HHSC.

Increasing the uptake of CDS among persons on Medicaid is something long talked about, yet, outside of the CLASS program, few eligible consumers choose the option.

CDS is empowering, often results in more reliable attendant care, and raises attendant wages, while being budget neutral. A pool of more than 250,000 Texans are likely eligible. A marketing campaign similar to the successful Health Insurance Premium Program (HIPP) could move take-up to 10-15 percent. This is a reasonable target, the CLASS program has 50 percent participation and the State of Illinois has an 80 percent rate overall in community attendant programs.

As programs in DADS and HHSC are CDS eligible, the LAR funding could be split between the agencies.

*Vote 9-0-3 (Robert Ham, D&S Community Services; Rachel Hammon, Texas Association for Home Care and Hospice; and Kevin Warren, Texas Health Care Association, abstaining)*

**Recommendation 32:** PIAC should study barriers for individuals with IDD in jail to leave the prison system, including:

- Reasons why there is a backlog of individuals waiting to be released.
- If the designated SSLC can accommodate the number of individuals with IDD needing to be released.
- The Medically Recommended Intensive Supervision (MRIS) Program and how it helps individuals with IDD.

In Texas, individuals with IDD in jails are waiting up to two years before they are released into more appropriate settings.

Currently, the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) has more than 300 individuals with IDD in their caseloads.

*Vote 10-0-2 (Kevin Warren, Texas Health Care Association and Cindy Adams, Superior HealthPlan, abstaining)*
Recommendation 33: HHSC should develop a distinct Medicaid state plan service for peer support services, designating certified peer specialists and certified recovery specialists as approved providers. HHSC should develop rules defining peer support services, certified peer specialists, and certified recovery specialists. The rules should also specify requirements for peer certification and supervision and any other relevant issues identified by the executive commissioner as necessary to promote health and safety in peer specialist/recovery specialist services. Development of the rules should include input from certified peer specialists, certified recovery specialists, and other relevant stakeholders.

According to the Texas Council of Community Centers, certified peer specialists are currently employed at all 39 local mental health authorities (LMHAs). Medicaid rules allow peer specialists to be reimbursed for providing mental health rehabilitative services are currently only provided through the LMHAs. Peer specialists are approved providers of rehabilitation services, but peer support services are not currently a Medicaid reimbursable service. Certified Recovery Coaches for Substance Abuse currently are not allowed to be reimbursed through Medicaid. These restrictions drastically limit the ability of other provider types to hire and be reimbursed for services provided by peer specialists.

A number of peer specialists and recovery coaches are employed at several state psychiatric hospitals and recovery centers. There are many other settings in which peer support services could help reduce costs and achieve better outcomes for individuals. Prime settings for these services include hospital emergency rooms, integrated health care settings, community clinics, criminal/juvenile justice settings, and more.

*Vote 11-0-1 (Kevin Warren, Texas Health Care Association, abstaining)*

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8 Castle, D., executive director of the Texas Council of Community Centers. Mental health advocate meeting held on June 23, 2014.
## Appendix A:

### PROMOTING INDEPENDENCE ADVISORY COMMITTEE 2016

### MEMBERSHIP LIST

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