



# **2016 Revised Texas Promoting Independence Plan**

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**As Required by  
S.B. 367, 77th Legislature,  
Regular Session, 2001 and  
Executive Order RP-13**

**Health and Human Services**

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**TEXAS**  
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## Executive Summary

The *2016 Revised Texas Promoting Independence Plan* is the eighth update to the original plan submitted in January 2001. Texas' plan is a direct response to the United States (U.S.) Supreme Court's *Olmstead* ruling which requires states, within certain conditions, to provide individuals an opportunity to live in the most integrated setting to receive long-term services and supports (LTSS).<sup>1</sup> The plan and the subsequent Promoting Independence Initiative (Initiative) to implement the plan are far reaching in their scope and enactment efforts. The Initiative includes all LTSS and the state's efforts to improve the provision of community-based alternatives, ensuring these programs in Texas effectively foster independence and acceptance of people with disabilities and provide opportunities for people to live productive lives in their home communities. The biennial revision of the plan provides documentation of progress, challenges, and recommendations for improvement.

Following the *Olmstead* decision, the Texas Health and Human Services Commission (HHSC) embarked on the Initiative and appointed members to the Promoting Independence Advisory Board,<sup>2</sup> as directed by Executive Order GWB 99-2. The Board met during fiscal years 1999 and 2000 and assisted HHSC in crafting the state's response to the *Olmstead* decision, the original *Promoting Independence Plan*.<sup>3</sup> The original plan was submitted to the Governor and state leadership on January 9, 2001. Passage of Senate Bill (S.B.) 367, 77th Legislature, Regular Session, 2001, codified many of the recommendations made in the original plan. Subsequently, in April 2002, Governor Rick Perry issued Executive Order RP-13 to further the

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<sup>1</sup> *Olmstead v. L.C* ex rel. Zimring, 119 S.Ct. 2176, 2190 (1999).

<sup>2</sup> The Promoting Independence Advisory Board is now the Promoting Independence Advisory Committee.

<sup>3</sup> The original *Texas Promoting Independence Plan* may be found at: <http://www.dads.state.tx.us/providers/pi/piplan/2001piplan.pdf>.

state's efforts regarding the Initiative and community-based alternatives for individuals with disabilities.

Within the State of Texas, various advisory committees, including the Promoting Independence Advisory Committee (PIAC), advise HHSC on policy and oversight of the LTSS system. The PIAC's initial purpose was to assist HHSC with the development of a comprehensive working plan to ensure appropriate care settings for persons with disabilities. In accordance with Texas Government Code, Section 531.02441(i), PIAC submitted the *2016 PIAC Stakeholder Report* containing 33 recommendations for improved access to community-based LTSS. This plan incorporates and builds on the recommendations from the *PIAC Stakeholder Report*, recognizing in many instances legislative authorization and appropriations are necessary for implementation.

Texas continues to make significant contributions to the Initiative through expanding opportunities for greater service coordination and delivery of community-based services. Since the Initiative began in 2001, significant resources have been committed to reduce interest lists for community-based LTSS and offer services to divert the need for institutional services. The Texas system of LTSS has significantly evolved to increase access through development of new models of managed care service delivery. Legislatively directed changes to the Texas system include:

- expanding managed care incrementally to statewide coverage by September 1, 2014, for individuals with physical disabilities or who are elderly, replacing the Community Based Alternatives (CBA) program;
- including nursing facilities in a managed care model in March of 2015;
- providing acute care services for most adults receiving waiver services for individuals with intellectual and development disabilities (IDD) through a managed care model as of September 1, 2014;
- increasing appropriations since 2010 to transition individuals from institutions to fee-for-service waiver and community attendant services;

- adding diversion opportunities for adults and children at imminent risk of institutionalization to community fee-for-service waiver programs;
- implementing Community First Choice (CFC), effective June 1, 2015;
- providing acute care and some long term services to children through a managed care model in November 2016; and
- participating in the federal Money Follows the Person Rebalancing Demonstration Grant (MFPD) since 2008, earning approximately \$91 million in enhanced funding through fiscal year 2018 to support individuals who want to relocate from an institution to a community setting.

The 2016 plan documents the continuation of the work established in the original 2001 plan to help Texas reach its ultimate goals of individual choice and self-determination for people with disabilities. The 2016 plan includes policy modifications and updates on on-going initiatives grouped in the following eight categories: community based services, children's initiatives, managed care initiatives, mental and behavioral health, relocation services, housing, employment, and workforce/provider stabilization. Key updates include:

- continued, though reduced, appropriations for Promoting Independence slots to transition individuals from institutions to community waiver programs serving individuals with an intellectual or developmental disability;
- continued appropriations for Promoting Independence diversion slots in combination with a contingency plan to use attrition slots to allow individuals with an intellectual or developmental disability at imminent risk of nursing facility placement to enroll in the Home and Community-based Services (HCS) program;
- continued, though reduced, appropriations for Department of Family and Protective Services (DFPS) children aging out of foster care;
- increased training for staff and family members to learn how to better support transitions of individuals with complex medical and behavioral health needs;
- expanded Section 811 Program Rental Assistance (PRA) housing options in Texas for individuals with disabilities who are moving from an institution to the community; and

- developed and tested models for providers to transform their organizations from relying on day program services to community-based, integrated employment, thereby increasing the opportunities for individuals with disabilities become more independent.

# 1. Introduction

The 2016 plan is the eighth revision of the plan originally submitted in January 2001 as required by Governor George W. Bush's Executive Order GWB 99-2. Texas' plan is a direct response to the Supreme Court *Olmstead* ruling, which requires states, within certain conditions,<sup>4</sup> to provide individuals an opportunity to live in the most integrated setting to receive LTSS.<sup>5</sup> The plan describes how Texas will provide community-based options within the LTSS system.

Governor Rick Perry issued Executive Order RP-13 to reinforce and broaden the scope of the Initiative. The state's accomplishments in developing and providing community options for all Texans are significant. The LTSS system continues to evolve and is very different than it was in 2001. The Legislature significantly increased appropriations for the number of community waiver slots throughout the past decade. It also expanded community access through State of Texas Access Reform+ PLUS (STAR+PLUS), the Texas Medicaid managed care program for persons who are aged or who have disabilities.

The plan serves several purposes. First, it provides the comprehensive working plan in response to *Olmstead*. Second, it meets the requirements of Executive Order RP-13<sup>6</sup> and Texas Government Code, Section 531.0244,<sup>7</sup> which directs HHSC to develop a plan to ensure appropriate care settings for individuals with disabilities. The provision

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<sup>4</sup> The Court held public entities must provide community-based services to persons with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity.

<sup>5</sup> For more information about the *Olmstead* decision, go to: [http://www.ada.gov/olmstead/olmstead\\_about.htm](http://www.ada.gov/olmstead/olmstead_about.htm).

<sup>6</sup> Executive Order RP-13 follows Executive Order GWB 99-2 as the second community-based alternatives Executive Order. See Appendix A for Executive Order GWB 99-2 and Appendix B for Executive Order RP-13.

<sup>7</sup> As enacted by S.B. 367, 77th Legislature, Regular Session, 2001.

of a system of services and supports is required to foster independence and productivity, including meaningful opportunities for an individual with a disability to live in the most appropriate care setting. HHSC is directed to report on the plan's implementation status. Finally, the plan serves as an analysis of the availability, application, and efficacy of existing community-based supports for individuals with disabilities.

The overarching Initiative, and the plan supporting it, are far-reaching in scope and implementation efforts. The Initiative is more than just a philosophy; it is practiced in the reality of state policy and program development. The Initiative includes all LTSS delivered through the Medicaid managed care or fee-for-service delivery systems, and state efforts to enhance community-based services options. The goal is to ensure the LTSS system in Texas effectively fosters independence for all individuals with a disability and provides opportunities for individuals to have a quality life in the setting of their choice. The underlying theme of the Initiative is individual choice and the opportunity to live in the most integrated setting.

The plan articulates values which are the framework for the delivery of LTSS and future system improvements:

- Individuals are well informed about their program options, including community-based programs, and allowed the opportunity to make choices among affordable services and supports.
- A family's desire to care for their children with disabilities at home is recognized and encouraged by the state.
- Services and supports are built around a shared responsibility among families, state and local government, the private sector, and community-based organizations, including faith-based organizations.
- Programs are flexible, designed to encourage and facilitate integration into the community, and accommodate the needs of individuals.
- Programs foster hope, dignity, respect, and independence for the individual.

Since 2001, Texas has made significant progress transforming its LTSS system from an institutional-based to a community-based system, including:

- transitioning over 44,000 individuals from institutional settings to living in the community; and
- shifting LTSS system expenditures from institutional costs to less costly services delivered in the community.<sup>8</sup>

This progress has been achieved through appropriations by past legislatures and policies instituted by the HHS system. Texas continues to make significant contributions to Initiative efforts through expanding opportunities for greater service coordination and delivery of community-based services.

Recognizing the significant progress achieved over the last 15 years, the Initiative and the biennially revised plan maintain an emphasis on improving access and availability of community-based services, meeting statutory requirements, and compliance with the *Olmstead* decision. The plan is dedicated to building upon previous achievements and advocating for individual self-determination and availability of community-based options. The revised and regularly updated plan does not repeat information readily available on state agencies' websites, but rather builds upon the original plan and the subsequent revisions. While much has been accomplished, efforts must continue to ensure all individuals have community-based options when considering their LTSS. The biennial revision of the plan provides documentation of progress, challenges, and emerging recommendations for improvement.

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<sup>8</sup> <https://www.medicaid.gov/medicaid/ltss/downloads/balancing/mfp-field-reports-18.pdf>

## 2. Background

To fully understand the purpose, comprehensive nature, and implications of the Initiative within the state, it is important to start with the history of the Initiative and include relevant information related to *Olmstead* decision. *Olmstead* was filed in Georgia, on behalf of two individuals with mental and cognitive disabilities living in state operated institutions. They claimed a right to care in an integrated setting based on the guarantees under Title II of the Americans with Disabilities Act (ADA) of 1990.<sup>9</sup>

In 1999, the Supreme Court ruled in *Olmstead* the unnecessary institutionalization of persons with disabilities constitutes unlawful discrimination under the ADA. The Supreme Court ruled states are required to serve persons with disabilities in community settings, rather than in institutions, when:

- The state's treatment professionals have determined community placement is appropriate.
- The transfer from institutional care to a less restrictive setting is not opposed by the affected individual.
- The placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with disabilities.<sup>10</sup>

The U.S. Congress instructed the U.S. Attorney General to issue regulations implementing the ADA Title II discrimination proscriptions. One such regulation, known as the "integration regulation," requires a public entity to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."<sup>11</sup>

Under another ADA regulation, states must "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of

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<sup>9</sup> 42 U.S.C. Section 12131 *et seq.*

<sup>10</sup> *Olmstead v. L.C.*, 119 S.Ct. 2176, 2190

<sup>11</sup> 28 CFR Section 35.130(d).

disability, unless the public entity can demonstrate that making the modification would fundamentally alter the nature of the service, program or activity."<sup>12</sup> Fundamental alteration of a program takes into account three factors:

- the cost of providing services to the individual in the most integrated setting appropriate;
- the resources available to the state; and
- how the provision of services affects the ability of the state to meet the needs of others with disabilities.<sup>13</sup>

The Supreme Court suggested a state could establish compliance with Title II of the ADA if it demonstrates it has a: "Comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moves at a reasonable pace not controlled by the state's endeavors to keep its institutions fully populated . . . In such circumstances, a court would have no warrant effectively to order a displacement of persons at the top of the community-based treatment waiting list by individuals lower down who commenced civil actions."<sup>14</sup>

## History of the Initiative

Although the *Olmstead* decision only involved one type of institution, a psychiatric hospital, courts quickly made clear *Olmstead* applied to all state and Medicaid funded institutions, including nursing facilities. Following the *Olmstead* decision, HHSC embarked on the Initiative and appointed the Promoting Independence Advisory Board, as directed by Executive Order GWB 99-2. The Promoting Independence Advisory Board met during fiscal years 1999 and 2000 and assisted HHSC in crafting the state's initial response to the decision.

S.B. 367, 77th Legislature, Regular Session, 2001, codified many of the provisions in the original plan and re-named the Promoting Independence Advisory Board the Interagency Task Force on Appropriate Care Settings for Persons with Disabilities. The Task Force is commonly referred to as PIAC.

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<sup>12</sup> 28 CFR Section 35.130(b)(7)(1998).

<sup>13</sup> *Olmstead v. L.C.*, 119 S.Ct. 2176, 2188 -2189.

<sup>14</sup> *Olmstead v. L.C.*, 119 S.Ct. 2176, 2189 - 2190.

## Promoting Independence Advisory Committee

PIAC's initial charge was to assist the Texas Health and Human Services (HHS) system with the development of a comprehensive, effective working plan to ensure appropriate care settings for persons with disabilities.<sup>15</sup> Texas Government Code, Section 531.02441 guides PIAC to:

- study and make recommendations on developing a comprehensive, effective working plan to ensure appropriate care settings for persons with disabilities by submitting a stakeholder report to HHSC on an annual basis;
- advise HHSC on giving primary consideration to methods to identify and assess each person who resides in an institution but chooses to live in the community and for whom a transfer from an institution to the community is appropriate, as determined by the person's treating professionals;
- advise HHSC on determining the HHS system agencies' availability of community care and support options and identifying, addressing and monitoring barriers to implementing the plan; and
- advise HHSC on identifying funding options for the plan.<sup>16</sup>

PIAC served in an advisory capacity as needed. First, it served as the federally mandated Development and Implementation Council for the execution of CFC as a state plan option.<sup>17</sup> Second, it functions as the MFPD Advisory Committee.

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<sup>15</sup> For a list of Promoting Independence Advisory Committee members, see: <https://hhs.texas.gov/about-hhs/leadership/advisory-committees/promoting-independence-advisory-committee-piac>.

<sup>16</sup> Originally, HHSC had responsibility for the Initiative, but the agency formally delegated daily management of the Initiative to the Department of Aging and Disability Services (DADS) from 2004-2014. This role was returned to HHSC with the beginning of fiscal year 2015 (September 1, 2014).

<sup>17</sup> 42 CFR Section 441-575

## Key Changes over Time

Since 2001, Texas has made significant progress transforming its LTSS system from an institutional-based to a community-based system, including:

- transitioning over 44,000 individuals from institutional settings to living in the community; and
- shifting expenditures of LTSS system from institutional costs to less costly services delivered in the community.<sup>18</sup>

This progress has been achieved through appropriations by past legislatures and policies instituted by the HHS system. Texas continues to make significant contributions to the Initiative efforts through expanding opportunities for greater service coordination and delivery of community-based services. Since the Initiative began in 2001, legislatively directed changes to the Texas system include:

- incremental expansion of managed care to statewide coverage by September 1, 2014, for individuals with physical disabilities or who are elderly, replacing the CBA program;
- including nursing facilities in a managed care model in March 2015;
- providing acute care services for most adults receiving waiver services for individuals with IDD through a managed care model as of September 1, 2014;
- increasing appropriations since 2010 to transition individuals from institutions to fee-for-service waiver and community attendant services;
- adding diversion opportunities for adults and children at imminent risk of institutionalization to community fee-for-service waiver programs;
- implementing Community First Choice, effective June 1, 2015;
- providing acute care and some long term services to children through a managed care model in November 2016; and
- participating in the federal MFPD grant since 2008, earning approximately \$91 million in enhanced funding through fiscal year 2018 to support individuals who want to relocate from an institution to a community setting.

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<sup>18</sup> <https://www.medicaid.gov/medicaid/ltss/downloads/balancing/mfp-field-reports-18.pdf>

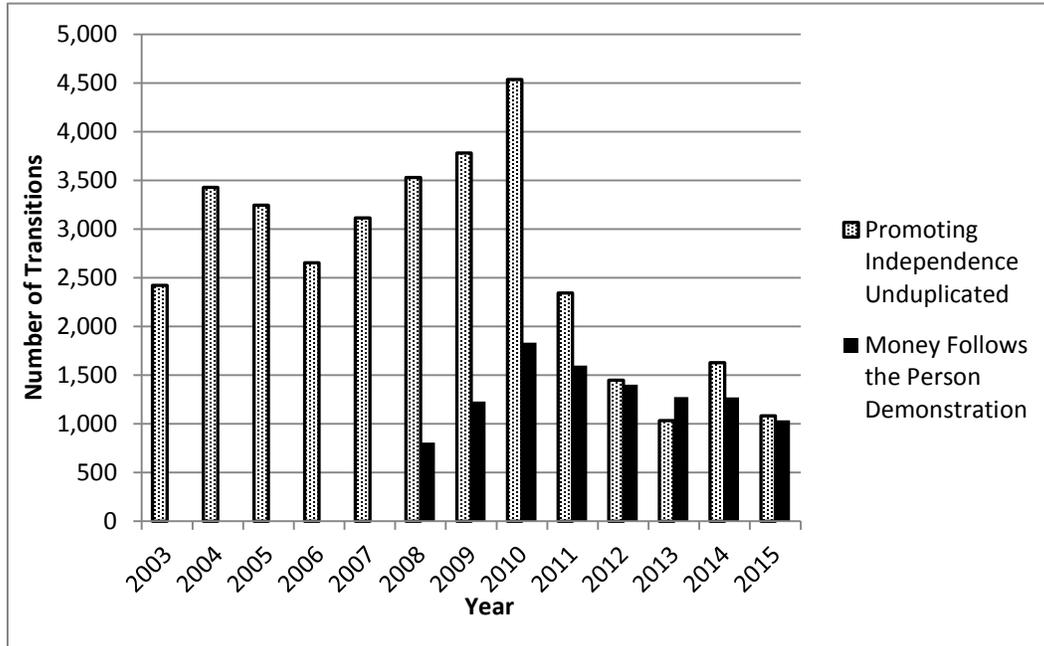
At the same time, the Texas Legislature directed two large scale reorganizations of the HHS system to streamline services to ensure they are provided in the most coordinated, responsive, and cost-effective manner possible. House Bill (H.B.) 2292, 78th Legislature, Regular Session, 2003, consolidated functions of 12 health and human service agencies into five new agencies under the leadership of HHSC. The second legislatively directed change involved transformation of the HHS system by combining functions from several agencies into HHSC effective September 1, 2016. Names of state agencies and corresponding responsibilities post transformation are reflected throughout the revised 2016 plan.

## **Promoting Independence Trends**

The data in this section provides snapshots over time showing progress made moving individuals from institutional care to community-based settings.

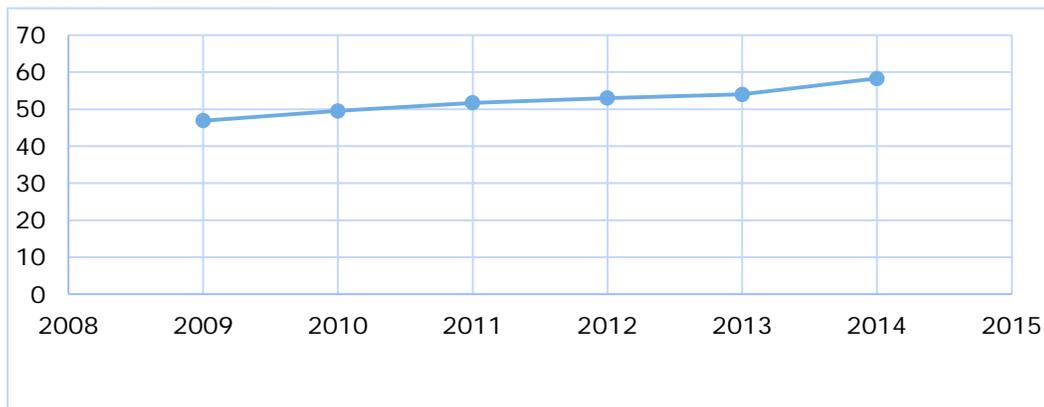
The Initiative and MFPD combined have had a significant impact in Texas. The 81st, 82nd, 83rd, and 84th Legislatures (2009, 2011, 2013, and 2015) appropriated a significant amount of general revenue (GR) into the community-based programs to reduce waiver interest lists and support individuals in transitioning from institutional to community-based settings. As Figure 1 indicates, since its implementation in 2003, 34,598 transitioned under the Texas Promoting Independence Initiative. The MFPD has helped over 10,000 individuals transition from institutional to community-based services.

**Figure 1. Texas Promoting Independence and Money Follows the Person Demonstration Transitions 2003-2015**



The percentage of Texas LTSS expenditures on community services increased over time. As shown in Figure 2, in 2014, community services accounted for 58.3 percent of expenditures, compared with 46.9 percent in 2009, when the MFPD project began collecting data.<sup>19</sup>

**Figure 2. Texas Medicaid LTSS Community Based Expenditures by Federal Fiscal Year**



<sup>19</sup> <https://www.medicaid.gov/medicaid/ltss/downloads/balancing/mfp-field-reports-18.pdf>

## 2016 Promoting Independence Plan

The *2016 PIAC Stakeholder Report* submitted to HHSC as required by Government Code Section 531.02441(i)<sup>20</sup> focuses on program funding and service system delivery changes designed to meet the intent of the *Olmstead* decision, the two Executive Orders, as well as S.B. 367 and S.B. 368, 77th Legislature, Regular Session, 2001.<sup>21</sup>

The *2016 PIAC Stakeholder Report* includes 33 recommendations organized into nine categories. The plan is organized similarly, identifying policy and appropriation related proposals furthering Initiative goals.

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<sup>20</sup> The 2016 *PIAC Stakeholder Report* is at:

<https://hhs.texas.gov/reports/2017/03/promoting-independence-advisory-committee-stakeholder-report-2016>.

<sup>21</sup> S.B. 368, 77th Legislature, Regular Session, 2001, modified Section 531.151 of the Texas Government Code to require permanency planning for all children in institutional care and for whom DFPS has been appointed permanent managing conservator. This bill, among other things, also modified Section 531.157 of the Government Code to require a state agency which receives notice a child is residing in an institution shall ensure the child is added to the interest list for community-based waiver programs.

## 3. Community Based Services

The state continues to work toward increasing access to and strengthening the community based service array. Each legislative session, HHSC historically brings forward several exceptional items focused on LTSS, specifically funding for:

1. reduction in community-based services interest lists;
2. promoting independence (transitions from institutions to the community and diversion from institutions); and
3. most recently, working to comply with federal rules that will go into effect in 2022.<sup>22</sup>

### Funding for Reduction in Community-based Services Interest Lists

Texas has six 1915(c) Medicaid waiver programs, and one home and community based services (HCBS) waiver program in the 1115 waiver, which serve people who have a physical, intellectual or developmental disability or a related condition. Community based services and supports delivered via Medicaid waiver programs are in high demand and interest consistently outweighs available resources. Wait times vary by program and exceed five years for approximately half of those interested in the HCS program.<sup>23</sup> Interest list numbers reflect individuals who have demonstrated interest in a 1915(c) waiver, but they may not be found eligible for the program after being assessed. Due to expansion of capitated managed care covered services, caseloads formerly at the Texas Department of Aging and Disability Services (DADS) have shifted to managed care. Individuals in the CBA waiver were moved to STAR+PLUS as of September 1, 2014. Children in the Medically Dependent Children Program (MDCP) transitioned to STAR Kids in November 2016.

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<sup>22</sup> <http://www.medicaid.gov/HCBS>

<sup>23</sup> <https://hhs.texas.gov/about-hhs/records-statistics/interest-list-reduction/fiscal-year-summaries>

Since the original plan, the PIAC's top priority has been full funding for community-based services so all interest lists are eliminated. To this end, the availability and array of community-based services for individuals with disabilities continues to expand. In 2015, the 84th Legislature appropriated funds to reduce interest lists and implement new services and programs throughout the HHS delivery system.<sup>24</sup>

The interest list includes individuals requesting services in the following 1915 (c) waiver programs:

- Community Living Assistance and Support Services (CLASS)
- Deaf-Blind with Multiple Disabilities (DBMD)
- HCS
- MDCP
- Texas Home Living (TxHmL)

Since individuals can request to be on the list for multiple programs, counts for enrolled or denied/declined may be counted more than once. Individuals are placed on a first come first service basis. Placement on an interest list does not necessarily mean the individual is eligible for the program. Once an individual's name comes to the top of the list, the service coordinator or case manager will assess for eligibility. For example, in 2015, of the 198,528 people on the interest list, 8,045 declined, withdrew or did not meet eligibility requirements and 3,220 enrolled on a waiver program, with another 2,853 in the assessment, service planning, or provider selection process.

It is important to look at the unduplicated counts on the interest list. As of June 2016, 110,019 individuals (unduplicated count) were on the HHS Medicaid 1915(c) waiver interest lists. Some of the individuals on the interest list may be receiving CFC, a Medicaid state plan benefit available beginning in Texas on June 1, 2015. CFC, delivered through a managed care model to those not already receiving waiver services, makes personal assistance services, habilitation, emergency response services, and support management available to individuals who previously did not have access to them.<sup>25</sup>

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<sup>24</sup> 2016-2017 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II)

<sup>25</sup> As of December 31, 2016, 34,078 individuals had enrolled in CFC through an MCO with an additional 3,389 in the enrollment process, according to an HHSC Update Presented at PIAC meeting, January 2017.

Typically, HHSC requests funding to reduce the interest list for community programs. This most recent request sought to reduce the interest lists for community-based services that include more than 100,000 unduplicated individuals across all waiver programs. HHSC did not receive funding to reduce the interest list for fiscal years 2018-2019.

By continuing to request funding for additional slots in all community-based services programs, it will be possible, if funded, to provide more timely service and give more individuals greater choice in the type of service they may access.

The need for substance abuse and community mental health services is growing and can be a key impediment to successfully remaining in the community. Additional funding would be needed to reduce the waiting list for youth and adult community mental health services provided by local mental health authorities (LMHAs). The community mental health wait list was an estimated 838 individuals as of April 2016.

H.B. 2463, 84th Legislature, Regular Session, 2015, directed the integration of the legacy Department of Assistive and Rehabilitative Services (DARS) Independent Living program for individuals who are blind or have visual impairments, and the Independent Living Services (ILS) program for individuals with significant disabilities into a single ILS program by September 1, 2016. The bill also directed the agency to ensure all services are directly provided by Centers for Independent Living (CILs) or other nonprofit organizations. During federal fiscal year 2016, 3,883 individuals used ILS services. Additional funding would be needed to reduce the interest list for the ILS program.

## **Transition to Community Services (formerly Promoting Independence)**

The Initiative and MFPD have been successful in shaping LTSS public policy since 2001 by providing community living opportunities for over 44,000 individuals in nursing facilities, State Supported Living Centers (SSLCs), and large and medium community Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) who have

transitioned to the community, as well as services diverting the need for institutional care.

### **Diversion Strategies for Persons with Intellectual and Developmental Disabilities at Imminent Risk of Institutionalization**

The state's approach to supporting individuals and families to remain in their community as an alternative to institutional placement is made available through two types of legislatively directed diversion categories for the HCS program, one specifically targeting individuals at imminent risk of nursing facility placement, and the second for supporting those at imminent risk of being placed in an SSLC. HHSC contracts with local intellectual and developmental authorities to support and assist individuals with access to HCS diversion slots for both categories, and to provide ongoing support and choice ensuring individuals live in the most integrated setting possible. Continued focus on community alternatives to institutional care was supported through HHSC's fiscal years 2018-2019 Legislative Appropriations Request (LAR) for Promoting Independence slots.

Funding under this exceptional item proposed to provide approximately 400 HCS slots for residents of SSLCs and 100 HCS slots for residents of large and medium ICF/IID transitioning to the community. The request also included:

- 236 HCS slots for DFPS children aging out of foster care;
- 400 HCS crisis slots for persons at imminent risk of institutionalization;
- 120 HCS slots for the movement of individuals with IDD from Texas State Hospitals;
- 40 HCS slots for DFPS children transitioning from general residence operations facilities;
- 700 slots for individuals with IDD moving from nursing facilities;
- 600 HCS slots for individuals with IDD diverted from nursing facility placement; and
- 550 MDCP slots for children diverted from nursing facility placement.

The funding request represented an increase in the number of slots for children transitioning from General Residential Operations (GRO)

facilities and new diversion slots for medically fragile children to enter the MDCP waiver without going into an institution.

For the fiscal year 2018-2019 biennium, HHSC received appropriations for the following HCS slots:

- 325 for residents of SSLCs and large ICFs/IID;
- 110 for DFPS children aging out of foster care;
- 150 for individuals with IDD moving from nursing facilities; and
- 150 for individuals with IDD diverted from nursing facility placement.

The state developed a contingency plan to prioritize attrition slots in order to continue to enroll individuals in the waiver programs.

Individuals also have the option of receiving habilitation or personal assistance services through state plan CFC.

## **Expanding Community-based Services to Meet Challenging Behavioral or Medical Needs**

Many individuals in institutional settings who are seeking to transition have increasingly complex medical, psychiatric, and behavioral health needs, creating challenges to living successfully in the most integrated community setting. Enhancement to the LTSS service array and delivery system will provide greater choice for these individuals.

Originally funded by MFPD, Enhanced Community Coordination (ECC) and Transition Support Teams augment the service and supports array for individuals who have both IDD and complex medical/behavioral health needs as they relocate from institutions to community settings.

Services include:

- eight medical, psychiatric, and behavioral support teams to provide training, technical assistance and peer review support to Local Intellectual and Developmental Disability Authorities (LIDDAs) and service providers across the state;
- community coordination to ensure the necessary medical, and/or behavioral services for individuals with complex needs transitioning to the community are accessed, coordinated, and delivered in a person-centered manner;

- pre- and post-transition monitoring; and
- flexible spending support for one-time purchases needed to move to the community.

Since its inception in 2016, 565 individuals received support through ECC and 467 transitioned out of institutions, primarily nursing facilities.

### **Day Habilitation**

Day habilitation type programs for people with disabilities can play an important role supporting people with disabilities to be as independent as possible and increase meaningful involvement in their community. The Centers for Medicare & Medicaid Services (CMS) HCBS settings rule requires services to be provided in the most integrated community setting with choice, right to privacy, dignity and respect, and individual autonomy. Day habilitation, as currently provided in Texas, occurs in a congregate setting.

HHSC held multiple stakeholder meetings to obtain feedback regarding ways to redesign day habilitation, such as linking with meaningful employment. The state surveyed providers, service coordinators, and individuals. Based on the survey results, the state will revise the *Statewide Transition Plan* and update remediation activities and the timeline for revising rules, policies, and seeking funding for areas, including day habilitation, that require resources to ensure compliance by the new deadline.

## 4. Children's Initiatives

Moving children out of institutions into the most integrated family setting possible continues to be a major focus of the Initiative, requiring on-going collaboration between DFPS and HHS system agencies. Children's initiatives focus on transitioning children to family-based settings and enhancing community-based supports for children with behavior challenges. HHSC's Fiscal Years 2018-2019 LAR included an exceptional item for funding for additional children to be moved into HCS from GRO facilities.

### Transitioning Children to Family-Based Settings

S.B. 368, 77th Legislature, Regular Session, 2001, amended the Texas Government Code to require permanency planning for Texas children residing in an institution. Permanency planning refers to a philosophy and planning process that focuses on the outcome of family support by facilitating a permanent living arrangement with the primary feature of an enduring and nurturing parental relationship. In accordance with the statutory definition of "institution," permanency planning applies to individuals under 22 years of age residing in:

- small, medium, and large community ICF/IID;
- SSLCs;
- HCS residential settings (i.e., supervised living or residential support);
- nursing facilities; and
- institutions for individuals with an intellectual disability licensed by DFPS.

Since 2001, more than 4,800 children have returned to their birth families or moved to family based alternatives.<sup>26</sup> These opportunities

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<sup>26</sup>See the *HHSC Permanency Planning Report – August 2016* at: [https://www.dads.state.tx.us/news\\_info/publications/legislative/permanencyplanning-8-16.pdf](https://www.dads.state.tx.us/news_info/publications/legislative/permanencyplanning-8-16.pdf)

have significantly improved the lives of individuals under age 22 and their families.

Table 1, below, provides the number of children residing in institutions at three points in time and the percent of change. Between February 2016 and August 2016, the number of children in all institution types, including HCS residential settings, decreased by three percent; and the number of children in all institution types, excluding HCS, decreased by two percent.

Compared to August 31, 2002, the number of children in all institution types (including HCS) decreased by 27 percent; and the number of children in all institution types excluding HCS homes decreased by 59 percent.

**Table 1. Trends in Number of Children in Institutions<sup>i</sup>**

Type	Baseline as of Aug. 31, 2002	Number as of Feb. 29, 2016	Number as of Aug. 31, 2016	Percent Change Since Aug. 2002	Percent Change in Past 6 Months
Nursing Facilities	234	74	74	-68%	0%
Small ICF/IID	418	171	154	-63%	-10%
Medium ICF/IID	39	41	40	3%	-2%
Large ICF/IID	264	15	19	-93%	27%
SSLC	241	183	182	-24%	-1%
HCS	312	661	636	104%	-4%
DFPS-Licensed ID Facility	73	41	48	-34%	17%
<b>Total</b>	<b>1,581</b>	<b>1,186</b>	<b>1153</b>	<b>-27%</b>	<b>-3%</b>
<b>Total with HCS Excluded</b>	<b>1,269</b>	<b>525</b>	<b>517</b>	<b>-59%</b>	<b>-2%</b>

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<sup>i</sup> Source: <https://hhs.texas.gov/sites/hhs/files//sb368-permanency-planning-report.pdf>

As of August 31, 2016, of the 1,153 children and young adults residing in institutions:

- the majority (65 percent) were young adults, ages 18 to 21;
- more than half (55 percent) of all children were in HCS;
- a relatively small number (six percent) of all children resided in a nursing facility; and
- the majority (94 percent) of children had a current permanency plan.

In accordance with S.B. 49, 83rd Texas Legislature, Regular Session, 2013, the HHS system provides transitional living assistance for children who have disabilities who also reside in GROs. GROs are a residential child-care operation that provides child care for 13 or more children or young adults. The care may include treatment services and/or programmatic services. These operations include formerly titled emergency shelters, operations providing basic child care, residential treatment centers, and halfway houses.<sup>27</sup>

Transitional living assistance allows children and youth with IDD timely access to HCS waivers similar to children in SSLCs, large ICFs/IID, and nursing facilities. DFPS and Every Child Inc. staff work together to find homes for the children in GROs who receive HCS waivers. Legacy DADS allocated 25 HCS slots in GROs for children in DFPS conservatorship who have IDD in fiscal years 2014-2015 and another 25 in fiscal years 2016-2017. As of April 2015, all 25 HCS slots were released for children with disabilities who were residing in DFPS licensed institutions. As described in the Community Services section of this report, HHS sought an increase from 25 to 40 HCS slots available to this population of children through HHSC's fiscal year 2018-2019 LAR. HHSC was appropriated funds to transition 110 DFPS children aging out of foster care.

## **Community Based Supports for Children with Serious Behavioral Challenges**

The 1915(c) Youth Empowerment Services (YES) waiver program provides comprehensive home and community-based services for

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<sup>27</sup> Texas Administrative Code, Title 40, Part 19, Chapter 748, General Residential Operations, Section 748.43.

children, ages 3-18, up to one month before a child's 19th birthday, at risk of institutionalization or out-of-home placement due to their serious emotional disturbance. Children enrolled in YES are eligible for all Medicaid behavioral health services as well as those specific to the YES service array. YES services include community living supports, family supports, flexible funding for transition services, minor home modifications, adaptive aids and supports, respite, specialized therapies, and paraprofessional services.

2014-2015 General Appropriations Act, S.B. 1, 83rd Legislature, Regular Session, 2013 (Article II, HHSC, Rider 90) directed statewide expansion of the YES waiver, making YES accessible to eligible children in every county. Beginning on September 1, 2015, YES was expanded statewide. In addition, effective July 10, 2016, the population served in the YES waiver was expanded to include children and adolescents who are in conservatorship of the state.

The YES waiver served 1,902 participants in the first quarter of fiscal year 2017. The YES waiver continues to grow its comprehensive waiver provider base and anticipates increased provider interest in fiscal year 2017 when an updated provider application becomes available. The LMHA serves as the waiver administrator as well as the comprehensive waiver provider to afford additional choice across the state. In addition to the LMHAs, as of November 30, 2016, there are six private providers serving as YES comprehensive waiver providers. The YES Waiver served 25 children in DFPS conservatorship in the first quarter of fiscal year 2017.

## **Parent Child Safety Placement**

A Parental Child Safety Placement (PCSP) is a temporary, short-term, out of home placement made voluntarily by a parent or legal guardian when it is determined by a Child Protective Services (CPS) worker that the child is not safe remaining in his or her own home. Parental child safety placements occur primarily in the Investigation and Family Based Safety Services stages of service but can occasionally occur in the Conservatorship reunification stage.

PCSPs often prevent children from entering into the foster care system or institutional placements by providing a short term-placement with a

relative or family friend. PCSPs often conclude when safety threats are alleviated through services. PCSPs can, at times, be precursors to the removal of a child if services are unsuccessful in mitigating the ongoing dangers.

In December 2015, a unit of Region 3 initiated a pilot to create 18 PCSP caseworkers and the PCSP State Office quality assurance (QA) team, comprised of 5 specialists). A caseworker must only consider a PCSP as an option if, after assessing dangers in the child's home, protective factors, and household strengths, the caseworker determines the:

- child cannot safely stay with a parent; or
- placement is needed to protect a victim from a sibling perpetrator.

A PCSP should only be considered when all other options to keep the child safe in his or her own home, or with a parent, have been explored. Region 3 PCSP caseworkers provide support to PCSP caregivers of children age 6 and under. The caseworker also conducts check-ins with the caregivers at the 6- and 12-month mark if the case is closed with the child remaining in the care of the PCSP caregiver. The QA team reviews PCSPs in real-time, providing valuable feedback to the Region and is also part of the closure process. The QA team also does period check-ins by phone with PCSP caregivers post-closure. DFPS plans to expand the pilot statewide in the future.

## **Access to Mental Health Services for Children in Department of Family and Protective Services Conservatorship**

S.B. 1889, 84th Legislature, Regular Session, 2015, attempts to make it easier for families to receive mental health services for their child in DFPS conservatorship without having a finding of abuse or neglect, and to encourage joint managing conservatorship (JMC) in certain cases. The bill adds an exemption to the definition of "neglect" in the Family Code, prohibits DFPS from making a finding of abuse or neglect against parents in a case in which DFPS is named managing conservator of the child solely because the family is unable to obtain mental health services for the child, and requires DFPS to develop a process for removing from the registry names of families for which

DFPS was made managing conservator of a child only because of the child's mental health needs. This bill requires biennial reporting to the legislature, and repeals S.B. 44, 83rd Legislature, Regular Session, 2013, language regarding a study and report. The report was completed and submitted to the legislature in October 2016. CPS published Policy 2390 in December 2015 which explains the changes to JMC being offered to the parents who wish for CPS to take custody of their child solely to obtain mental health services. In fiscal year 2016, 168 children who came into care met these criteria. In addition, dispositions of an abuse, neglect, or exploitation finding for 125 were overturned and removed from the registry.

## 5. Managed Care Initiatives

### Long Term Support Services Medicaid Managed Care Expansion

HHSC contracts with managed care organizations (MCOs) and pays a monthly capitation for each member enrolled in an MCO. The MCO is responsible for the delivery of all medically-necessary covered Medicaid services in the same amount, duration, and scope as the traditional Medicaid benefit package authorized under the *State Plan*.

H.B. 3523, 84th Legislature, Regular Session, 2015, builds on requirements outlined in S.B. 7, 83rd Legislature, Regular Session, 2013. S.B. 7 continued previous legislative efforts to improve Medicaid quality and outcomes with an emphasis on improving the LTSS system for individuals with IDD.

The HHS system continues to move forward with incorporating community-based LTSS services for individuals with IDD or related conditions into managed care on the following timeline:

- September 1, 2020: TxHmL
- September 1, 2021: CLASS, DBMD, HCS

Private community ICFs/IID are scheduled to be carved into managed care September 1, 2021.

S.B. 7 established the IDD System Redesign Advisory Committee (SRAC) to work in consultation with HHSC to implement the S.B. 7 provisions affecting individuals with IDD and directed HHSC to develop and implement a pilot program to test one or more integrated acute care and LTSS service delivery models using a managed care capitation strategy. H.B. 3523 delayed the pilot implementation from September 1, 2016 until September 1, 2017. S.B. 7 and H.B. 3523 amended Texas Government Code, Chapter 533, to include required goals of the pilot, including:

- increase access to LTSS;
- improve quality of acute care services and LTSS;

- promote meaningful outcomes by using person-centered planning, individualized budgeting, and self-determination, and promote community inclusion and customized, integrated, competitive employment;
- promote integrated service coordination of acute care services and LTSS;
- promote efficiency and the best use of funding;
- promote the placement of an individual in housing that is the least restrictive setting appropriate to the individual's needs;
- promote employment assistance and supported employment;
- provide fair hearing and appeals processes in accordance with applicable federal law; and
- promote sufficient flexibility to achieve the goals through the pilot.

In April 2015, HHSC surveyed the IDD SRAC committee members to obtain feedback on pilot development and structure. On July 20, 2015, HHS issued a Request for Information and used the responses to identify next steps. HHSC posted a draft Request for Proposals (RFP) on May 2, 2016. After incorporating relevant feedback, HHSC issued the RFP on September 26, 2016. The proposal deadline was February 21, 2017.

## 6. Mental and Behavioral Health

HHS is undertaking a number of activities designed to improve access to comprehensive behavioral health services within the home and community-based services array.

### Peer Specialists in Mental Health Services

Peer providers do not provide clinical services, but build relationships with individuals receiving services based upon shared life experiences. The role of the peer provider is to be non-judgmental and model trust, commitment, stability, and a life in recovery. A peer provider is an individual who is in recovery from mental health and/or substance use issues, has maintained recovery, typically for a year or longer, and has taken special training to work with others. In Texas, there is an official certification process for mental health peer providers which includes required training and testing to become a Certified Peer Specialist. There is a separate, but similar, process to become either a Certified Recovery Support Specialist or Certified Recovery Coach for substance use disorders. Both types of peer providers must be at least 18 years of age, have at least a high school diploma or General Equivalent Degree, and have experience receiving behavioral health services in the community. As of fiscal year 2016, there were 789 Certified Peer Specialists and 625 Certified Recovery Coaches.

Certified Peer Specialists and Certified Recovery Coaches work in a variety of settings in the public behavioral health system including LMHAs, state hospitals and Consumer Operated Service Providers (COSPs). COSPs are peer-run service programs owned, administratively controlled, and managed by mental health and substance use disorder consumers. These providers emphasize self-help as their operational approach. In Texas, the most frequently cited services provided by peers include group facilitation and individual peer support. In LMHAs, they may deliver and bill Medicaid for rehabilitation services.

## **Mental Health Peer Re-Entry Program**

The 2016-2017 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015, (Article II, DSHS, Rider 73) required implementation of a mental health peer support re-entry program. The mental health peer re-entry program, structured to incorporate stakeholder feedback, provides community-based peer services and access to services from licensed mental health professionals to incarcerated individuals and assists with transition to the community. Program goals include:

- decreasing hospitalization;
- decreasing recidivism and criminal behavior;
- decreasing symptomology of mental health and substance use issues; and
- increasing life domain functioning such as residential stability, employment, and living skills.

Three LMHA providers were selected (Harris Center for Mental Health and Intellectual and Developmental Disabilities, Tarrant County MHMR, and Tropical Texas Behavioral Health) and services began in the fourth quarter of fiscal year 2016. HHSC expects this program to continue.

## **Clubhouses**

During the 84th Legislature, Regular Session, 2015, DSHS received \$1.3 million in GR to expand and develop recovery-focused clubhouses across the state. The Clubhouse Model is an evidence-based, recovery-oriented program for adults diagnosed with a mental illness.

Clubhouses are a cost effective way to assist people with mental health challenges to stay out of hospitals while improving their ability to function successfully in the community through involvement in a peer-focused environment. Members are encouraged to participate in clubhouse operations, such as clerical duties, reception, food service, transportation, and financial services. By participating in all of the tasks necessary to operate the clubhouse, members develop confidence and skills in independent living and return to employment. Members are also encouraged to participate in activities to promote outside employment, education, meaningful relationships, housing, and an overall improved quality of life. Contracts have been executed

with four clubhouses across the state including Austin Clubhouse, Concho Valley Clubhouse in San Angelo, Magnificat Clubhouse in Houston, and San Antonio Clubhouse.

## **Mental Health Workforce and Training**

The 2016-2017 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015, (Article IX, Section 10.04) created the Statewide Behavioral Health Coordinating Council (Coordinating Council). This council comprises state agencies receiving state funding for behavioral health services and was tasked with creating a five-year *Statewide Behavioral Health Strategic Plan* and expenditure proposal. The Coordinating Council identified the behavioral health workforce shortage as a gap in service. More than 80 percent of Texas counties are designated as Mental Health Professional Shortage Areas, which are defined as more than 30,000 residents per clinician. Many of the most experienced and skilled practitioners are approaching retirement, as more than one-third of Texas psychiatrists are over the age of 55. Texas higher education institutions have been unable to produce enough graduates to meet the predicted demand.<sup>28</sup> The *Statewide Behavioral Health Strategic Plan* addresses increasing the number of mental health professionals in an objective under Goal 2: Program and Service Delivery of in the *Statewide Behavioral Health Strategic Plan*. Objective 2.4 aims to strengthen the behavioral health workforce by fiscal year 2021 with the following strategies:

2.4.1 Expand opportunities to address behavioral health workforce shortages in rural and urban areas through such activities as residency programs, student loan forgiveness, paid internships, and collaborations with universities.

2.4.2 Support and increase the competency of the workforce through joint training efforts, and continuing education in identified best, promising, and evidence-based practices.

2.4.3 Enhance the recruitment and retention of a diverse workforce.

Since the beginning of fiscal year 2017, the Coordinating Council has worked on implementation of the *Statewide Behavioral Health Strategic Plan* by identifying short term opportunities toward

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<sup>28</sup> The Mental Health Workforce Shortage in Texas: As Required by H.B. 1023, 83rd Legislature, Regular Session, 2014.

implementation. As an example of a short term opportunity, the participating agencies identified using The Centralized Training Infrastructure for Evidence Based Practices (CTI-EBP) as a centralized platform for communicating about trainings related to behavioral health.

## **Centralized Training Infrastructure for Evidence Based Practices**

The CTI-EBP is designed to aid the development of a training infrastructure to support the delivery of mental health services in Texas for the adult and youth populations. The project was developed as a mechanism to ensure providers contracted by HHSC and delivering mental health services did so using evidence-based practices. The infrastructure promotes and supports the use of evidence-based and promising practices to facilitate resiliency and recovery, and increase positive outcomes for individuals using behavioral health services in the Texas mental health system. HHS has contracted with the University of Texas Health Science Center, Department of Psychiatry, to coordinate and implement this project.

The training infrastructure includes evidence-based practices, including, but not limited to the following:

- Illness Management & Recovery
- Cognitive Adaptation Training (CAT)
- Cognitive Processing Training
- Social Skills and Aggression Replacement
- Nurturing Parent
- Motivational Interviewing
- Person Centered Recovery Planning

As of November 2016, approximately 18,869 providers completed online or face-to-face training modules within the infrastructure.

The CTI-EBP is free to those with HHS funded contracts and through partnerships with other state agencies. As of December 1, 2016, the CTI-EBP E-Commerce charges non-subsidized (non-HHSC contracted providers) for web-based training offering continuing education units.

Additionally, legacy DADS and the Department of State Health Services (DSHS) Mental Health and Substance Abuse (MHSA) Division

collaborated on a training for Direct Service Workers on the behavioral health needs of individuals with an IDD. The training is titled, Mental Health Wellness for Individuals with Intellectual and Developmental Disabilities (MHW-IDD). The MHW-IDD training was developed to address a gap in workforce knowledge of behavioral health issues that affect individuals with IDD. It is available for free to the public and is also offered on the CTI-EBP. The training is expected to maximize workforce training, ensure development of a competent workforce, and impact workforce retention and appropriate service delivery. The MHW-IDD training series officially rolled out in June 2016, with the trauma-informed care module being rolled out ahead of the others in January 2016. Since the rollout of the entire training series in June 2016, there has been an average of 592.55 modules completed per week

## **Home and Community-Based Services Adult Mental Health Program**

The 83rd Legislature, Regular Session, 2013, required DSHS to establish an HCBS program for adults with serious mental illness (SMI) and a history of extended inpatient psychiatric hospital stays. The Legislature further directed HHSC and Legacy DSHS MHSA Division to seek a Medicaid state plan amendment under §1915(i) of the Social Security Act. Texas received federal approval from CMS on October 13, 2015. In addition, the 84th Legislature, Regular Session, 2015, required DSHS to expand HCBS to divert populations with serious mental illness from jails and emergency departments into community treatment programs. HHSC formally submitted the state plan amendment to expand the 1915(i) to CMS on May 20, 2016. CMS has reviewed the amendment and has requested two rounds of additional information to date. HHSC anticipates approval in fiscal year 2017. HHS operates the expansion using GR until CMS has approved the expansion.

The HCBS-Adult Mental Health (AMH) program provides home and community-based services and supports to help individuals achieve stable tenure in their community of choice. HCBS-AMH services are provided in addition to traditional state plan benefits and include residential services, employment services, nursing, peer support,

adaptive aids, minor home modifications, home delivered meals, non-medical transportation, psychosocial rehabilitation, substance use disorder services, and recovery management. As of October 2016, the state has executed contracts with Texoma Community Center to provide both HCBS-AMH comprehensive service array and recovery management in Sherman, Texas. In addition, HHSC has two additional recovery management executed contracts and one additional comprehensive service provider executed contract. There are 17 additional contracts which, once executed, will serve eight additional service regions aligned with the LMHA service regions. Once executed, HCBS-AMH referrals will open in the following service regions:

- Dallas Emergence
- Gulf Coast
- Harris
- Helen Farabee
- Tarrant
- Texana
- Tropical

Currently HCBS-AMH has 10 individuals enrolled: 8 who meet long-term hospitalization criteria, 1 meeting jail diversion criteria, and 1 meeting emergency room diversion criteria. Exponential enrollment is anticipated as providers ramp-up to implementation in the service areas.

## **Money Follows the Person Demonstration Behavioral Health Pilot**

In 2008, Texas began a five-year Behavioral Health Pilot (BHP) under the federal MFPD grant from CMS. The BHP operated in several central Texas counties, including Bexar and Travis. It was designed to help adult Medicaid clients with serious mental illness and substance use disorders leave nursing facilities. Participants in the pilot were MFPD eligible, met a nursing facility level of care, and were transitioning into the STAR+PLUS HCBS waiver. The pilot has enabled Texas to test the efficacy of new services and techniques for this special population. The pilot served 125 individuals in fiscal year 2016. Since inception, the pilot has served more than 425 individuals.

Pilot participants have ranged in age from 27 to 89 and have multiple health challenges, including chronic health conditions, physical disabilities, serious mental illness, and substance use disorders. Pilot services included community-based substance abuse treatment and CAT, a rehabilitative service designed to help individuals establish daily routines, organize their environment, and build social skills. Services were provided up to six months before discharge (pre-transition) and up to one year after discharge. Services are critical as they provide tools to support skill acquisition, including improvement in medication adherence, personal care, activities of daily living, social skills, and integration into the community. In addition, pilot participants receive transition assistance, relocation assistance, and receive STAR+PLUS HCBS waiver services through their Medicaid MCO.

Outcomes for those who participated in the pilot include:

- over 425 individuals have transitioned to the community;
- 70 percent successfully completed a year in the community and over 65 percent remain in the community to date;
- cost of living in the community under the BHP was 71 percent of the cost of living in a nursing facility; and
- it takes only 1.4 months of community residence to recover initial program costs.

Examples of increased independence include getting a paid job at competitive wages, driving to work, volunteering, getting a GED, teaching art classes, leading substance use peer support groups, and working toward a college degree.

Funding for clinical services from this five-year demonstration pilot has ended and individuals are being transitioned to other community providers. As approved in the *MFPD Sustainability Plan*, the state will bring the evidence-based behavioral health practices piloted under MFPD to scale, systematically incorporating and sustaining them in STAR+PLUS, the statewide integrated managed care system for adults. As of September 1, 2014, STAR+PLUS included mental health rehabilitation and substance use treatment in its service array.

Beginning in 2016, legacy DSHS MHSA Division used MFPD administrative funds to provide training and technical assistance to MCOs and their networks to enable them to deliver evidence-based rehabilitative services. In addition, with MFPD administrative funds,

the University of Texas Health Science Center in San Antonio has created a learning community with resources to assist MCOs in understanding the implications of substance use disorders for institutionalized populations and provide them with strategies to deliver substance use disorder services to individuals transitioning from institutions.

### **Money Follows the Person Demonstration Self-directed Services Pilot Program for Individuals with Mental Illness**

As part of the MFPD Behavioral Health Pilot, Texas is piloting evidence-based self-directed services for people with mental illness in the statewide managed care system. Self-directed service options provide individuals with the ability to manage a flexible budget to purchase Medicaid services and supports. Self-directed care options provide the most complete expression of “money following the person” by empowering individuals with tools designed to assist them in living the lives they choose in the communities they desire. Additionally, client choice promotes recovery and increases the likelihood that individuals will return to and remain in their communities. Historically, in Texas, self-direction has been available to individuals receiving community-based personal attendant and HCBS waiver services, but not to individuals with severe mental illness who are receiving community-based mental health services and supports.

Texas has the opportunity to pioneer self-direction with this population. A recent randomized trial of self-directed mental health services in a capitated behavioral health carve-out program in the Dallas service delivery area demonstrated very positive outcomes, including better functioning, higher satisfaction, and lower institutional costs with no greater expenditure of funds than in the traditional system of care. To create sustainable mental health self-directed care options in the Medicaid system, Texas proposes to develop and implement a pilot program in the statewide integrated behavioral/physical health managed care system for adults with disabilities (STAR+PLUS). MFPD administrative funds support planning, stakeholder involvement, and administration of the self-directed pilot and enables the state to develop the structures, processes, and

policies needed to successfully bring mental health self-direction to scale in the statewide managed care system.

## 7. Relocation Services

Relocation assistance includes outreach about community living, assessment of transition needs, and coordination of transition services. Housing assistance is provided if needed, as well as one-time funds to purchase household goods to assist in the transition from an institution to the community. Historically, CILs and an Aging and Disability Resource Center provided relocation services for those transitioning from nursing facilities to the STAR+PLUS HCBS waiver. Since the nursing facility carve-in to managed care in March 2015, managed care organizations, through their service coordination activities, have played an increasing role in assessment and relocation assistance for their members in nursing facilities who wish to return to the community. Continued efforts to ensure residents are educated about their options and appropriately supported in their choice to move to the community in the redesigned service delivery system are ongoing through the development of new roles and relationships between the MCOs and the organizations that have historically provided relocation services.

Recent efforts in response to stakeholder input have focused on supporting members who are ventilator dependent transition to the community.

### Ventilator Workgroup

HHS convenes a quarterly workgroup meeting with MCO staff, nursing facility staff, advocates, an individual who is ventilator dependent, and staff who provide services to her in the community. One of the purposes of the workgroup is to track the number of individuals residing in nursing facilities, how many have requested to leave the facility, and how many live in the community.

HHS data from July 2016 suggest MCOs have a process to facilitate community options with more than 300 individuals receiving services outside of a nursing facility. The number of ventilator-dependent members in a nursing facility is less than half of those receiving

ventilator care in the community. Of the 151 ventilator-dependent individuals currently in a nursing facility, less than one percent have expressed a desire to return to the community.

The group also identifies barriers and potential solutions to relocating institutionalized ventilator-dependent members to the community.

The workgroup prioritized several areas for additional effort including:

- more robust quarterly reporting by MCOs of the number of ventilator-dependent members residing in nursing facilities;
- educational material for informed decision making by the member or Legally Authorized Representative;
- adequate community supports and services; and
- continued identification of any unknown obstacles preventing community transitions.

## 8. Housing

One of the barriers to successful relocation from an institutional setting is the lack of affordable, accessible, and integrated housing. Integrated housing is defined as normal, ordinary living arrangements typical of the general population. Integrated housing is achieved when individuals with disabilities have the choice of ordinary, typical housing units located among individuals who do not have disabilities or other special needs.

This section provides an update of accomplishments by HHS in partnership with the Texas Department of Housing and Community Affairs (TDHCA) and local public housing authorities.

### Multi-Agency Collaboration

Collaboration between state agencies is the foundation for continued efforts to address housing barriers for those who desire to live in the most integrated setting. The Housing and Health Services Coordination Council role “is to increase state efforts to offer Service Enriched Housing through increased coordination of housing and health services.”<sup>29</sup> This council, created by S.B. 1878, 81st Legislature, Regular Session, 2009, is composed of 17 members: 8 members appointed by the Governor and 9 state agency representative members from HHS, the Texas Department of Agriculture, Texas Veterans Commission, and Texas State Affordable Housing Corporation.<sup>30</sup> While the scope of the Housing and Health Services Coordination Council is broader than those leaving institutions, it offers another forum for discussion and problem solving.

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<sup>29</sup> See: <http://www.tdhca.state.tx.us/hhsc/>.

<sup>30</sup> The HHSCC 2016-2017 Biennial Plan and the Report of Findings and Recommendations of the Housing and Health Services Coordination Council are available on the TDHCA website at: <http://www.tdhca.state.tx.us/hhsc/biennial-plans.htm>

## **Texas Department of Housing and Community Affairs Section 811 Project Rental Assistance Program**

The Section 811 PRA Program provides project-based rental assistance for persons with extremely low incomes who have a disability and receive services and supports. Texas' Section 811 PRA serves the following target populations:

- persons with disabilities exiting institutions (e.g., nursing facilities and ICF/IID), who are eligible to receive long-term services and supports through a Medicaid waiver;
- persons with SMI who receive services through HHS; and
- youth or young adults with disabilities exiting DFPS foster care.

The rental assistance covers the difference between the tenant payment (no more than 30 percent of the household's income) and the property's asking rent. The program is a collaboration between TDHCA, HHS, participating properties, and local disability service organizations. The Section 811 PRA creates the opportunity for persons with disabilities to live as independently as possible through the coordination of voluntary services and supports and subsidized, integrated rental housing. Individuals with disabilities, service providers, and state agency partners determined the target populations. Effective November 2016, 5 households had moved into units and 23 were on a wait list.

Based in part on Texas' efforts to create community-integrated housing options for persons with disabilities and TDHCA's ongoing collaboration with HHS to jointly operate a housing voucher program (see Project Access, below), TDHCA was awarded funding from the Department of Housing and Urban Development (HUD) Fiscal Year 2012 Section 811 PRA Program Demonstration round to support approximately 350 units of affordable, accessible, and integrated housing.

Texas applied for and was approved by HUD for an additional \$12 million to support approximately 296 additional units under HUD's Fiscal Year 2013 Section 811 PRA Program round.

Due to complexities with 811 PRA, developers are not inclined to participate unless incentivized to do so. Therefore, in the 2015 and 2016 Competitive Housing Tax Credit Application Cycles, Texas included in its *Housing Tax Credit Qualified Allocation Plan* points for developers to participate in Section 811 PRA.

PRA can be applied to new or existing multifamily developments owned by a nonprofit or private entity with at least five housing units if the developments received funding or are in the process of applying for funding through TDHCA's multifamily housing programs and/or any federal agency or any state or local government program. TDHCA multifamily housing programs include:

- Housing Tax Credit Program
- Multifamily Bond Program
- Multifamily Direct Loan Program
- Neighborhood Stabilization Program
- Housing Trust Fund

Only properties located in the following Metropolitan Statistical Areas are eligible to participate in the program:

- Austin-Round Rock
- Brownsville-Harlingen
- Corpus Christi
- Dallas-Fort Worth-Arlington
- El Paso
- Houston-The Woodlands-Sugar Land
- McAllen-Edinburg-Mission
- San Antonio-New Braunfels

As of January 2017, TDHCA has executed Owner Participation Agreements with 39 properties committing an average of 10 units each to the Section 811 PRA. Approximately two-thirds are still under construction and will become available later this year or next year. As units become available in these properties, they are offered to qualified Section 811 PRA households. The Owner Participation Agreement has a term of 30 years and ensures participating properties and TDHCA work together to complete program requirements.

## **Project Access Vouchers (Section 8 Housing Choice Vouchers)**

Project Access (PA) was originally a pilot program developed by HUD and the U.S. Department of Health and Human Services operated within the Section 8 Housing Choice Voucher Program. The goal of the pilot program was to assist low-income, non-elderly persons with disabilities to transition out of institutions into the community by providing access to affordable housing and necessary supportive services.

TDHCA applied for the pilot program and received 35 Section 8 housing vouchers from HUD in 2001. After the expiration of the HUD pilot program in 2003, the TDHCA governing board elected to continue the program out of a portion of its own traditional Section 8 vouchers in recognition of housing need and expressed public interest. TDHCA has continued to operate the program since then with periodic increases in the number of PA vouchers. In 2013, the TDHCA governing board elected to increase the voucher to 140. It should be noted the staff member at TDHCA who administers the PA Program is funded in part through the MFPD grant. Through the support of MFPD funds, TDHCA was able to administratively absorb the increase in vouchers.

The program is designed to “recycle” vouchers. A voucher is recycled when local housing authorities are able to absorb the cost of a PA voucher originally issued by TDHCA. When this occurs, the TDHCA voucher funds are freed up to be made available to offer a voucher to another individual on the PA wait list. As of October 31, 2016, over 1,320 households have used the voucher program.

TDHCA set a goal for the PA program to assist 165 households in 2018 and 165 households in 2019.<sup>31</sup>

### **Project Access Pilot Program**

Since 2012, 10 of the 140 PA housing vouchers were reserved for persons exiting state psychiatric hospitals who are participating in a

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<sup>31</sup> TDHCA 2018-2019 Legislative Appropriations Report, <https://www.tdhca.state.tx.us/bond-finance/docs/LAR-2018-2019-Final.pdf>

pilot program coordinated by TDHCA and DSHS. The PA Pilot Program uses Housing Choice Vouchers to help low-income people with disabilities transition from state-funded psychiatric hospital beds into the community by providing access to affordable housing. Eligible applicants must meet the disability criteria and either be a current resident of a state-funded psychiatric hospital or have been discharged from a state-funded psychiatric hospital within 60 days of the application date.

Since the program started, over 108 individuals have been referred and assisted with a Project Access Voucher.<sup>32</sup>

## **HOME Investment Partnerships Program Tenant-Based Rental Assistance**

HOME Tenant-Based Rental Assistance (TBRA) is funded by the federal HOME Investment Partnerships Program focusing on serving rural and special needs populations.

If a TDHCA local TBRA administrator is operating in the area, individuals exiting an institution can use this program to obtain rental assistance while waiting for a PA voucher (contingent upon eligibility and funding). Eligible individuals receive the PA voucher when their names comes up on the PA wait list. While participating in the TDHCA TBRA program, an individual will not lose their place on the wait list for a PA voucher.

TDHCA does not set aside HOME TBRA rental assistance funds for this transition activity. Relocation contractors or other entities providing relocation assistance to individuals leaving nursing facilities can work with a local TBRA administrator to implement this process. The TDHCA TBRA administrator can choose to use existing TBRA resources to provide temporary rental assistance (potentially for up to five years, contingent upon funding availability) to individuals moving from a nursing facility to a community setting. The temporary rental assistance is made available until the individual's name comes up on the PA or a public housing authority wait list.

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<sup>32</sup> DSHS, Project Access Pilot Program (March 21, 2016).

From 2013 through 2015, TDHCA's HOME TBRA program has assisted 25 households transition to the community using HOME TBRA funds while they waited to come up on the PA waiting list. Funding remains available to support this population. The average rental assistance amount provided under the TBRA Program to this population was \$4,998, and the average assistance term was about 10 months.

## **Amy Young Barrier Removal Program**

The Amy Young Barrier Removal (AYBR) program is a TDHCA program funded by the Texas Housing Trust Fund (HTF). HTF was established by the 72nd Legislature in 1991, to provide loans, grants, or other comparable forms of assistance to individuals and families with low- and very low-incomes to finance, acquire, rehabilitate, and develop decent, safe, and sanitary housing.

Funding sources consist of appropriations or transfers made to the fund, unencumbered fund balances, and public or private gifts or grants. HTF provides greater funding flexibility and has fewer regulatory restrictions than federally-funded programs. As a result, AYBR funds can be more easily tailored to meet the unique needs of Texans with low-incomes who have disabilities.

The AYBR program supports people with disabilities needing housing modifications. Launched in 2010, the program is named in honor of the late Amy Young, an advocate for Texans with disabilities. The program provides one-time grants up to \$20,000 for people with disabilities who need home modifications to increase accessibility and eliminate hazardous conditions. Program beneficiaries must include a person with a disability (any age), must have a household income not exceeding 80 percent of the Area Median Family Income, and may be tenants or homeowners. Of the \$20,000 total grant, at least 75 percent must be applied toward barrier removal, with no more than 25 percent applied to correction of unsafe and hazardous housing conditions. Common modifications include: installing handrails and ramps; widening doors; adjusting countertops and cabinets to appropriate heights; installing buzzing or flashing devices; installing accessible showers, toilets, and sinks; and customizing other modifications based on the participants' unique needs. People who participate in the AYBR program can remain in their communities,

maintain existing social networks, and decrease dependence on institutional assistance.

AYBR administrators are Texas nonprofit organizations and local governments which process intake applications, verify eligibility, work with program beneficiaries to design modifications, and oversee construction.

For the 2016-2017 biennium, TDHCA allocated \$3,051,925 for the AYBR program. To promote equitable funds distribution across the state, HTF applies a geographic allocation formula to the program funds. Per this formula, both rural and urban regions of the state have a predetermined amount reserved only for their region for the initial period of funding availability. After this period, any remaining funds are rolled into one pool for use by any AYBR administrator across the state. This reservation system model expedites program approvals through an encrypted, paperless, online system which makes funds available on a first-come, first-served basis.

Since 2010, the AYBR Program has assisted Texans with disabilities in over 827 households increase their independence through creative design and barrier removal. In state fiscal year 2016 alone, HTF and AYBR program administrators modified 105 homes to become more accessible and safe.

## 9. Employment

### Money Follows the Person Demonstration Supported Employment

MFPD funded several projects designed to improve the competitive, integrated employment possibilities for individuals with IDD. In December 2016, HHS concluded a five year employment pilot designed to help individuals with disabilities achieve meaningful, competitive employment in an integrated community setting. The two participating providers, a LIDDA and an HCS provider, transformed their organizations from relying on day program services to community-based, integrated employment. The Texas Center for Disability Studies at the University of Texas evaluated the pilot to determine successful approaches to improving employment outcomes through organizational change activities.<sup>33</sup>

Changes implemented by the two participating agencies included:

- a revised mission statement to address the employment first philosophy;
- policies and procedures created to ensure all staff, individuals served, and their families are aware of the agency's focus on competitive employment;
- intake policies and procedures that offered employment services as the first option for people seeking services (e.g. DADS funded services) at intake;
- employment program policies and procedures that incorporated the use of the evidence-based, person centered Individual Placement and Support model of Supported Employment;
- depending on the particular needs of participants, employment specialist to provide job readiness training (concurrently) as part of employment assistance;

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<https://disabilitystudies.utexas.edu/sites/default/files/DADS%20Report%20FINAL.pdf>

- an employment program to serve individuals in any program or county served by the provider, along with a referral process service coordinators can use to refer people to the program;
- a referral process to support people who request services provided by legacy DARS or its predecessor;
- close collaboration between the employment program and service coordination;
- a professionally trained work force of employment specialists that provide only employment services;
- adaptation of the onsite resale/thrift store to serve as a vocational training center for participants;
- informational presentations and trainings about benefits, work incentives, and reporting income to Social Security; and
- a tracking application to track jobs available in the community.

More than 100 people participated in the customized employment pilot between January 2014 and July 2016. Pilot evaluation results indicated that 50 percent of the 30 participants tracked over time were successfully placed in competitive employment in integrated settings. They received employment services in coordination with other services and supports provided through HHS's 1915(c) waiver programs.

Lessons learned from the customized employment pilot include:

- Inter-agency collaboration between HHS and the Texas Workforce Commission (TWC) proved helpful with enhancing employment outcomes for participants in the pilot.
- Job readiness training provided to participants prior to seeking employment resulted in successful job placement.
- Collaboration between employment service providers and local community employers resulted in successful job placements.
- Benefits and work incentives training alleviated concerns regarding maintaining benefits while also participating in competitive, integrated work in the community.

MFPD also funds an employment specialist who conducts outreach and education with businesses throughout the state to increase employment opportunities for individuals with IDD who use Medicaid services. In collaboration with TWC, MFPD funds a position to provide training and technical assistance to Medicaid providers, Community Rehabilitation Programs, and HHS staff.

## **10. Workforce and Provider Stabilization**

Direct support workers, typically referred to as attendants, provide the majority of services to consumers in a number of community-based programs. Texas faces serious challenges in meeting current and future needs for a stable and adequate attendant workforce. The demand for new attendants in Texas is expected to increase substantially over the next decade due to numerous factors, including the aging of the baby boomer generation, the aging of family caregivers, and the increasing prevalence of various disabilities. Meanwhile, retention of attendants has long been a challenge as high rates of job turnover exist throughout the state. Low compensation is a significant issue with attendant wages in Texas ranking among the lowest in the nation. Higher wages contribute to a more stable workforce and improved service quality.

### **Recruitment and Retention of Direct Service Workforce**

The 84th Legislature, Regular Session, 2015, appropriated \$38.1 million GR and \$88.9 million All Funds to increase the base wage for attendants by \$0.14 to \$8.00 an hour. This represented a 1.7 percent increase. Even though millions of dollars were appropriated to raise the minimum wage of attendants over the federal minimum wage, cost of living increases outweigh the increase in attendant wages. Therefore, providers had difficulty hiring and retaining qualified attendants.

The 2016-2017 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, HHSC, Rider 89) directed HHSC to develop recruitment and retention strategies to address the projected shortage of community attendants. In response, HHS is collecting data from LTSS providers who provide attendant services through cost reports and a provider survey. The 2015 cost reports collected data on

attendant hourly wages, benefits and turnover. The survey, which was conducted online, collected detailed data on:

- initial wages paid to attendants;
- basis of wage increases (e.g., additional training completed; length of employment; merit-based increases);
- additional opportunities for wage enhancements for certain attendant types, such as:
  - ▶ bilingual and American Sign Language proficient attendants;
  - ▶ attendants working in high wage areas of the state;
  - ▶ attendants working in remote areas of the state;
  - ▶ attendants working with high needs consumers; and
- estimated time required to fill an attendant vacancy; and
- average length of employment for direct care workers.

Results will be available in a separate report.

## **Money Follows the Person Demonstration Funded Direct Workforce Training**

Increasingly, Texas is losing providers of direct services, direct service workers, physicians, licensed nurses, and other professionals who provide LTSS to all individuals regardless of disability or age. Serving individuals with complex needs, including co-occurring and multiple occurring needs, is becoming very challenging as the state competes with the private sector for contracts with specialists and providers who can serve these individuals. It is critical for LTSS provider agencies and managed care systems to have adequate numbers of direct service workers and other network providers in place to serve all individuals in a community-based setting.

In 2016, the state used MFPD rebalancing funds to develop a computer-based training for staff who provide community-based services to individuals with complex behavioral and/or medical needs. The training was offered in response to direct service worker survey results indicating the need for additional training on this topic. In addition, MFPD funded five in-person workshops for providers on positive behavior outcomes.

In fiscal year 2017, the state is using MFPD funds to:

- hold six forums on trauma-informed care for direct service workers and professionals across the state;
- develop a computer-based training on trauma informed care, leveraging information gathered from the training forums;
- provide statewide training and resources on caring for an individual with Alzheimer's disease; and
- facilitate multiple meetings across the state on the Consumer Directed Services Option, which is structured to allow the individual to pay the provider a slightly higher hourly wage compared to agencies.

## 11. Conclusion

The state has made significant progress offering Texans community-based alternatives to institutional placement due to a significant increase in legislative appropriations during the past six legislative sessions. Even with support through funding and policy changes, a large number of individuals continue to remain in institutions or remain on an interest list for Medicaid waiver services.

HHSC and the HHS system remain committed to maintaining relationships with stakeholders. Stakeholders, including individual and families, service providers, and advocacy groups provide valuable input on the state's progress implementing the existing and previous plans and make recommendations to ensure community options for individuals with disabilities. HHSC will continue to seek stakeholder input on progress, challenges, and recommendations for improvement in future biennial revisions of the plan.

## **List of Acronyms**

<b>Acronym</b>	<b>Full Name</b>
ADA	Americans with Disabilities Act of 1990
AYBR	Amy Young Barrier Removal
BHP	Behavioral health pilot
CAT	Cognitive Adaptation Training
CBA	Community Based Alternatives
CFC	Community First Choice
CIL	Center for independent living
CLASS	Community Living Assistance and Support Services
CMS	Centers for Medicare and Medicaid Services
COSP	Consumer operated service providers
CPS	Child Protective Services
CTI-EBP	Centralized training infrastructure for evidence based practices
DADS	Department of Aging and Disabilities Services
DARS	Department of Assistive and Rehabilitative Services
DBMD	Deaf Blind with Multiple Disabilities
DFPS	Department of Family and Protective Services
DSHS	Department of State Health Services
ECC	Enhanced Community Coordination
GR	General revenue
GRO	General residential operations
HCBS	Home and community based services
HCS	Home and Community-based Services program for individuals with an intellectual disability
HHS	Health and Human Services
HHSC	Health and Human Services Commission

H.B.	House Bill
HTF	Housing trust fund
HUD	Department of Housing and Urban Development
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
IDD	Intellectual or developmental disability
ILS	Independent living services
Initiative	Promoting Independence Initiative
JMC	Joint managing conservatorship
LAR	Legislative appropriations request
LIDDA	Local intellectual and developmental disability authority
LMHA	Local mental health authority
LTSS	Long term services and supports
MCO	Managed care organization
MDCP	Medically Dependent Children Program
MFPD	Money Follows the Person Demonstration
MHSA	Mental Health and Substance Abuse
MHW-IDD	Mental Health Wellness for Individuals with Intellectual and Developmental Disabilities
PA	Project Access
PCSP	Parental Child Safety Placement
PIAC	Promoting Independence Advisory Committee
PRA	Project Rental Assistance
QA	Quality assurance
RFP	Request for Proposals
S.B.	Senate Bill
SMI	Serious mental illness
SRAC	System redesign advisory committee
SSLC	State supported living center
STAR+PLUS	State of Texas Access Reform+ PLUS

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STAR+PLUS HCBS	State of Texas Access Reform+ PLUS Home and Community Based Services program
TBRA	Tenant-Based Rental Assistance
TDHCA	Texas Department of Housing and Community Affairs
TWC	Texas Workforce Commission
TxHmL	Texas Home Living program
U.S.	United States
YES	Youth Empowerment Services

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## Appendix A. Executive Order GWB 99-2

EXECUTIVE ORDER GWB 99-2

by the GOVERNOR OF THE STATE OF TEXAS Executive Department Austin, Texas

RELATING TO COMMUNITY-BASED ALTERNATIVES FOR PEOPLE WITH DISABILITIES

WHEREAS, The State of Texas Is committed to providing community-based alternatives for people with disabilities and recognizes that such services advance the best interests of all Texans; and

WHEREAS, Texas seeks to ensure that Texas' community-based programs effectively foster independence and acceptance of people with disabilities; and

WHEREAS, programs such as Community Based Alternatives and Home and Community Services provide the opportunity for people to live productive lives in their home communities; and

WHEREAS, as Governor, I have been a consistent advocate for increasing funds to expand community-based services for the elderly and people with disabilities and, working with the Legislature, have increased funding for such programs by more than \$1.7 billion, a 72 percent increase, since taking office; and

WHEREAS, the 76th Legislature has provided funding to allow an additional 15,000 Texans to live outside of institutional settings through our Medicaid waiver and non-waiver community services; and

WHEREAS, Texas must build upon its success and undertake a broader review of our programs for people with disabilities and ensure services offered are in the most appropriate setting.

NOW, THEREFORE, I, GEORGE W. BUSH, GOVERNOR OF TEXAS, by virtue of the power vested in me, do hereby order the following directives:

1. The Texas Health and Human Services Commission (HHSC) shall conduct a comprehensive review of all services and support systems available to people with disabilities in Texas. This review shall analyze the availability, application, and efficacy of existing community-based alternative for people with disabilities. The review shall focus on identifying affected populations, improving the flow of information about supports in the community, and removing barriers that impede opportunities for community placement. The review shall examine these issues in light of the recent Supreme Court decision in *Olmstead v. Zimring*.

2. HHSC shall ensure the involvement of consumers, advocates, providers and relevant agency representatives in this review.
3. HHSC shall submit a comprehensive written report of its findings to the Governor, the Lieutenant Governor, the Speaker of the House, and the appropriate committees of the 77th Legislature no later than January 9, 2001. The report will include specific recommendations on how Texas can improve its community-based programs for people with disabilities by legislative or administrative action.
4. All affected agencies and other public entities shall cooperate fully with HHSC's research, analysis, and production of the report. This report should be made available electronically.
5. As opportunities for system improvements are identified, HHSC shall use its statutory authority to effect appropriate changes.

George W. Bush, Governor of Texas

Filed: September 28, 1999

## Appendix B. Executive Order RP 13

EXECUTIVE ORDER RP 13

by the GOVERNOR OF THE STATE OF TEXAS Executive Department  
Austin, Texas April 18, 2002

**WHEREAS**, The State of Texas is committed to providing community-based alternatives for people with disabilities and recognizes that such services and supports advance the best interests of all Texans; and

**WHEREAS**, it is imperative that consumers and their families have a choice from among the broadest range of supports to most effectively meet their needs in their homes, community settings, state facilities or other residential settings; and

**WHEREAS**, as Governor, I am committed to ensuring that people with disabilities have the opportunity to enjoy full lives of independence, productivity and self-determination; and

**WHEREAS**, working with the Texas Legislature last session as Governor, I signed legislation totaling \$101.5 million dollars in general revenue to expand community waiver services; and

**WHEREAS**, also last session, I signed legislation promoting independence for people with disabilities and directing agencies to redesign service delivery to better support people with disabilities; and

**WHEREAS**, programs such as Community Based Alternatives, Home and Community-based Services, and other community support programs provide opportunities for people to live productive lives in their home communities; and

**WHEREAS**, accessible, affordable and integrated housing is an integral component of independence for people with disabilities; and

**WHEREAS**, Texas recognizes the importance of keeping children in families, regardless of a child's disability, and support services allow families to care for their children in home environments;

**NOW, THEREFORE**, I, Rick Perry, Governor of Texas, by virtue of the power and authority vested in me by the Constitution and laws of the State of Texas, do hereby order the following:

Review of State Policy. The Texas Health and Human Services Commission ("HHSC") shall review and amend State policies that impede moving children and adults from institutions when the individual desires the move, when the State's treatment professionals determine that such placement is appropriate, and when such placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others who are receiving state-supported disability services.

Promoting Independence Plan. The Health and Human Services Commission shall ensure the Promoting Independence Plan is a comprehensive and effective working plan and thorough guide for increasing community services. HHSC shall regularly update the plan and shall evaluate and report on its implementation. In the Promoting Independence Plan, HHSC shall report on the status of community-based services. In the plan, HHSC shall:

1. update the analysis of the availability of community-based services as a part of the continuum of care;
2. explore ways to increase the community care workforce;
3. promote the safety and integration of people receiving services in the community; and
4. review options to expand the availability of affordable, accessible and integrated housing.

Housing. The Health and Human Services Commission shall incorporate the efforts of the Texas Department of Housing and Community Affairs ("TDHCA") to assure accessible, affordable, and integrated housing in the recommendations of the Texas Promoting Independence Plan.

The Texas Department of Housing and Community Affairs shall provide in-house training of key staff on disability issues and technical assistance to local public housing authorities in order to prioritize

accessible, affordable, and integrated housing for people with disabilities.

The Texas Department of Housing and Community Affairs and HHSC shall maximize federal funds for accessible, affordable, and integrated housing for people with disabilities. These agencies, along with appropriate health and human services agencies, shall identify, within existing resources, innovative funding mechanisms to develop additional housing assistance for people with disabilities.

Employment. The Health and Human Services Commission shall direct the Texas Rehabilitation Commission and the Texas Commission for the Blind to explore ways to employ people with disabilities as attendants and review agency policies so they promote the independence of people with disabilities in community settings.

The Health and Human Services Commission shall coordinate efforts with the Texas Workforce Commission to increase the pool of available community-based service workers and to promote the new franchise tax exemption for employers who hire certain people with disabilities.

Families. The Health and Human Services Commission shall work with health and human services agencies to ensure that permanency planning for children results in children receiving support services in the community when such a placement is determined to be desirable, appropriate, and services are available.

The Health and Human Services Commission shall move forward with a pilot to develop and implement a system of family-based options to expand the continuum of care for families of children with disabilities.

Selected Essential Services Waiver. Dependent on its feasibility, HHSC shall direct the Texas Department of Mental Health and Mental Retardation to implement a selected essential services waiver, using existing general revenue, in order to provide community services for people who are waiting for the Home and Community-based Services waiver.

Submission of Plan. The Health and Human Services Commission shall submit the updated Texas Promoting Independence Plan to the Governor, the Lieutenant Governor, the Speaker of the House, and the

appropriate legislative committees no later than December 1st each even numbered year, beginning with December 1, 2002.

All affected agencies and other public entities shall cooperate fully with the Health and Human Services Commission during the research, analysis, and production of this plan. The plan should be made available electronically.

This executive order complements GWB 99-2 and supersedes all previous executive orders on community-based alternatives for people with disabilities. This order shall remain in effect until modified, amended, rescinded, or superseded by me or by a succeeding Governor.

Given under my hand this the 18th day of April, 2002.

RICK PERRY (signature) Governor

GWYNN SHEA (signature) Secretary of State