



**2014/2015**  
**Revised Texas Promoting  
Independence Plan**

**In Response To**  
**S.B. 367, 77<sup>th</sup> Texas Legislature, Regular Session, 2001**  
**And**  
**Executive Order RP-13**

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**Health and Human Services Commission**  
**May 2016**

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## EXECUTIVE SUMMARY

The *2014/2015 Revised Texas Promoting Independence Plan* (Plan) is the seventh update to the original plan submitted in January 2001. Texas' Plan is a direct response to the Supreme Court of the United States (Supreme Court) ruling in *Olmstead v. L.C.*, 119 S.Ct. 2176 (1999) (*Olmstead*) which requires states, within certain conditions, to provide individuals an opportunity to live in the most integrated setting in order to receive their long-term services and supports.

### INTRODUCTION

The Plan serves several purposes. First, the Plan provides the comprehensive working plan called for as a response to the Supreme Court ruling in *Olmstead*. Second, the Plan meets the requirements of the report required by Executive Order, RP-13<sup>1</sup> and §531.0244, Texas Government Code<sup>2</sup> which direct the Health and Human Services Commission (HHSC) to develop a plan to ensure appropriate care settings for individuals with disabilities, and the provision of a system of services and supports that foster independence and productivity, including meaningful opportunities for an individual with a disability to live in the most appropriate care setting, and to report the status of the implementation of the plan. Finally, the Plan serves as an analysis of the availability, application, and efficacy of existing community-based supports for individuals with disabilities.

The *2014/2015 Plan*<sup>3</sup> continues the work of the original plan and will help Texas reach its ultimate goals of individual choice and self-determination for people with disabilities.

### BACKGROUND

The purpose, comprehensive nature, and implications of the Texas Promoting Independence Initiative (Initiative) must be understood within the context of the history of the Initiative and all relevant information related to the *Olmstead* decision. In June 1999, the Supreme Court affirmed a judgment in the *Olmstead* case, which has had far reaching effects for states regarding services for individuals with disabilities. This case was filed in Georgia, on behalf of two individuals with mental and cognitive disabilities living in state operated institutions. The individuals claimed a right to care in an integrated setting based on the guarantees under Title II of the Americans with Disabilities Act of 1990 (ADA).<sup>4</sup>

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<sup>1</sup> Executive Order RP-13 follows Executive Order GWB 99-2 as the second community-based alternatives Executive Order. See Appendix B for Executive Order GWB 99-2 and Appendix C for Executive Order RP-13.

<sup>2</sup> As enacted by S.B. 367, 77<sup>th</sup> Legislature, Regular Session, 2001.

<sup>3</sup> The 2014/2015 Plan reflects actions of the 84<sup>th</sup> Legislature, on-going system reforms, and additional recommendations that are contingent on legislative direction and, when necessary, appropriations.

<sup>4</sup> 42 U.S.C § 12131 *et seq.*

Following the *Olmstead* decision, HHSC embarked on the Initiative and appointed members to the Promoting Independence Advisory Board (Board)<sup>5</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>6</sup> The original *Plan* was submitted to the Governor and state leadership on January 9, 2001. Passage of S.B. 367, 77<sup>th</sup> 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 state's efforts regarding the Initiative and community-based alternatives for individuals with disabilities.

## PROMOTING INDEPENDENCE ADVISORY COMMITTEE

Within the state of Texas, the Promoting Independence Advisory Committee (PIAC) is acknowledged as one of the leading forums in providing policy leadership and oversight of the long-term services and supports system. The purpose of the PIAC is to assist HHSC in developing a comprehensive, effectively working plan to ensure appropriate care settings for persons with disabilities. The executive commissioner for HHSC appoints members to the PIAC. Texas Government Code § 531.02441 specifies that members must include representatives of appropriate health and human service agencies, representatives of related workgroups, representatives of consumer advocacy groups, and representatives of service providers for individuals with disabilities.

The *2014/2015 Plan* is based on recommendations made by PIAC<sup>7</sup> in its *2014 Promoting Independence Advisory Committee Stakeholder Report*<sup>8</sup> submitted to HHSC as required by §531.02441(i), Texas Government Code. PIAC meets on a quarterly basis to:

- Continue the work of the Initiative;
- Coordinate and oversee the implementation of the *Plan*;
- Provide ongoing policy discussions on issues pertaining to community integration; and
- Recommend policy initiatives for the *Plan*.

PIAC is charged with two additional functions. First, it serves as a Development and Implementation Committee for the execution of Community First Choice (CFC) as a state plan option. Second, it functions as the Money Follows the Person Demonstration Advisory Committee.

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<sup>5</sup> The Promoting Independence Advisory Board is now the Promoting Independence Advisory Committee.

<sup>6</sup> The original Texas Promoting Independence Plan to HHSC may be found at:

<http://www.dads.state.tx.us/providers/pi/piplan/2001piplan.pdf>.

<sup>7</sup> See Appendix A for a current list of committee members.

<sup>8</sup> The *2014 Promoting Independence Advisory Committee Stakeholder Report* is located at:

[http://www.dads.state.tx.us/providers/pi/piac\\_reports/piac-2014-stakeholder.pdf](http://www.dads.state.tx.us/providers/pi/piac_reports/piac-2014-stakeholder.pdf).

## **2014/2015 PROMOTING INDEPENDENCE PLAN**

Texas continues to make a significant contribution to efforts of the Initiative through the statewide expansion of STAR+PLUS, implementation of Community First Choice (effective June 1, 2015), and participation in the federal Money Follows the Person Rebalancing Demonstration Grant (MFPD).

The MFPD will provide 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 final total amount of the award is contingent upon the number of individuals who relocate from institutional settings.

The efforts in Texas to provide community-based long term services and supports have helped to prevent institutionalization and move to a higher percentage of expenditures for home and community-based services. In early calendar year 2013, Texas reported 53.13 percent of long term services and support expenditures were for community-based care. At the end of calendar year 2014, community-based services accounted for 58.8 percent of expenditures for long-term support services versus 41.2 percent of expenditures for institutional long-term services and supports.

## **CONCLUSION**

HHSC is committed to a continuing relationship with the PIAC and all of the stakeholders who participate on many health and human services workgroups and advisory committees.

HHSC is committed to meeting the spirit and goals of the Initiative, the *Plan*, and the Supreme Court's 1999 *Olmstead* decision. Texas has a process to offer community options so individuals may choose to live in the most integrated setting. The primary philosophy of the Initiative is that each individual exercises the principles of self-determination in choosing where to receive long-term services and supports.

A large number of individuals remain on an interest list for Medicaid waiver services.<sup>9</sup> Some of these individuals are now able to receive community-based support from Community First Choice until a waiver slot become available. HHSC continues implementing additional initiatives in response to legislative direction and appropriations.

HHSC would like to thank the Governor's Office and the Legislature for their ongoing commitment to the Initiative. Their foresight and willingness to support long-term services and supports systems change has made Texas' response to the *Olmstead* decision one of the leaders in the nation. HHSC would like to thank all members of PIAC and state agency staff who have dedicated their time, resources, knowledge, abilities and work on the Initiative and with

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<sup>9</sup> As of March 31, 2015, there are 101,090 individuals (unduplicated count) on the Interest Lists. Updated Interest List data may be found on the DADS website at: <http://www.dads.state.tx.us/services/interestlist/>.

development of the *Plan*. HHSC would also like to thank those members of the public who responded to its invitation for comment at each PIAC meeting.

## INTRODUCTION

The *2014/2015 Revised Texas Promoting Independence Plan (Plan)* is the seventh revision of the original *Plan* 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 of the United States (Supreme Court) ruling in *Olmstead v. L.C.*, 119 S.Ct. 2176 (1999) (*Olmstead*), which requires states, within certain conditions<sup>10</sup>, to provide individuals an opportunity to live in the most integrated setting in order to receive their long-term services and supports.<sup>11</sup> The *Plan* describes how Texas will provide community-based options within the long-term services and supports 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 long-term services and supports 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 STAR+PLUS, a Texas Medicaid managed care program for persons who are aged or who have disabilities.

The *Plan* serves several purposes. First, the *Plan* provides the comprehensive working plan called for as a response to *Olmstead*. Second, the *Plan* meets the requirements of the report required by Executive Order, RP-13<sup>12</sup> and §531.0244, Texas Government Code<sup>13</sup>, which directs the Health and Human Services Commission (HHSC) to develop a plan to ensure appropriate care settings for individuals with disabilities, the provision of a system of services and supports that foster independence and productivity, including meaningful opportunities for an individual with a disability to live in the most appropriate care setting, and to report on the status of implementation of the *Plan*. Finally, the *Plan* serves as an analysis of the availability, application, and efficacy of existing community-based supports for individuals with disabilities.

The overarching Promoting Independence Initiative (Initiative), and the *Plan* that supports it, are far-reaching in their scope and implementation efforts. The Initiative is more than just a

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<sup>10</sup> The Court held that 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>11</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>12</sup> Executive Order RP-13 follows Executive Order GWB 99-2 as the second community-based alternatives Executive Order. See Appendix B for Executive Order GWB 99-2 and Appendix C for Executive Order RP-13.

<sup>13</sup> As enacted by S.B. 367, 77<sup>th</sup> Legislature, Regular Session, 2001.

philosophy; it is practiced in the reality of state policy and program development. The Initiative includes all long-term services and supports and the state's efforts to enhance its community-based services options. The goal is to ensure the long-term services and supports 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 a set of values that serve as the framework for future system improvements:

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

Since 2001, Texas has made significant progress transforming its health and human services system from an institutional-based to a community-based system. This progress has been achieved through appropriations and policies instituted by past legislatures and through policy by the health and human services system.

Recognizing the significant progress that has been achieved, the Initiative and *Plan* remain necessary and relevant components for maintaining an emphasis on community-based services, meeting the state's statutes, and complying with the requirements under *Olmstead*. As of December 2014, non-institutional services and supports accounted for 58.8 percent of long term services and support (LTSS) expenditures, and 100,480 individuals (unduplicated count) were on the Department of Aging and Disabilities Services (DADS) and HHSC interest lists. This is a decrease of 7,696 individuals on the interest lists since December 2013.<sup>14</sup> The lists include individuals who have shown interest in community-based waiver services. Persons are placed on an interest list on a first-come, first-served basis and are assessed for financial and functional eligibility when their name comes to the top of the interest list and services are available. The *Plan* is dedicated to building upon previous achievements and advocating for the ultimate goal of individual self-determination and availability of community-based options.

The *Plan* does not attempt to repeat information available on state agencies' websites, but rather builds upon the original *Plan* and the subsequent revisions. While much has been accomplished,

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<sup>14</sup> See DADS website at: <http://www.dads.state.tx.us/services/interestlist/index.html>.

efforts must continue to ensure all individuals have community-based options when considering their long-term services and supports.

## BACKGROUND

To fully understand the purpose, comprehensive nature, and implications of the Initiative within the state we must start with the history of the Initiative and include relevant information related to the 1999 *Olmstead v. L.C. (Olmstead)* decision.

In 1999, the Supreme Court of the United States (Supreme Court) ruled in *Olmstead* that unnecessary institutionalization of persons with disabilities would constitute unlawful discrimination under the Americans with Disabilities Act (ADA)(42 U.S.C. § 12132). The Supreme Court ruled that states are required to serve persons with disabilities in community settings, rather than in institutions, when:

1. The state’s treatment professionals have determined that community placement is appropriate;
2. The transfer from institutional care to a less restrictive setting is not opposed by the affected individual; and
3. The placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with disabilities. (119 S.Ct. 2176, 2190).

The Supreme Court further determined nothing in the ADA condones the termination of institutional settings for persons unable to benefit from community settings (119 S.Ct. 2176, 2187), and that the state's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not boundless (119 S.Ct. 2176, 2188).

The United States 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.” (28 CFR § 35.130(d)).

Under another ADA regulation, states are obliged to “make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modification would fundamentally alter the nature of the service, program or activity.” (28 CFR § 35.130(b)(7)(1998)). 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. (119 S.Ct. 2176, 2188 -2189)

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. (119 S.Ct. 2176, 2189 - 2190).

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 response to the *Olmstead* decision.

S.B. 367, 77<sup>th</sup> Legislature, Regular Session, 2001 was a significant piece of legislation. The goal of this bill was to continue the efforts of the Promoting Independence Plan, and among other things, it re-named the Promoting Independence Advisory Board to the S.B. 367 Interagency Task Force on Appropriate Care Settings for Persons with Disabilities. H.B. 2291, 78<sup>th</sup> Legislative Session, 2003 was enacted, and it required HHSC to certify various advisory committees as exempt from abolition. HHSC Executive Commissioner Albert Hawkins certified this taskforce as exempt from abolition, although HHSC and stakeholders agreed to simplify its name. The taskforce is now referred to as the Promoting Independence Advisory Committee (PIAC).

The purpose, comprehensive nature, and implications of the Texas Initiative, must be understood within the context of the history of the Initiative and all relevant information related to the *Olmstead* decision. In June 1999, the United States Supreme Court affirmed a judgment in the *Olmstead* case, which has had far reaching effects for states regarding services for individuals with disabilities. *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 of 1990 (ADA).<sup>15</sup>

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<sup>15</sup> 42 U.S.C. § 12131 *et seq.*

## PROMOTING INDEPENDENCE ADVISORY COMMITTEE

In Texas, PIAC is acknowledged as one of the leading forums in providing policy leadership and oversight of the long-term services and supports system. The purpose of the PIAC is to assist HHSC in developing a comprehensive, effectively working plan to ensure appropriate care settings for persons with disabilities. The executive commissioner for HHSC appoints members to the PIAC. Texas Government Code § 531.02441 specifies that members must include representatives of appropriate health and human service agencies, representatives of related workgroups, representatives of consumer advocacy groups, and representatives of service providers for individuals with disabilities.

The Committee continues to meet on a quarterly basis to:

- Continue the work of the Promoting Independence Initiative;
- Coordinate and oversee the implementation of the *Plan*;
- Provide ongoing policy discussions on issues pertaining to community integration; and
- Recommend policy initiatives for this *Plan*.

The Committee is also directed to make recommendations and advise HHSC on an annual basis. Consequently, Government Code Section 531.02441 guides the Committee 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 health and human services agencies' availability of community care and support options and identifying, addressing and monitoring barriers to implementation of the *Plan*; and
- Advise HHSC on identifying funding options for the *Plan*.<sup>16</sup>

The Committee is charged with two additional functions. First, it serves as the federally mandated Development and Implementation Council for the execution of Community First Choice (CFC) as a state plan option.<sup>17</sup> Second, it functions as the Money Follows the Person Demonstration Advisory Committee.

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<sup>16</sup> Originally, HHSC had responsibility for the Initiative, but the agency formally delegated daily management of the initiative's 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 § 441-575

The basis of the *Plan* is the result of recommendations made by the PIAC in its *Stakeholder Report 2014* submitted to HHSC as required by §531.02441(i), Government Code.<sup>18</sup>

The PIAC *Stakeholder Report 2014*, 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, 77<sup>th</sup> Legislature, Regular Session, 2001.<sup>19</sup>

The PIAC *Stakeholder Report 2014* includes 27 recommendations organized into nine categories with no specific order of priority. Categories include:

|              |                                      |
|--------------|--------------------------------------|
| Section I    | Community-Based Services             |
| Section II   | Children’s Initiatives               |
| Section III  | Managed Care Initiatives             |
| Section IV   | Mental and Behavioral Health         |
| Section V    | Relocation Services                  |
| Section VI   | Housing                              |
| Section VII  | Employment                           |
| Section VIII | Workforce and Provider Stabilization |
| Section IX   | Miscellaneous                        |

Each of the 27 recommendations is included in Appendix D. See the 2014/2015 Promoting Independence Plan section of this report for information related to efforts to address some of these recommendations as well as other efforts to promote independence.

## PROMOTING INDEPENDENCE AND RELOCATION SNAPSHOT DATA

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

The 81<sup>st</sup>, 82<sup>nd</sup>, 83<sup>rd</sup>, and 84<sup>th</sup> Legislatures (2009, 2011, 2013, and 2015) appropriated a significant amount of general revenue (GR) into the community-based programs to reduce interest lists.

Promoting independence initiatives and appropriations from the legislature have resulted in the transition of individuals from nursing facilities to community-based services. A growing number of individuals residing in state supported living centers (SSLCs) and large and medium intermediate care facilities for individuals with intellectual and developmental disabilities (ICD/IIDs) have been able to use available community-based services and supports to move to

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<sup>18</sup> The PIAC *Stakeholder Report 2014* is at: [http://www.dads.state.tx.us/providers/pi/piac\\_reports/index.html](http://www.dads.state.tx.us/providers/pi/piac_reports/index.html).

<sup>19</sup> S.B. 368 modified the § 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 §531.157 of the Government Code to require a state agency that receives notice that a child is residing in an institution shall endure that the child is added to the interest list for community-based waiver programs.

less restrictive homes. The number of individuals leaving SSLCs and ICF/IIDs in calendar year 2010 was 269, and 141 respectively. In 2015, the number of individuals leaving SSLCs and ICF/IIDs was 191, and 593 respectively.

DADS, the Department of Family and Protective Services (DFPS), EveryChild, Inc. (the HHSC family-based alternatives contractor), child placement agencies, and Medicaid waiver program providers work together to enable children to return to their families' homes or move to family-based alternative. In the six-month period ending February 28, 2015, 93 children moved from an institution back home or to live with another family.<sup>20</sup>

The average daily census in SSLCs continues to decline. In 2010, more than 4,300 individuals resided in SSLCs across Texas. By the end of fiscal year 2015, this number declined to less than 3,250.

The *Rider 23 Cost Comparison, September 2014*<sup>21</sup>, prepared by DADS reports the costs of state and federally funded residential and non-residential services for individuals with intellectual disabilities and related conditions. According to this report, the fiscal year 2013 average monthly client care costs for an individual in an SSLC was \$14,143.81, with \$5,090.40 average monthly administrative/overhead costs. The table below shows the average monthly long-term and acute costs for non-state operated ICF/IIDs and waiver program services.

**Table 1: Monthly Average Cost per Individual Served by Setting FY 2013**

| <u>Setting</u>             | <u>Long-Term Costs</u> | <u>Acute Care Costs</u> | <u>Total</u>      |
|----------------------------|------------------------|-------------------------|-------------------|
| Community ICF/IID          | <u>\$4,225.45</u>      | <u>\$330.67</u>         | <u>\$4,556.12</u> |
| HCS Waiver Residential     | <u>\$5,116.89</u>      | <u>\$356.21</u>         | <u>\$5,473.10</u> |
| HCS Waiver Non-Residential | <u>\$2,602.98</u>      | <u>\$523.06</u>         | <u>\$3,126.04</u> |
| HCS Waiver- All Settings   | <u>\$3,472.29</u>      | <u>\$465.15</u>         | <u>\$3,937.44</u> |
| Texas Home Living Waiver   | <u>\$872.61</u>        | <u>\$595.52</u>         | <u>\$1468.13</u>  |

## COMMUNITY SERVICES FUNDS AND AVERAGE MONTHLY CASELOADS

Medicaid state plan services listed in Table 2 and Table 3 include Primary Home Care (PHC), Community Attendant Services (CAS), and the Medicaid 1915(c) waivers: Home and Community-based Services (HCS); Community Living Assistance and Support Services

<sup>20</sup> Permanency Planning and Family-Based Alternatives Report, HHSC, July 2015

<sup>21</sup> 2014-15 General Appropriations Act (Article II, Department of Aging and Disability Services, Rider 23), S.B. 1, 83<sup>rd</sup> Legislature, Regular Session 2013

(CLASS); Deaf-Blind Multiple Disabilities (DBMD); Texas Home Living (TxHmL) and the Medically Dependent Children Program (MDCP). The Community-based Alternatives (CBA) program, which was part of this table in prior plans is no longer included as it transitioned to managed care, and these individuals are now served through STAR+PLUS.

**Table 2: DADS Waiver and Attendant Care  
2016-2017 Appropriations**

| <b>Program</b>              | <b>FY 2010<br/>Expended</b> | <b>FY 2016<br/>Appropriations</b> | <b>FY 2017<br/>Appropriations</b> |
|-----------------------------|-----------------------------|-----------------------------------|-----------------------------------|
| HCS                         | \$726,805,788               | \$1,081,380,184                   | \$1,211,979,830                   |
| CLASS                       | \$179,612,564               | \$246,822,300                     | \$265,013,658                     |
| DBMD                        | \$7,373,162                 | \$13,548,337                      | \$14,771,219                      |
| MDCP                        | \$48,450,319                | \$44,114,365                      | \$45,484,446                      |
| TxHmL                       | \$7,292,127                 | \$63,457,262                      | \$67,542,827                      |
| <b>DADS Total Waivers</b>   | <b>\$969,533,960</b>        | <b>\$1,449,322,448</b>            | <b>\$1,604,791,980</b>            |
| PHC                         | \$558,591,887               | \$16,567,987                      | \$17,018,717                      |
| CAS                         | \$414,606,029               | \$638,889,868                     | \$659,148,030                     |
| <b>DADS Total Attendant</b> | <b>\$973,197,916</b>        | <b>\$655,457,855</b>              | <b>\$676,166,747</b>              |
| <b>GRAND TOTAL</b>          | <b>\$1,942,731,876</b>      | <b>\$2,104,780,303</b>            | <b>\$2,280,958,727</b>            |

Source Documents:

- FY 2010 Expended DADS waivers and DADS attendant programs: DADS Fiscal Year 2012 Operating Budget
- 2016 and 2017 appropriations DADS waivers and DADS attendant programs: 2016-17 General Appropriations Act, H.B. 1, 84<sup>th</sup> Legislature, Regular Session

**Table 3: DADS Waiver and Attendant  
2016-2017 Average Monthly Caseload Projections**

| <b>Program</b> | <b>FY 2010<br/>Avg. #/Month</b> | <b>FY 2016<br/>Appropriated<br/>Avg. #/Month</b> | <b>FY 2017<br/>Appropriated<br/>Avg. #/Month</b> |
|----------------|---------------------------------|--|--|
| HCS            | 17,172                          | 24,472   | 26,850   |
| CLASS          | 4,167                           | 5,522  | 5,946  |
| DBMD           | 153                             | 268  | 293  |

| <b>Program</b>                   | <b>FY 2010<br/>Avg. #/Month</b> | <b>FY 2016<br/>Appropriated<br/>Avg. #/Month</b> | <b>FY 2017<br/>Appropriated<br/>Avg. #/Month</b> |
|----------------------------------|---------------------------------|--|--|
| MDCP                             | 2,626                           | 2,516  | 2,604  |
| TxHmL                            | 914                             | 6,059  | 6,467  |
| <b>DADS Total Waivers</b>        | <b>25,032</b>                   | <b>38,837</b>                                    | <b>42,160</b>                                    |
| PHC                              | 55,528                          | 1,372  | 1,413  |
| CAS                              | 43,247                          | 54,468   | 56,320   |
| <b>DADS Total Attendant</b>      | <b>98,775</b>                   | <b>55,840</b>                                    | <b>57,733</b>                                    |
| <b>TOTAL: Attendant Programs</b> | <b>123,807</b>                  | <b>94,677</b>                                    | <b>99,893</b>                                    |

Source Documents:

- FY 2010 Expended DADS waivers and DADS attendant programs: DADS Fiscal Year 2012 Operating Budget
- 2016 and 2017 DADS waivers and DADS attendant programs: 2016-17 General Appropriations Act, H.B. 1, 84<sup>th</sup> Legislature, Regular Session
- PHC became a benefit within STAR+PLUS beginning September 1, 2015, and resulted in a significant decrease in the number of individuals receiving PHC services from DADS.

## 2014/2015 PROMOTING INDEPENDENCE PLAN

Texas continues to make a significant contribution to efforts of the Initiative through the statewide expansion of STAR+PLUS, implementation of Community First Choice (effective June 1, 2015), and participation in the federal Money Follows the Person Rebalancing Demonstration Grant (MFPD).

The MFPD will provide 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 final total amount of the award is contingent upon the number of individuals who relocate from institutional settings.

The efforts in Texas to provide community-based long term services and supports have helped to prevent institutionalization and move to a higher percentage of expenditures for home and community-based services. In early calendar year 2013, Texas reported 53.13 percent of long term services and support expenditures were for community-based care. At the end of calendar year 2014, community-based services accounted for 58.8 percent of expenditures for long-term support services versus 41.2 percent of expenditures for institutional long-term services and supports.

Systems change at multiple levels continues to advance the state's efforts towards rebalancing. Activities are generated through a variety of initiatives. While the *Plan* is organized around the 2014 PIAC recommendations, the information included is the latest available in 2015.

## **SECTION I: COMMUNITY-BASED SERVICES**

The PIAC made four recommendations related to community-based services. Two of those recommendations are addressed in this plan: (1) increased funding for community-based services to interest lists, and (2) implementation of Community First Choice (CFC), and establishing the PIAC as the CFC Development and Implementation Council.

### **Community-Based Supports and Interest List Funding**

Community-based services and supports are in high demand and interest often outweighs available resources. Since the original plan, the PIAC's top priority has been full funding for community-based services so that all interest lists are eliminated.

To this end, the availability and array of community-based services for individuals with disabilities continues to expand. Appropriations to reduce interest lists and implement new services and programs were received throughout the health and human services delivery system during the 84<sup>th</sup> Texas Legislative Session.

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

#### *Department of Aging and Disability Services Waiver Programs*

Current 1915(c) waivers as of Fiscal Year (FY) 2015 include: Community Living Assistance and Support Services (CLASS); Deaf Blind with Multiple Disabilities (DBMD); Home and Community-based Services (HCS); Texas Home Living (TxHmL); and Medically Dependent Children Program (MDCP). Due to many services being added to capitated managed care covered services, caseloads at DADS are shifting. Individuals in the Community Based Alternatives (CBA) waiver were moved to STAR+PLUS as of September 1, 2014. At present, children in the Medically Dependent Children Program (MDCP) will remain at DADS through FY 2016 and will transition to STAR Kids in FY 2017.

As of March 31, 2015 there remained 147,108 individuals in the duplicated count on the interest lists and 101,090 in the unduplicated count. At the close of FY 2013 (August 31, 2013), there were 154,538 individuals in the duplicated count and 102,766 individuals in the unduplicated count. This is a reduction of 7,430 individuals (unduplicated count or 1676 duplicated count) in the last 18 months. These numbers reflect individuals who have demonstrated interest in a 1915(c) waiver, but they may not necessarily be eligible for the program after being assessed. Table 4 provides an overall summary.

**Table 4: March 2015 - Summary of DADS Interest List Releases<sup>22</sup>**

| <b>Item</b>                                      | <b>CLASS</b>                           | <b>DBMD</b>   | <b>HCS<sup>1</sup></b> | <b>MDCP</b>   | <b>Totals</b> |                |
|--|--|---------------|------------------------|---------------|---------------|----------------|
| Previous Biennium Counts                         | As of August 31, 2013                  | 48,182        | 545                    | 67,050        | 27,037        | <b>142,814</b> |
|  | Enrolled <sup>4</sup>                  | 499           | 76                     | 1,714         | 877           | <b>3,166</b>   |
| Released/Removed from Interest List <sup>2</sup> | Denied/Declined/Withdrawn <sup>4</sup> | 804           | 279                    | 949           | 7,146         | <b>9,178</b>   |
|  | Pipeline                               | 469           | 277                    | 1,842         | 4,389         | <b>6,977</b>   |
| <b>Total Releases This Biennium<sup>3</sup></b>  | <b>Since September 1, 2013</b>         | <b>1,772</b>  | <b>622</b>             | <b>4,505</b>  | <b>12,386</b> | <b>19,285</b>  |
| Added This Biennium                              | New Requests                           | 7,750         | 251 <sup>5</sup>       | 11,506        | 7,789         | <b>27,296</b>  |
| <b>Interest List Counts<sup>6</sup></b>          | <b>As of March 31, 2015</b>            | <b>53,281</b> | <b>209</b>             | <b>72,566</b> | <b>21,052</b> | <b>147,108</b> |

**Notes**

1. HCS counts for Released/Removed and total Releases are derived from CARE data source, not CSIL, and provided by Local Authority staff.
2. Released/Removed counts include individuals in the pipeline as of August 31, 2013, excluding MFP.
3. An individual may be counted more than once in the Enrolled and Denied/Declined/Withdrawn categories, but only once in Total Releases. Therefore, Release/Removal counts may be higher than the total count of released individuals.
4. Total unique individuals removed from the list who also had a release date (excluding HCS).
5. Some persons on the DBMD interest list have reached the top of the list multiple times and declined services, yet choose to remain on the list.
6. The total of Current Interest List Counts in the above table is a duplicated count. The Unduplicated count for all four lists as of February 28, 2015 is: **101,090**.

Table 5 gives the percentage of individuals on a specific interest list and their ability to qualify for the program.<sup>23</sup>

<sup>22</sup> See: <http://www.dads.state.tx.us/services/interestlist/index.html>.

<sup>23</sup> Also note that these numbers reflect a specific time frame. For the most current information, access <http://www.dads.state.tx.us/services/interestlist/index.html>. For archived Interest List data, go to: <http://www.dads.state.tx.us/services/interestlist/archive/index.html#Jan13>.

**Table 5: March 2015 – DADS Interest List Counts, by Years on List<sup>24</sup>**

| Years on List | CLASS         |             | DBMD        |             | HCS           |             | MDCP          |             |
|---------------|---------------|-------------|-------------|-------------|---------------|-------------|---------------|-------------|
|               | Individuals   | %           | Individuals | %           | Individuals   | %           | Individuals   | %           |
| 0-1           | 4,804         | 9.0%        | 156         | 74.6%       | 7,131         | 9.8%        | 5,047         | 24.0%       |
| 1-2           | 5,089         | 9.6%        | 53          | 25.4%       | 7,388         | 10.2%       | 4,520         | 21.5%       |
| 2-3           | 5,231         | 9.8%        | -           | -           | 8,407         | 11.6%       | 4,511         | 21.4%       |
| 3-4           | 6,096         | 11.4%       | -           | -           | 8,240         | 11.4%       | 5,002         | 23.8%       |
| 4-5           | 7,141         | 13.4%       | -           | -           | 8,866         | 12.2%       | 1,971         | 9.4%        |
| 5-6           | 6,484         | 12.2%       | -           | -           | 8,467         | 11.7%       | 1             | 0.0%        |
| 6-7           | 5,857         | 11.0%       | -           | -           | 6,826         | 9.4%        | -             | -           |
| 7-8           | 5,104         | 9.6%        | -           | -           | 5,723         | 7.9%        | -             | -           |
| 8-9           | 3,911         | 7.3%        | -           | -           | 4,595         | 6.3%        | -             | -           |
| 9-10          | 2,395         | 4.5%        | -           | -           | 3,542         | 4.9%        | -             | -           |
| 10-11         | 1,171         | 2.2%        | -           | -           | 3,025         | 4.2%        | -             | -           |
| 11-12         | -             | -           | -           | -           | 354           | 0.5%        | -             | -           |
| 12-13         | -             | -           | -           | -           | 1             | 0.0%        | -             | -           |
| 13-14         | -             | -           | -           | -           | 1             | 0.0%        | -             | -           |
| <b>TOTALS</b> | <b>53,283</b> | <b>100%</b> | <b>209</b>  | <b>100%</b> | <b>72,566</b> | <b>100%</b> | <b>21,052</b> | <b>100%</b> |

2016-2017 appropriations for the Initiative include an additional 5,601 slots for long-term care waiver clients. Specifically, the 84<sup>th</sup> Legislature appropriated \$29.7 million in general revenue (GR) / \$81.8 million all funds (AF) for 1,261 additional waiver slots supporting the Promoting Independence Initiative,<sup>25</sup> and \$51.1 million GR / \$122.2 million AF to reduce interests lists by 3,040.<sup>26</sup> The 84<sup>th</sup> Legislature also appropriated \$29.1 million GR / \$84.5 million AF for an additional 1,300 HCS slots to meet Federal PASRR<sup>27</sup> requirements. These include 700 transition slots for individuals with IDD moving out of nursing facilities and 600 diversion slots for individuals with IDD who are diverted from being admitted to a nursing facility.

<sup>24</sup>See: <http://www.dads.state.tx.us/services/interestlist/index.html>.

<sup>25</sup> Slots for 500 individuals to move from medium or large Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID), for 216 children aging out of foster care, for 400 the prevention of institutionalization/crisis, to move 120 individuals with intellectual and developmental disabilities (IDD) from state hospitals, and for 25 DFPS children who are transitioning from general residential operations facilities.

<sup>26</sup> 104 Medically Dependent Children (MDCP), 752 Community Living and Support Services (CLASS), 2,134 Home and Community-based Services (HCS), and 50 Deaf-Blind with Multiple Disabilities (DBMD) slots

<sup>27</sup> Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long-term care.

*Department of State Health Services (DSHS) Programs*

The 84th Legislature appropriated funding for the Department of State Health Services (DSHS) to address the waiting list for community mental health services. While the waiting list changes from month to month and varies by local service area, funding was based on the number of adults and children on the waiting list as of May 2015. DSHS also received additional dollars to balance per capita funding for mental health services.

***Additional Persons to be Served***

- Waiting List: 960
- Project increase from per capita adjustments: 3,745

***Dollars Appropriated in 2016-2017***

- Waitlist: \$9,433,728
- Additional funding for per capita adjustments: \$37,052,273

All funds appropriated to support ongoing services were allocated to Local Mental Health Authorities (LMHAs) using a negotiated methodology that encompassed legislative directives and ensured a fair and equitable distribution.

*Department of Assistive and Rehabilitative Services (DARS) Programs*

The Autism Program provides treatment services, such as applied behavior analysis (ABA), to children with an autism spectrum disorder. The program impacts families of children with autism who receive services, as well as schools, and the community at large. Children who experience significant improvements in cognitive, language, social, and adaptive skills can participate in typical classroom and community settings with minimal or no supports. This enables families to fully participate in their communities and minimizes long-term costs for families and education and other services. The 84th Legislature through the appropriations act directed DARS to phase out the comprehensive ABA services program, which provided high intensity services targeting multiple developmental delays. However, \$5 million in general revenue funding was provided to increase the availability of focused ABA services by all program contractors and allow the program to expand autism treatment services in Health and Human Services regions in which DARS did not have an Autism Program contract provider. Focused ABA services are provided at a lower intensity level and target only one or two developmental delays at a lower cost, allowing more children to receive services.

The Comprehensive Rehabilitation Services program fills a service gap for intensive rehabilitation services for individuals who have experienced a traumatic brain injury (TBI) or traumatic spinal cord injury (SCI). Before the Comprehensive Rehabilitation Services program was available, consumers with TBI and SCI had few, if any, rehabilitation options. Two options were typically available for these individuals: spend the rest of their lives in a nursing home or live at home with the need for disability services and supports, which often were provided by family members. Living at home often required a family member to leave the workforce, which caused financial and other stress on the family. The Comprehensive Rehabilitation Services program provides services needed to help consumers live independently in their home and

community. The program focuses on three primary areas that affect both function and quality of life: mobility, self-care, and communication skills. Services are provided in the person's home, a hospital, a residential facility, an outpatient clinic or in a combination of settings. The 84<sup>th</sup> Legislature appropriated \$800,000 to reduce the waiting list for the Comprehensive Rehabilitation Services program and serve an additional 16 consumers.

The Independent Living Services (ILS) Program helps people with disabilities, live independent lives by promoting a self-directed lifestyle and improving abilities to perform daily living activities. The program supports help people with disabilities expand their independent living options as they acquire new skills, abilities, and technologies. ILS promotes independence at home and in the community and enhances quality of life for people with significant disabilities. Services focus on mobility, communications, personal adjustment to living with a disability, social skills, and self-direction. DARS independent living counselors work with eligible consumers to develop goals to overcome specific barriers and then formulate strategies to achieve those goals. Independent Living counselors work with each consumer to develop an individualized plan, which is designed to help the consumer achieve the greatest level of independence possible. Program services may include counseling and guidance and the purchase of telecommunications, sensory, and other assistive technology aids for people who are deaf or hard of hearing; wheelchairs and braces; home and vehicle modifications, and other devices or services needed to achieve meaningful independent living goals. The 84<sup>th</sup> Legislature appropriated \$1.3 million in all funds to reduce the waiting list for ILS and serve an additional 214 consumers.

### **Community First Choice**

Community First Choice (CFC) was implemented in Texas on June 1, 2015, offering additional community-based supports and making community-based services available to individuals who previously did not have access to them. The Affordable Care Act established CFC as a Medicaid state plan option in October 2011. CFC allows states to provide home and community-based attendant services and supports to eligible Medicaid enrollees. Services offered include personal assistance services (PAS), habilitation (HAB), emergency response services (ERS), and support management. Texas is one of five states with an approved state plan amendment for CFC.

In order to receive CFC, an individual must be eligible for Medicaid, meet an institutional level of care (but not residing in an institution), and require assistance with activities of daily living (ADLs) which include but not limited to bathing, eating, and toileting, and/or instrumental activities of daily living (IADLs), which relate to living independently such as meal planning, managing finances, household chores, shopping and participating in the community. Institutional levels of care include; hospital, nursing facility, an intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID), an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over. Individuals with IDD on an interest list that meet eligibility requirements will have an opportunity to receive CFC PAS and/or HAB while continuing to hold their place on an interest list. HHSC and DADS have estimated this number to be as many as 14,883 individuals.

CFC is the first state plan benefit in Texas to offer HAB as a service. HAB typically includes a teaching component for the individual that includes acquisition, maintenance, and enhancement of skills necessary for an individual to accomplish ADLs.

CFC also includes ERS, a backup system and support. Backup systems and supports include electronic devices, such as a push button to wear around the neck, and are available for individuals who live alone, who are alone for significant parts of the day or have no regular caregiver for extended periods of time. The device can be used to trigger an emergency response if the individual falls or is in need of assistance and cannot get to a telephone.

Support management is voluntary training on how to select, manage, and dismiss attendants. This includes practical skills training related to recruiting, screening, hiring, and managing attendants. Support management is available to individuals across service delivery systems.

Federal legislation requires states to consult and collaborate with a CFC Development and Implementation (D&I) Council as the state plan amendment for CFC is drafted and implemented. HHSC designated PIAC members to function as this council.

S.B. 7 83<sup>rd</sup> Legislature, Regular Session, 2013 (S.B. 7) directed HHSC to “implement the most cost-effective option for the delivery of basic attendant and habilitation services for individuals with IDD under the STAR+PLUS Medicaid managed care program that maximizes federal funding for the delivery of services for that program and other similar programs.”<sup>28</sup> The state receives a six percent increased federal match for service expenditures related to CFC. This additional federal match, compared to the match for PAS and prior waiver services, supports CFC for funding individuals who previously did not receive these community-based long term services and supports. HHSC is meeting the S.B. 7 requirement with CFC.

## **SECTION II: CHILDREN'S INITIATIVES**

Since the passage of S.B. 368, 77<sup>th</sup> Legislature, Regular Session, 2001 more than 4,800 children have returned to their birth families or moved to family based alternatives.<sup>29</sup> These opportunities have significantly improved the lives of individuals under age 22 and their families.

S.B. 368 includes HCS supervised living and residential support in the definition of an institution. Including children in Home and Community-based Services (HCS) waiver program residential settings (i.e., supervised living or residential support), the total number of children with developmental disabilities residing in institutions declined 28 percent in the past 12 years. When HCS and DFPS-licensed IID settings are excluded, the data reveals a decline of 57 percent in the number of children residing in institutions since 2002, as children have experienced a shift to smaller, less restrictive environments. The number of individuals living in all types of DADS

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<sup>28</sup> §534.152 Texas Government Code. S.B. 7 83<sup>rd</sup> Legislature Regular Session, 2013 added the Texas Government Code by adding Chapter 534.

<sup>29</sup>See the *HHSC Permanency Planning Report – July 2015* at: <http://www.hhsc.state.tx.us/reports/2015/SB-368-Permanency-Planning-July-2015.pdf>

institutions, except HCS residential settings, decreased by 10 percent in the past year. Excluding HCS, the total number of children in DADS and DFPS institutions combined decreased by 9 percent over the past year, while showing a decline of 58 percent since 2002. Reasons for the continued placement of children in facilities include lack of access to needed family and community-based supports, behavioral health services for children with co-occurring disabilities, and forensic placement. Table 6 details the trend in the number of children residing in DADS and DFPS institutions since 2002.

**Table 6: Number of Children Residing in Institutions by Facility Type, DADS and DFPS Data Combined Six-Month Period Ending February 28, 2015<sup>30</sup>**

| <b>Institution Type</b>   | <b>Baseline Number<br/>8/31/2002</b> | <b>as of<br/>8/31/2014</b> | <b>as of<br/>2/28/2015</b> | <b>Percentage<br/>Change<br/>Since August<br/>2002</b> | <b>Percentage<br/>Change in<br/>Six Months</b> |
|---|--------------------------------------|----------------------------|----------------------------|--|--|
| Nursing Facilities  | 234                                  | 71                         | 71                         | -70%   | 0%   |
| Small ICF/IID   | 418                                  | 195                        | 178                        | -57%   | -9%  |
| Medium ICF/IID  | 39                                   | 39                         | 45                         | 15%  | 15%  |
| Large ICF/IID   | 264                                  | 13                         | 16                         | -94%   | -23%   |
| SSLC  | 241                                  | 181                        | 172                        | -29%   | -5%  |
| HCS Residential   | 312                                  | 632                        | 625                        | 100%   | -2%  |
| <b><i>Total DADS<br/>Facilities</i></b>                             | <b>1,508</b>                         | <b>1,131</b>               | <b>1,107</b>               | <b>-25%</b>  | <b>-2%</b>                                     |
| <i>Total DFPS-<br/>Licensed ID<br/>Institutions/<br/>Facilities</i> | 73                                   | 40                         | 37                         | -49%   | -8%  |
| <b>Total DADS &amp;<br/>DFPS Facilities</b>                         | <b>1,581</b>                         | <b>1,171</b>               | <b>1,144</b>               | <b>-28%</b>  | <b>-2%</b>                                     |
| <b>Total DADS &amp;<br/>DFPS without HCS</b>                        | <b>1,269</b>                         | <b>529</b>                 | <b>519</b>                 | <b>-59%</b>  | <b>-4%</b>                                     |

In the 2012 report, PIAC recommended community-based services for children and youth with intellectual and developmental disabilities residing in Department of Family and Protective Services (DFPS) licensed long-term care facilities. DADS, in accordance with S.B. 49, 83<sup>rd</sup> Texas Legislature, Regular Session, 2013, is providing transitional living assistance for children who have disabilities who also reside in General Residential Operations (GROs). GROs are 24 hour residential facilities for children with intellectual and developmental disabilities and who

<sup>30</sup> <http://www.hhsc.state.tx.us/reports/2015/SB-368-Permanency-Planning-July-2015.pdf>.

are in Child Protective Services (CPS) custody. This allows them timely access to HCS waivers similar to children in State Supported Living Centers, large Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and nursing facilities. CPS and Every Child Inc. staff are working together to find homes for the children in GROs who received HCS waivers. DADS allocated 25 HCS slots in General Residential Operations for children in DFPS Conservatorship who have intellectual and developmental disabilities in FY 2014-15 and another 25 in FY 2016-17. As of April 2015, all 25 HCS slots have been released for children with disabilities who are currently residing in DFPS licensed institutions.

DADS allocated 192 HCS slots for CPS youth aging out of care for FY 2014-2015 and an additional 216 HCS slots for these youth in FY 2016-17. CPS continues to issue 12 HCS slots per month for youth aging out of care. As of April 2015, all HCS slots have been released for youth aging out of care.

During the 83<sup>rd</sup> Regular Legislative Session DSHS was appropriated funds for 10 relinquishment prevention slots. This project was implemented in collaboration with the Department of Family and Protective Services (DFPS). The goal of the project is to prevent parental relinquishment of children to DFPS due solely to a lack of mental health resources. During the 84<sup>th</sup> Regular Legislative Session, DSHS received \$4.8 million for an additional 20 slots. DSHS contracts with private residential treatment centers throughout Texas to offer 30 ongoing beds for children who are referred by DFPS and who have a clinical need for residential treatment. Receiving needed residential treatment center services prevents more restrictive psychiatric hospital care, in addition to preventing parental relinquishment of custody.

During the 83<sup>rd</sup> Regular Legislative Session DSHS was appropriated \$10 million to provide substance abuse treatment and intervention services on demand for referrals from DFPS. Services include screening, assessment and treatment services, expanded eligibility in the pregnant and postpartum intervention programs for DFPS clients, and a new fatherhood intervention program created for DFPS clients. Over 3,000 additional DFPS clients have been served thus far through DSHS substance abuse support services. In support of these new on demand referrals for DFPS, DSHS provided training to DFPS staff in specific referral process, the DSHS-funded service array, eligibility requirements and resources available when problems are encountered with accessing services. Additionally, DSHS developed computer-based training which was accessed by just over 3,500 persons as of November 3, 2014. DFPS placed the DSHS training on their published website for continuous access for all their caseworkers.

The General Appropriations Act, 84th Legislature, Regular Session, (Article II, DFPS, Rider 42), includes \$4.2 million in all funds for sub-acute inpatient treatment care. The sub-acute treatment program provides 24-hour specialized treatment to individuals with severe mental and/or behavioral health issues in an inpatient non-hospital setting designed to deliver specified results for children and youth for whom continued outpatient treatment or less intrusive levels of care are not appropriate. The program serves children diagnosed with severe emotional disturbances, including children with self-harming and/or aggressive behaviors. Eligibility criteria include that the child must have (1) had three or more hospitalizations within the past twelve months, and (2) an extensive history of multiple placement moves or both inpatient and outpatient interventions

that have failed. With funding approved this legislative session, it is estimated that a monthly average of 43 children can be served.

The 2016-17 General Appropriations Act, H.B. 1, 84<sup>th</sup> Legislature, Regular Session, includes \$4.5 million in GR / \$5 million AF for DFPS to implement a Parental Child Safety Placement Caseworker pilot project that ensures consistent and frequent contact with caregivers of children who are in parental child safety placements. A Parental Child Safety Placement is a temporary, short-term out-of-home placement a parent can make when child protective services (CPS) determines that the child is not safe remaining in his or her own home.<sup>31</sup> CPS may offer parents the option of placing the child out of the home rather than CPS petitioning for court-ordered removal of the child. The option of parental child safety placements help children remain in their home communities.

DSHS administers the Mental Health 1915(c) Youth Empowerment Services (YES) waiver program, which provides comprehensive home and community-based services for children, ages 3 through 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 (SED). In 2013, the 83<sup>rd</sup> Legislature directed the YES waiver to expand statewide. Centers for Medicare and Medicaid Services (CMS) approved the amendment to the YES waiver in March 2016 that allows the state to draw down federal dollars for YES services provided statewide. This approval is retroactive to September 1, 2015.

The objective of the Waiver is to provide community-based services, in lieu of institutionalization, to eligible youth in accordance with the approved Waiver and program capacity. Statewide expansion makes YES accessible to eligible children in every county of Texas. Children enrolled in YES are eligible for all Medicaid behavioral health services as well as those that are 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.

### **SECTION III: MANAGED CARE INITIATIVES**

The 2014 PIAC recommendations include establishing more accountability within managed care for long-term services and supports and investment in a community care ombudsman. It is helpful to understand the history of managed care and managed care expansion and how managed care impacts the Initiative.

#### **Medicaid Managed Care Expansion**

In Texas, most Medicaid services are delivered through managed care health plans under contract with the state. This service delivery option is generally referred to as managed care. 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-

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<sup>31</sup> [http://www.dfps.state.tx.us/handbooks/CPS/Resource\\_Guides/PCSP\\_Resource\\_Guide.pdf](http://www.dfps.state.tx.us/handbooks/CPS/Resource_Guides/PCSP_Resource_Guide.pdf)

necessary covered Medicaid services in the same amount, duration, and scope as the traditional Medicaid benefit package authorized under the State Plan.

### *History of Managed Care*

H.B. 7, 72<sup>nd</sup> Legislature, First Called Session, 1991, directed the then Texas Department of Health to begin offering managed health care to certain Medicaid-eligible consumers in certain Texas counties as a new Medicaid service delivery program. The first managed health care pilot program, called LoneSTAR (State of Texas Access Reform), was implemented in August 1993 in Travis County. The delivery system, primarily serving children, low-income families, and pregnant women, was eventually expanded to cover all counties and continues today as the STAR Medicaid managed care program.

In December 1997 following legislative direction, Texas established a managed care pilot in Harris County to include certain Medicaid consumers who were aged or who had a disability. The pilot was administered as 1915(b) and 1915(c) waivers. The STAR+PLUS program was created as an integrated managed care system which would combine Medicaid acute care with long-term services and supports (LTSS) to adults who are aged, individuals with disabilities, and the chronically ill. Some goals of the STAR+PLUS program are to increase access to community services and improve coordination and efficiency between LTSS and acute care. Service coordination helps to address these goals and is a cornerstone of the STAR+PLUS program. All STAR+PLUS members are eligible to receive comprehensive service coordination from qualified professionals. The service coordinator works with the member's primary care physician to coordinate all STAR+PLUS covered services and any applicable non-capitated services. They actively involve the member's primary and specialty care providers, behavioral health service providers, and providers of non-capitated services. MCOs also provide information about and refer to community organizations that may improve the health and wellbeing of members, even if those organizations do not provide Medicaid services.

The 1915(c) Community-Based Alternatives (CBA) waiver program, which had been available in Texas prior to expansion of managed care, was operationalized within managed care as the HCBS STAR+PLUS waiver (SPW). The SPW provided community-based LTSS for adults who are elderly or disabled as a cost-effective alternative to living in a nursing facility. CBA waiver services continued to be available to individuals in service areas where STAR+PLUS did not yet operate.

### *Expansion of STAR+PLUS*

Effective February 1, 2007, STAR+PLUS expanded to cover the following service areas and surrounding counties: Travis Service Area, Harris Service Area, Nueces Service Area, and Bexar Service Area.

In July 2011, Texas submitted a section 1115 Demonstration proposal to the Centers for Medicare and Medicaid Services (CMS) with the intent to expand risk-based managed care statewide during the life of the demonstration. In December 2011, HHSC received federal approval to operate STAR+PLUS under the Texas Health Care Transformation and Quality Improvement Program 1115 waiver. By the end of 2012, STAR+PLUS had expanded to 90

counties. Beginning March 1, 2012, STAR+PLUS services include acute care, long-term services and supports and pharmacy services.

On September 1, 2014, the STAR+PLUS Medicaid managed care program expanded to rural service areas and effectively became available statewide.<sup>32</sup> With this statewide expansion, STAR+PLUS was also expanded to include individuals receiving LTSS from the CBA program and individuals with intellectual disabilities or a related condition. With this expansion of STAR+PLUS, CBA. An estimated 520,184 individuals were enrolled in STAR+PLUS with this expansion, approximately 11,450 individuals from the CBA program and approximately 12,930 individuals with intellectual disabilities or a related condition. At the same time as this expansion new services were added to STAR+PLUS. New STAR+PLUS services include mental health rehabilitation, targeted case management services, cognitive rehabilitation therapy (CRT) services, supported employment, and employment assistance.<sup>33</sup>

As of April 2015, there are an estimated 581,425 individuals being served by the STAR+PLUS program in Texas.

#### *STAR+PLUS Nursing Facility*

In March 2015, roughly 50,000 individuals with Medicaid living in nursing facilities (NFs) were enrolled in STAR+PLUS. The STAR+PLUS MCOs are responsible for reimbursing providers for services rendered to NF managed care members, ensuring appropriate utilization of NF add-on and acute care services, ensuring service coordination and helping to reduce preventable hospital admissions, readmissions, and emergency room visits.

As part of this transition, HHSC worked closely with DADS and NF stakeholders to develop outreach and education information and materials, such as information letters, enrollment packets, and YouTube informational videos. Enrollment events were also held at NFs to help increase individual health plan choice rate. There were 47,508 individuals enrolled in a STAR+PLUS Medicaid managed care health plan in nursing facilities as of June 1, 2015.

#### **Quality Measures for Long Term services and Supports (LTSS)**

HHSC recognizes the need for performance measures specific to the quality of care provided through long-term services and supports (LTSS), both for community-based and institutional care. Unfortunately, there has historically been a general absence of nationally recognized and validated performance measures focusing on the provision of long-term services and supports through managed care. In an attempt to fill this gap, HHSC has led two recent initiatives to develop state-specific measures for both community-based and institutional provision of LTSS.

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<sup>32</sup> For a map of *Managed Care Service Areas* as of September 1, 2014, see:

<http://www.hhsc.state.tx.us/medicaid/managed-care/mmc/STARPLUS-MRSA-map.pdf>.

<sup>33</sup> Mental health services and targeted case management were added by S.B. 58, 83<sup>rd</sup> Legislature, Regular Session, 2013. Supportive employment and employment assistance were added by S.B. 45, 83<sup>rd</sup> Legislature, Regular Session, 2013. Cognitive rehabilitation therapy was part of CBA and continued in STAR+PLUS to maintain services. For further details on Supported Employment and Employment Assistance, see Section VII of the recommendations in this document.

Effective March 1, 2015, *HHSC's Performance Indicator Dashboard for Quality Measures*<sup>34</sup> has included two sets of LTSS measures. First, HHSC added performance measures that will provide nursing facility quality of care data. HHSC worked with DADS and external stakeholders to develop a set of quality indicators that will incentivize managed care organizations (MCOs) to ensure their contracted nursing facilities are providing a high quality of care. These measures address aspects of care such as; the impact of nursing facility services being provided through a managed care model rather than the traditional fee-for-service model, potentially preventable events, nursing facility resident perception of care, and care transitions. Second, HHSC added performance measures focused on the provision of community-based LTSS. In 2013, HHSC convened a workgroup tasked with developing a set of performance measures that will allow HHSC to evaluate the quality of community-based LTSS currently provided through Medicaid managed care in Texas. The workgroup included representation from managed care organizations, provider associations, and advocacy groups. The dashboard standards for both sets of measures are currently "to be determined." Once sufficient baseline data is obtained (typically a year after data collection begins) HHSC will determine appropriate standards for each measure. HHSC will also evaluate the measures for inclusion in one or more of its managed care incentive programs.

A national project that HHSC is participating in is the *National Core Indicators-Aging and Disabilities (NCI-AD) Project*. It is led by the National Association of States United for Aging and Disabilities, working in collaboration with the Human Services Research Institute and the National Association of State Directors of Developmental Disabilities Services. The NCI-AD Project Survey will collect information on the experiences of individuals' receiving various long-term services and supports. While DADS has administered individual experience surveys to the populations it serves for a number of years, this survey will be the first collection of comparable data for the managed care LTSS programs. Data collected through this survey will fill a gap in an otherwise fairly comprehensive managed care quality assurance system. It will be used at least in part to demonstrate to external parties, including state and federal stakeholders, the quality of LTSS provided through Texas' managed care system. A report of the results of the survey is expected in October 2016.

### **HHSC Office of the Ombudsman**

Statutory authority and responsibility for the HHSC Office of the Ombudsman (OO) was revised by S.B. 200, 84<sup>th</sup> Legislature, Regular Session, 2015. OO is required to provide dispute resolution services, perform consumer protection and advocacy functions, and collect inquiry and complaint data relating to HHS consumers. It also establishes a process for consolidating ombudsman functions across the HHS agencies, with the exception of the SSLC Ombudsman and the Long Term Care Ombudsman.

Additionally, S.B. 760, 84<sup>th</sup> Legislature, Regular Session, 2015, amended an existing requirement for HHSC to provide support and information services to Medicaid consumers. The new legislation requires services to be provided through a network of entities, including OO, the Long Term Care Ombudsman, the HHSC Medicaid / CHIP Division, Area Agencies on Aging,

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<sup>34</sup>See Chapter 10.1.7 of the *Uniform Managed Care Manual*, at: [http://www.hhsc.state.tx.us/medicaid/managed-care/umcm/Chp10/10\\_1\\_7.pdf](http://www.hhsc.state.tx.us/medicaid/managed-care/umcm/Chp10/10_1_7.pdf).

and Aging and Disability Resource Centers. It also clarifies that support services should be available to managed care consumers in the Medicaid, CHIP, and dental programs.

To help address PIAC 2014 Recommendation 6, within OO, the team that assists consumers in managed care is undergoing an expansion to 17 positions. In addition to the existing Manager and Team Lead, the number of Advocates has been increased from eight to ten. Two additional positions have been authorized to act as in-house escalation positions to work on cases needing additional follow-up. An additional position has been authorized to serve as a planning and training coordinator and another two positions are planned to focus on coordination with resources within the HHS agencies as well as with community partners.

Finally, a rider in the new state budget, 2016-2017 General Appropriations Act, H.B. 1, 84<sup>th</sup> Legislature, 2015 (Article II, Special Provision Relating to Coordination of Interagency Nursing Facility Resident Complaint Data and Information Section 46), directs OO to prepare information that identifies a Medicaid managed care organization's performance related to nursing facility consumer complaints. The information will be distributed to managed care consumers annually.

#### **SECTION IV: MENTAL AND BEHAVIORAL HEALTH**

In addition to addressing the PIAC recommendation for expanding use of certified peer specialists in mental health services, the plan also presents information continuing initiatives and new initiatives created in response to recent direction from the 84<sup>th</sup> Legislature.

##### **Peer Specialists in Mental Health Services**

DSHS is also dedicated to the development of peer providers. A peer provider is an individual who is in recovery from mental health and/or substance use issues, has maintained that 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 that includes required training and testing to become a Certified Peer Specialist (CPS). 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.

CPSs, Certified Recovery Support 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 that are owned, administratively controlled, and managed by mental health and substance use disorder consumers. These providers emphasize self-help as their operational approach. Peer services typically include support, advocacy, role modeling, and life skill building.

A total of 769 individuals completed training to become a Certified Peer Specialist. Currently, there are 505 individuals with active certifications. The table below identifies the number of

Certified Peer Specialists in each of their county of residence at the time they received the training. Additionally, 1,276 individuals completed training to become a Recovery Coach. Currently, there are 502 certified Recovery Coaches.

The 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, Department of State Health Services, Rider 73) requires the Department of State Health Services (DSHS) to implement a mental health peer support re-entry program. DSHS utilized stakeholder feedback to structure the pilot program. DSHS provided an opportunity for interested LMHAs to submit proposals to develop this pilot program that identify local need, capacity, and existing relationships with law enforcement. DSHS estimates that 96 individuals will be served in fiscal year 2016 and 648 will be served in fiscal year 2017. DSHS plans to establish and monitor performance outcome measures that support the successful transition from county jail into clinically appropriate community-based care. DSHS is also partnering with the Hogg Foundation for Mental Health to do an evaluation of the pilot.

The 83<sup>rd</sup> Texas Legislature required DSHS to establish a home and community-based services program (HCBS) for adults with serious mental illness (SMI) and a history of extended inpatient psychiatric hospital stays. The Legislature further directed HHSC and DSHS to seek a Medicaid state plan amendment under §1915(i) of the Social Security Act. Texas received federal approval of the HCBS-AMH SPA from Centers for Medicare and Medicaid Services (CMS) on October 13, 2015. The HCBS-AMH service array includes Peer Support as a Medicaid service available to program participants.

Additionally, DSHS, in partnership with Health and Human Services Commission, is working to expand Medicaid reimbursement opportunities for peer support services in mental health and substance use disorders and revising supervision requirements to expand the provision of peer support service settings.

### **Clubhouses**

During the 84<sup>th</sup> Regular Legislative Session, DSHS received \$1.3 million in general revenue to expand and develop recovery-focused clubhouses across the state. Currently, there are at least three operational Clubhouses in Texas. There are Clubhouses in San Antonio, Houston and Austin certified by ICCD. The Clubhouse Model is an evidence-based, recovery-oriented program for adults diagnosed with a mental illness. The goal of the program is to improve an individual's ability to function successfully in the community through involvement in a supportive peer-focused environment. Members are encouraged to participate in the operations of the Clubhouse such as clerical duties, reception, food service, transportation, cleaning, and financial services. Members are also encouraged to participate in activities to promote outside employment, education, meaningful relationships, housing, and an overall improved quality of life.

Clubhouses are certified and coordinated through the International Center for Clubhouse Development (ICCD). Certification and oversight by ICCD is critical to the success of clubhouses, because it is essential that these programs adhere to the evidence-based model. Clubhouse personnel work with members to organize activities, manage employment

placements, address housing issues, and access community supports. Staff typically have diverse life experiences and backgrounds in a variety of disciplines, including psychology, counseling, social work, and education. The number of staff is kept low to encourage maximum interaction with, and inclusion of, members in every aspect of operating the Clubhouse, including all decision-making activities related to the facility and its activities.

### **Mental Health Workforce and Training**

H.B. 1023, 83<sup>rd</sup> Legislature, Regular Session, 2013, charged HHSC or a designated health and human services agency to research and analyze the state's mental health workforce shortage in order to make improvements. DSHS conducted the analysis. DSHS leveraged existing information and data in lieu of a literature review and continued by soliciting stakeholder input from partners such as the Statewide Health Coordinating Council, mental health care providers, advocacy organizations, and professional organizations in order to produce recommendations that might target core factors impacting the workforce shortage. Five possible themes were identified for state consideration in policy making:

1. Increasing the size of the mental health workforce;
2. Improving distribution of the mental health workforce;
3. Improving diversity of the mental health workforce;
4. Supporting innovative educational models; and
5. Improving data collection and analysis.

The report's findings offer in-depth details regarding activities that may be currently impacting the workforce crisis and providing recommendations that speak to the aforementioned themes.<sup>35</sup>

The *Centralized Training Infrastructure for Evidence Based Practices (CTI-EBP)* is designed to aid development of a training infrastructure to support the delivery of mental health services for adult and youth Texans. It was developed by DSHS' Mental Health and Substance Abuse Division to ensure that their contracted mental health service providers are using scientific, evidence-based practices. The infrastructure promotes and supports the utilization of evidence-based and promising practices to facilitate resiliency, recovery, and positive outcomes for individuals in the Texas mental health system. The University of Texas Health Science Center at San Antonio, Department of Psychiatry is contracted to implement this project.

Training protocols include Illness Management & Recovery and Cognitive Adaptation Training which are used to enhance and/or develop skills critical to remediation and management of symptoms associated with mental illness. Building critical skills needed to maintain community tenure, reduce recidivism, and assist with transitioning out of inpatient facilities, will enable

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<sup>35</sup> The September 2014 report can be found on the DSHS Legislative Reports page at <http://www.dshs.state.tx.us/Legislative/Reports-2014.aspx>. In addition, statistics on ratios of mental health providers to the population can be found in the 2015-2016 Update to the 2011-2016 State Health Plan provided by DSHS at: <http://www.dshs.state.tx.us/chs/shcc/>.

individuals to be served in their communities. Approximately 5,062 supervisors and direct care staff members at the time of this publication.

Additionally, DSHS and DADS collaborated on a Mental Health/IDD training for Direct Service Workers. The training is expected to maximize workforce training, ensure development of a competent workforce, and impact workforce retention and appropriate service delivery. In January, 2016, DADS released a free online course which teaches how to support someone with an IDD who has suffered trauma. This is the second module in a 6-part e-learning training series titled, Mental Health Wellness for Individuals with Intellectual and Developmental Disabilities. In addition, DSHS is also exploring opportunities with other enterprise partners such as Department of Family Protective Services (DFPS) to leverage the training infrastructure.

In 2016, DSHS will use MFP administrative funds to provide training and technical assistance to MCOs and their networks that will enable them to deliver evidence-based rehabilitative services (CAT). In addition, UTHSCSA will create 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.

H.B. 2789, 84<sup>th</sup> Legislature, Regular Session, 2015 revised the Human Resources Code § 161.088 to require the development or adoption of trauma-informed care training for employees who work directly with individuals with IDD who live in state supported living centers and intermediate care facilities. All new employees are required to take this training before working with individuals with IDD.

## **SECTION V: RELOCATION SERVICES**

Relocation services help individuals remain in the community or assist them in their relocation from an institutional placement into the community.

### **HCS Program Changes**

Beginning November 2015, Transition Assistance Services and pre-move minor home modifications will be added to HCS. Transitional Assistance Services provide assistance to an HCS applicant with setting up a household in the community before enrolling in the HCS program. Examples of TAS are payment for a security deposit on a lease or the purchase of essential home furnishings. The addition of pre-move minor home modifications will allow minor modifications prior to an individual relocated from a qualifying institution into a community setting.

### **DSHS: HCBS Adult Mental Health Services**

In their 2014 Stakeholder report, the PIAC stated that, in order to increase opportunities for recovery, DSHS must develop and implement a program to provide relocation and transition for individuals leaving state psychiatric facilities and those with frequent hospital readmissions

services (similar to those available to individuals leaving other institutions including nursing facilities and state supported living centers).

Beginning in 2011, Texas used federal Mental Health Block Grant funds to implement a small pilot which uses MFP-like interventions (CAT and substance use treatment) plus transition assistance to help individuals move from a state psychiatric facility to the community. Despite more limited resources and multiple challenges, half of 70 individuals served moved to the community. The percent relocated has improved over time. In 2015, 67% of participants transitioned to the community. This pilot will help inform implementation of HCBS-AMH.

The 83<sup>rd</sup> Texas Legislature required DSHS to establish a home and community-based services program (HCBS) for adults with serious mental illness (SMI) and a history of extended inpatient psychiatric hospital stays. The Legislature further directed HHSC and DSHS to seek a Medicaid state plan amendment under §1915(i) of the Social Security Act.<sup>36</sup> Texas received federal approval of the HCBS-AMH State Plan Amendment from Centers for Medicare and Medicaid Services (CMS) on October 13, 2015. Program details may be found on the HCBS-AMH web page.<sup>37</sup>

DSHS operates and administers Home and Community-based Services—Adult Mental Health (HCBS-AMH) under executive directive and oversight by HHSC, the single state Medicaid agency. HCBS-AMH provides individualized services to support long term recovery from mental illness, and is designed for individuals who have resided in a mental health facility long term. DSHS continues implementation efforts of this program including provider recruitment and program outreach and education. These implementation efforts and experience of developing the existing HCBS-AMH program has informed plans to expand HCBS to divert people with SMI from jails and avoidable emergency department visits. H.B. 1, 84<sup>th</sup> Texas Legislature, Regular Session, 2015 (Article II, DSHS, Rider 61b) requires DSHS to develop an HCBS program to divert populations with SMI from jails and emergency departments into community treatment programs. DSHS plans to request federal approval of additional populations into the HCBS-AMH program to include jail diversion and emergency department diversion.

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

In 2008, Texas began a Behavioral Health Pilot (BHP) under the federal Money Follows the Person demonstration grant (MFP) from the Centers for Medicare and Medicaid Services (CMS). The BHP operates in several central Texas counties, including Travis and Bexar. It is designed to help adult Medicaid clients with serious mental illness and substance use disorders leave nursing facilities. The pilot has enabled Texas to test the efficacy of new services and techniques for this special population. To date, 419 individuals receiving pilot services have transitioned to the community. Pilot participants have ranged in age from 27 to 89 and have multiple health

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<sup>36</sup> 2016-2017 General Appropriations Act, H.B. 1, 84<sup>th</sup> Legislature, Regular Session, 2015, (Article II, Department of State Health Services, Rider 61) appropriating \$32 million GR to develop a home and community-based program for adults with complex needs and extended or repeated inpatient psychiatric stays, and seek federal approval for a Medicaid 1915(i) state plan amendment to enable federal financial participation.

<sup>37</sup> HCBS-AMH program details are at: <http://www.dshs.state.tx.us/mhsa/hcbs-amh/>. For entities interested in becoming providers, please refer to the Electronic State Business Daily (ESBD) <http://esbd.cpa.state.tx.us/>.

challenges, including chronic health conditions, physical disabilities, serious mental illness and substance use disorders. Pilot services include community-based substance abuse treatment and Cognitive Adaptation Training (CAT), a rehabilitative service designed to help individuals establish daily routines, organize their environment, and build social skills. Services are 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 HCBS waiver services through their Medicaid managed care organization (MCO).

## **SECTION VI: HOUSING**

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

This section outlines accomplishments made in the housing arena by the health and human services system in partnership with the Texas Department of Housing and Community Affairs (TDHCA), DSHS, The Texas Department of Agriculture (TDA), and the local public housing authorities. This section is split into subsections based on content and are presented in alphabetical order by program.

### **Amy Young Barrier Removal Program**

Through TDHCA's *Amy Young Barrier Removal Program* (AYBR), Texas offers individuals with disabilities an alternative to institutionalization through the one-time grants of up to \$20,000 for home modifications to increase accessibility and eliminate critically hazardous conditions. The lack of affordable and accessible housing is an obstacle to living in the community. Individuals with disabilities need home modifications to allow them to remain in their homes.

The PIAC recommended that TDHCA exempt the AYBR program from the Single Family Umbrella rules. These rules prevented use of AYBR grants from being used on manufactured housing units. After receiving this recommendation, TDHCA worked with stakeholders to make an administrative rule change. Now, for this program, homes are defined as single family dwellings, rental units, or manufactured housing units.<sup>38</sup>

This program is funded through the Texas State Legislature via the Texas Housing Trust Fund (HTF). The 72<sup>nd</sup> Texas Legislature (1991) established the HTF to provide loans, grants, or other comparable forms of assistance for low- and very low-income individuals and families to

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<sup>38</sup> Amy Young Barrier Removal Program – Program Manual <https://www.tdhca.state.tx.us/htf/forms/docs/16-17-BRProgramManual.pdf>

finance, acquire, rehabilitate and develop decent, safe and sanitary housing. It is the only state-authorized source of funding for affordable housing programs. Funding sources consist of appropriations or transfers made to the fund, unencumbered fund balances, and public or private gifts or grants. 84<sup>th</sup> Legislature allocated \$3,229,295 for AYBR in the 2016-17 biennium. A geographic allocation formula allows equitable distribution of funds to both rural and urban areas of the state. A reservation system expedites the distribution process using an encrypted, paperless, online system that makes funds available on a first-come, first served basis and is adjusted for regional considerations.

AYBR administrators are Texas nonprofit organizations and local governments who process intake applications, verify eligibility, work with program beneficiaries to design modifications and oversee construction. The HTF provides greater funding flexibility and has fewer regulatory restrictions than federally-funded programs. As a result, the HTF can respond to the unique housing needs of low-income Texans—especially people with disabilities.

Beneficiary households must include an individual with a disability (any age), must have a household income that does not exceed 80 percent of the Area Median Family Income, are tenants or homeowners, and may live in a site-built home, apartment, or manufactured housing unit. At least 75 percent each home's total grant must be applied toward barrier removal activities, with no more than 25 percent of each home's grant applied to correction of other critically unsafe and hazardous housing conditions.

Common home modifications include: adding 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 participants' unique needs. The AYBR Program is one of the few at TDHCA that facilitates accessibility modifications for manufactured housing units.

People who participate in the AYBR program can remain in their communities, keep existing social networks intact, and decrease dependence on institutional assistance. In FY 2014-2015, HTF assisted approximately 247 households, 12 of these were manufactured housing units. Since 2010, the AYBR Program has helped over 680 households of Texans with disabilities increase their independence through creative design and barrier removal.

### **HOME Tenant Based Rental Assistance**

HOME Tenant-Based Rental Assistance (TBRA) is funded by the federal HOME Investment Partnerships Program that focuses on serving rural and special needs populations. Individuals exiting an institution can use this program to obtain rental assistance while waiting for a Project Access voucher.

Note that the percentage of monies necessary for TBRA administrative costs has fluctuated in the past decade between 4-10 percent. As a result, HOME staff conducted a soft cost survey of TBRA administrators and determined that 4 percent for administrative costs (plus \$1200 in soft costs per unit) was reasonable. Soft costs monies are used for inspections and income

determination. On August 23, 2013 TBRA administrative costs were reduced from 8 percent to 4 percent when the amended Federal HOME Final Rule 24 CFR Part 92 went into effect that allowed for soft costs to be charged for the first time. Plans are to remain at 4 percent for the biennium.

### **The Housing and Health Services Coordinating Council**

The purpose of the Housing and Health Services Coordination Council (HHSCC) “is to increase state efforts to offer service-enriched housing through increased coordination of housing and health services.”<sup>39</sup> The Council was created by S.B. 1878, 81<sup>st</sup> Legislature, Regular Session, 2009. The HHSCC *2014-2015 Biennial Plan* is available on the TDHCA website.<sup>40</sup>

### **Housing and Services Partnership Academy**

TDHCA, on behalf of the Housing and Health Services Coordination Council, contracted with the Corporation for Supportive Housing to coordinate a Housing and Services Partnership (HSP) Academy. The HSP Academy provides local community teams the tools and education necessary to create safe, affordable, accessible housing for persons with disabilities and older Texans. Each team includes at a minimum:

1. A housing provider/developer;
2. A service provider; and
3. A person with a disability.

Teams receive training and technical assistance to help develop comprehensive plans for improving the quantity and quality of affordable, accessible, integrated housing and supportive services for people with disabilities and older Texans, and prepare communities to address the housing needs of this population. Each team will participate in a follow-up needs assessment that will guide and customize technical assistance for each community plan. Outcomes will guide future technical assistance based on the planning process during the Academy.

### **Supportive Housing Program**

During the 83<sup>rd</sup> Legislative Session, DSHS requested and received \$10.9 million to fund 18 LMHAs. Two additional LMHAs were added in fiscal year 2015. While all LMHAs may choose to use general revenue funds to provide brief rent and utility assistance, the Supportive Housing Program is specifically designed to enhance the ability of some LMHAs to provide rent and utility assistance to individuals with mental illness, who were homeless and imminently homeless. Short-term housing assistance (up to 6 months) or longer-term housing assistance (up to 1 year) is provided based on the individual’s identified need. Each program is required to have a dedicated staff person providing evidence-based supportive housing services in conjunction with the provision of the housing and/or utility assistance. As a result, staff must utilize the Substance Abuse and Mental Health Services Administration (SAMHSA) Permanent Supportive Housing curriculum when serving these individuals. Since implementation, LMHAs have

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<sup>39</sup> See: <http://www.tdhca.state.tx.us/hhsc/>.

<sup>40</sup> See: <http://www.tdhca.state.tx.us/hhsc/biennial-plans.htm>.

provided housing services to 3,766 individuals with mental illness and housing needs.<sup>41</sup> At the end of fiscal year 2015, 825 individuals have moved on to either independent living, or permanent supportive housing while continuing to receive mental health services.<sup>42</sup> The LMHAs have exceeded their targets in fiscal years 2014, 2015 and continue to do so for fiscal year 2016.

### **Project Access Vouchers (permanent Section 8 housing vouchers)**

The Project Access Program utilizes Section 8 Housing Choice Vouchers administered by TDHCA to assist low-income persons with disabilities in transitioning from institutions into the community by providing access to affordable housing.

In the Legislative Appropriations Request (LAR) for the 2016-17 biennium, the agency states that, “TDHCA’s ability to issue vouchers is not tied to a number of vouchers from the Department of Housing and Urban Development (HUD) but rather on a budget. There is variability and adjustments to this budget by HUD periodically throughout the year. Factors affecting Section 8 performance include HUD budget, constricting administrative funding based on HUD’s methodology, the revolving nature of vouchers as households move on or as other Public Housing Authorities absorb these, and the lack of alternative rental assistance resources in the communities served. Lower than anticipated households served in SFY 2014 reflect initial implementation of efforts to give priority to Project Access vouchers, which serves persons with fewer placement options. New procedures will address this in SFY 2015-17. The [TDHCA] continues to seek more effective strategies for implementing the Section 8 program in rural areas”<sup>43</sup>.

For 2016-2017, TDHCA set a goal for the Project Access program to assist 130 households in 2016 and 145 households in 2017, and increase to the 2014-2015 estimates of 88 and 100 households respectively.<sup>44</sup> TDHCA provides outreach and technical assistance regarding current activity that allows a household on TDHCA’s Project Access waiting list to transition out of an institution using assistance from the HOME TBRA program (a time-limited housing assistance program). As of 2013, participants may exit an institution using TBRA support while they wait out the time it takes for their name to come up on the Project Access waiting list.<sup>45</sup> TBRA may be accessed for two years, with the possibility to renew for up to an additional three years, for a total of five years, if funding is available.

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<sup>41</sup> Department of State Health Services, Supported Housing Program (March 21, 2016).

<sup>42</sup> Department of State Health Services, Supported Housing Program (March 21, 2016).

<sup>43</sup> TDHCA 2016-17 Legislative Appropriations Report, page 54. <https://www.tdhca.state.tx.us/bond-finance/docs/LAR-2016-2017-Final.pdf>

<sup>44</sup> TDHCA 2016-17 Legislative Appropriations Report, page 51. <https://www.tdhca.state.tx.us/bond-finance/docs/LAR-2016-2017-Final.pdf>

<sup>45</sup> “Any household who is eligible for the Project Access program may be eligible to participate in TBRA while waiting for their name to come up on the Project Access waitlist. Individuals on the Project Access waiting list who participate in the TBRA activity will keep their position on the Project Access waiting list. Households receiving support from TBRA may be able to do so for up to five years if on a Section 8 waitlist, including the Project Access waiting list, depending on continued household eligibility and HOME availability of funding.” See: <http://www.tdhca.state.tx.us/section-8/project-access/index.htm>.

### **Project Access Pilot Program**

Since 2012, 10 Project Access housing vouchers have been reserved for persons exiting state psychiatric hospitals that are participating in a pilot program coordinated by TDHCA and DSHS. The Project Access 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 be either a current resident of a state-funded psychiatric hospital bed or have discharged from a state-funded psychiatric hospital bed within 60 days of the application date and meet the disability. The program is designed to create new vouchers. New vouchers are created when local housing authorities are able to absorb the cost of a voucher that came from TDHCA. When this occurs, funds are freed up to create another voucher. Since the program started, over 70 individuals have been referred to the program and 31 individuals have received housing.<sup>46</sup>

### **Low Income Housing Tax Credit Program**

TDHCA's *Housing Tax Credit* program is the largest production program at TDHCA. However, this rental program has design challenges in reaching people with the lowest incomes without utilizing other gap financing. This program, as well as a number of other TDHCA programs could focus more on the SSI level of income to open up community integration. With the high demand for affordable housing for individuals with disabilities, it is critical that the maximum amount of resources be allocated for this assistance.

The Low Income Housing Tax Credit program requires each state agency that allocates tax credits, generally called a housing finance agency, to have a Qualified Allocation Plan (QAP). The QAP sets out the state's eligibility priorities and criteria for awarding federal tax credits to housing properties and provides a mechanism to support development of affordable accessible housing. TDHCA recently conducted an in-depth review and revision of its QAP. Changes made in 2014-15 include, but are not limited to the following items.

- The agency added an incentive for developers to participate in the Section 811 Project Rental Assistance Program beginning in 2015.
- In 2014, the Increase in Eligible Basis (also known as 30 percent boost) for developments located in a Qualified Census Tract (as determined by the HUD Secretary) was instituted for those who have less than 20 percent Housing Tax Credit Units per total households in the tract. Eligible groups can qualify for up to a 30 percent increase of the eligible basis.
- The Fair Housing Guidelines were used to update the Fair Housing Accessibility Requirements as of 2014. A minimum of 20 percent of each unit type must provide an accessible entry level, common-use facilities, and one bedroom and one bathroom or powder room at the entry level. Additionally, the modified requirement covers both 2 bed-1 bath and 2 bed-2 bath units.
- All applications proposing Rehabilitation (including Reconstruction) are considered Substantial Alterations. Accommodations include setting aside five percent of units for persons with mobility impairments and 2 percent for persons with visual impairments.

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<sup>46</sup> Department of State Health Services, Project Access Pilot Program (March 21, 2016).

## **Section 811 Project Rental Assistance Program**

The *Section 811 Project Rental Assistance (PRA) Program* provides project-based rental assistance for extremely low-income persons with disabilities who are linked with long-term services and supports. 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 Section 811 PRA Program creates the opportunity for persons with disabilities to live as independently as possible through the coordination of voluntary services and providing a choice of subsidized, integrated rental housing options.

Based in part on Texas' efforts to create community-integrated housing options for persons with disabilities and due to TDHCA's ongoing collaboration with HHSC (through DADS and DFPS) to jointly operate the Project Access Program, TDHCA was awarded funding from HUD's FY 2012 Section 811 PRA Program Demonstration round to support approximately 350 units of affordable, accessible, and integrated housing.

Through a planning process that included persons with disabilities, service providers and state agency partners, Texas' Section 811 PRA Program focuses on the following target populations:

- Persons with disabilities exiting institutions (e.g., nursing facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities or Related Conditions [ICF/IID]), who are eligible to receive long-term services and supports through a DADS waiver or STAR+PLUS;
- Persons with serious mental illness who receive services through Medicaid funded behavioral health services; and
- Youth or young adults with disabilities exiting DFPS foster care.

Texas is working to ensure the Section 811 PRA Program provides an effective housing opportunity for eligible participants by providing ongoing technical assistance, support, and training to service providers, housing developers, and property managers.

Texas applied for an additional \$12 million dollars to develop 296 units under HUD's fiscal year 2013 Section 811 PRA Program round. TDHCA received a preliminary Award Letter for these funds and anticipates signing the HUD Cooperative Agreement in the fall of 2015. Once the Cooperative Agreement is signed, Texas will begin programming this second round of funding.

## **SECTION VII: EMPLOYMENT**

### **Employment First Policy and Employment First Task Force**

The Employment First Task Force (Task Force) was established by the passage of S.B. 1226, 83<sup>rd</sup> Legislature, Regular Session, 2013(S.B. 1226). This requires HHSC, Texas Workforce Commission (TWC), and the Texas Education Agency (TEA) to adopt an employment first policy. The policy must affirm the expectation that individuals with disabilities are able to meet the same employment standards, ensure that individuals with disabilities are given factual information regarding employment and the relationship between earned income and public

benefits, promote partnerships with employers to overcome barriers, ensure and promote opportunities for training to allow for competitive employment, and to ensure that employment is not required to secure or maintain public benefits. Section 531.02447 of the Government Code outlines the Employment First policy in detail.<sup>47</sup> The Texas Education Agency (TEA), TWC and HHSC have each adopted an Employment First policy.

The resulting interagency Task Force is charged with ensuring individuals with disabilities are able to obtain competitive employment in the community. To fulfil the requirements of S.B. 1226, Texas utilized the pre-existing PIAC Subcommittee on Supported Employment as the basis of the Task Force. DADS provides administrative support and operations of the Task Force, while HHSC provides oversight.

Membership of the Task Force is composed so that at least one-third of members must be individuals with disabilities, and no more than one-third of the task force may be composed of advocates for individuals with disabilities. Stakeholders include individuals with a disability, family members of individuals with a disability, advocates of individuals with disabilities, providers of employment services, and employers or potential employers of individuals with disabilities as well as enterprise-wide representation from HHSC, DARS, the DADS, DSHS, DFPS, TEA, and TWC.

S.B. 1226 charges the Task Force to promote competitive employment of individuals with disabilities and disseminate the expectation that individuals with disabilities are able to meet the same employment standards, responsibilities, and expectations as any other working age adult. Responsibilities include: designing an education and outreach process for working-age individuals with disabilities; raising expectations of the success of individuals with disabilities in integrated, individualized, and competitive employment; developing recommendations for policy, procedure, and rules changes; and preparing and submitting a report on the task force's findings and recommendations to the Office of the Governor, the Texas Legislature, and the Executive Commissioner.<sup>48</sup> The Task Force continued to meet in 2014 and 2015.

To learn more about the work of the Task Force, go to:

<http://www.dads.state.tx.us/providers/supportedemployment/pi/index.html>.

### **Employment Services and Resources in the Waiver Programs**

S.B. 45, 83<sup>rd</sup> Legislature, Regular Session, 2013, (S.B. 45) instructed HHSC to offer employment assistance and supported employment to individuals on the Medicaid 1915(c) waivers, the Youth Empowerment Services waiver (YES), and the STAR+PLUS waiver.<sup>49</sup> Prior to S.B. 45, employment services were available in some waiver programs, but the supports were not comprehensive. S.B. 45 sought to remedy this by providing additional supports in employment

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<sup>47</sup> Government Code Chapter 531 is found at: <http://www.statutes.legis.state.tx.us/Docs/GV/htm/GV.531.htm>.

<sup>48</sup>To learn about the establishment and responsibilities of the Task Force in detail, a summary of S.B. 1226 is provided in PDF format at: <http://www.dads.state.tx.us/providers/supportedemployment/SB1226Overview.pdf>.

<sup>49</sup> See S.B. 45 or Human Resources Code, Section 1, Subchapter B, Chapter 32, Section 32.075 for full definitions of employment assistance and supported employment. HRC Chapter 32 may be accessed at: <http://www.statutes.legis.state.tx.us/Docs/HR/htm/HR.32.htm>.

assistance and supported employment, with the goal of individuals having person-centered support in preparing for, finding, and continuing employment. Effective September 1, 2014, these two services were added as a benefit to the STAR+PLUS Home and Community-based Services (HCBS) waiver and its array of services.

Employment assistance is a short term benefit to help individuals locate paid employment in the community. A referral to DARS for employment assistance is usually completed before waiver resources are utilized, since the waiver is payer of last resort. Supported employment is provided to an individual who, because of a disability, requires intensive, ongoing support to perform in a work setting in which individuals without disabilities are employed. The service includes adaptations, supervision, and training related to an individual's diagnosis.

Individuals are evaluated for the need for employment assistance and supported employment at their initial assessment for waiver services. They may request employment services at any time. A few of the services provided by job coaches include assisting with the application process, preparing for interviews, and working with the individual at the work site in order to learn the skills needed to succeed at his or her job. Job coaches also are available to provide employers with suggestions on how to help integrate individuals into the work environment.

Employment resources are also available online. First, DADS has created a *Guide to Employment for People with Disabilities* that gives information on how to access employment assistance and supported employment services through DADS and DARS.<sup>50</sup> Highlights of this 48-page document include: roles and responsibilities at each stage of a job search; strategies for transportation; tools for coordinating services with DARS; ways to maintain needed services while working (such as the Medicaid Buy-In); and a description of Social Security Administration work incentives. Second, the *Texas Transition and Employment Guide*<sup>51</sup> provides information to facilitate a young person's progress towards post-secondary goals of education, employment, and community living. The guide will be continually updated in English and Spanish. Finally, to access the DADS Supported Employment page, go to: <http://www.dads.state.tx.us/providers/supportedemployment/>.

### **Individual Placement and Supports (IPS) Supported Employment**

DSHS utilizes an evidence-based supported employment model developed at Dartmouth University called the *Individual Placement and Supports (IPS) Supported Employment*. These services and supports must be designed to encourage successful employment outcomes consistent with the individual's goals. The model has been tested through DSHS at the Local Mental Health Authorities (LMHAs), but requires further support and expansion. Eligibility is based on clients opting-in and is client-centered. The process includes benefits counseling, focused job searches, systematic job development, and time-unlimited support for individuals in this model program for securing competitive employment.

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<sup>50</sup>DADS' *Guide to Employment for People with Disabilities* is available in two formats. The PDF is at: <http://www.dads.state.tx.us/providers/supportedemployment/EmploymentGuide.pdf> and the online html guide is at: <http://www.dads.state.tx.us/providers/supportedemployment/index.html>.

<sup>51</sup> The *Texas Transition and Employment Guide* was first posted online in November 2014, but will be continually updated. To access the Guide, visit <http://www.transitionintexas.org/Page/143>.

Lessons learned from this initiative aided in program enhancement and problem solving to reduce barriers that may arise as LMHAs initiate and/or improve already existing supported employment programs. Subsequently, DSHS added performance targets and training requirements for employment and continues to assist LMHAs via collaborative discussions about implementation of the IPS model and guidance on meeting performance targets. To further support implementation, DSHS offers a variety of on-going IPS supports to LMHA providers, including: consultation with national experts; on-line training; and face to face training. As a result of these supports and the legislation passed, there has been a 37.7 percent change increase in the number of adults employed from fiscal year 2013 (14.2 percent) to the first half of fiscal year 2016 (19.6 percent).<sup>52</sup>

### **Medicaid Buy-In Programs for Adults and Children**

The *Medicaid Buy-In Program* (Buy-In) allows individuals with disabilities, who are working and earning more than the allowable limits for regular Medicaid, the opportunity to retain health care coverage through Medicaid. It allows individuals to earn more income without the risk of losing vital health care coverage. The Buy-In provides Medicaid benefits to working individuals with disabilities, regardless of age, who apply for Medicaid and meet the requirements established by HHSC. An individual may be required to pay monthly premiums, based on the amount of the individual's earned and unearned income.

This Buy-In eligibility applies to individuals who have a disability, are working, live in Texas, and do not live in a state nursing home or institution all of the time. Eligibility for other programs, such as Social Security Disability or Medicaid 1915(c) waivers, makes it more likely that the individual may qualify for the Buy-In program. Buy-In benefits are identical to regular Medicaid benefits. For more details about the program and directions on how to apply, go to HHSC's Buy-In program page at: <http://www.hhsc.state.tx.us/MBI.shtml>.

The *Medicaid Buy-In for Children* (Children) was established in 2011 to help families pay medical bills for children with disabilities. Senate Bill 187 (81<sup>st</sup> Legislature, Regular Session, 2009) added this important program for families who need health insurance, but whose income is at or below 300 percent of the federal poverty level. Families pay a monthly insurance premium. To be eligible, their child must be age 18 or younger, meet the same disability criteria used to dispense Supplemental Security Income (SSI), live in Texas, be a U.S. Citizen or legal resident, and be unmarried. If parents have access to health insurance through work, Medicaid may pay for services not covered by that insurance policy. Depending on overall income, there may be a cost-share component to the program. For more information, access HHSC's Children's Buy-In program page at: <https://www.hhsc.state.tx.us/help/healthcare/MBIC.shtml>.

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<sup>52</sup> Department of State Health Services, Clinical Management for Behavioral Health Services (CMBHS), Employment Performance Measure Report, (March 22, 2016).

## **SECTION VIII: WORKFORCE AND PROVIDER STABILIZATION**

The PIAC 2014 stakeholder report included several recommendations related to sustaining provider capacity and network readiness. The 84<sup>th</sup> Legislature appropriated funds for these purposes.

### **Direct Service Workforce**

The PIAC recommended that HHSC, DADS and DSHS seek an increase in appropriations for the base wage for entry-level direct-support workers (DSWs) in home and community-based programs. The 84<sup>th</sup> Legislature appropriated \$38.1 million GR / \$88.9 million AF 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 minimum wage of attendants over the federal minimum wage, cost of living increases outweigh the increase in attendant wages.

The demand for a direct service workforce (DSWs) in Texas is expected to increase substantially over the next decade due to numerous factors, including the aging baby boom generation, aging family caregivers, and the increasing prevalence of disabilities. Meanwhile, retaining DSWs has long been a challenge and job turnover rates are high statewide. Low pay is a significant factor in recruitment and retention. Evidence indicates that increased wages positively influence recruitment and retention. DSWs are the foundation of the community-based long-term services and supports system. Higher wages contribute to a more stable workforce and improved service quality. A significant decline in recruitment and retention will likely lead to a shortage of available community services, resulting in increased hospitalization and institutionalization. The agency is concerned, as the attrition rate is at 22.9 percent for community care attendants and other support staff.

Addressing workforce issues is critical to successful compliance with the *Olmstead* decision and to the Promoting Independence Initiative (Initiative). A stable DSW is necessary for individuals who choose to live in the community. The issue of retaining a trained and tenured workforce is a national problem as well as one confronting Texas.

Increasingly, the state is losing providers of direct services, direct service workers, physicians, licensed nurses and other professional who provide long-term services and supports 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 does not have sufficient contracts with specialists and providers who can serve these individuals. It is critical for the provider base and managed care systems to have an adequate direct service worker and network system in place to serve all in individuals in a community-based setting.

### **Increases in reimbursement and provider payments**

In addition to increased appropriation for attendant rates mentioned above, the 2016-2017 General Appropriations Act, H.B. 1, 84<sup>th</sup> Legislature, Regular Session, 2015 (Special Provisions

Relating to All Health and Human Services Agencies Section 47) included an additional \$7.5 million GR / \$17.5 million AF for rate enhancement across community-based programs.

2016-2017 General Appropriations Act, H.B. 1, 84<sup>th</sup> Legislature, Regular Session, 2015 (Article II DADS, Riders 39 and 40) appropriated funding for rate increases in the HCS waiver and ICF/IID programs, respectively. Additionally, the riders indicated that the appropriations were contingent upon a certification by the HHSC Executive Commissioner to the Legislative Budget Board and the Comptroller of Public Accounts that a system of spending accountability was to be established that ensured each provider expend at least 90 percent of all funds received through HCS and ICF/IID Medicaid payment rates on HCS and ICF/IID Medicaid services as captured by the provider's Medicaid cost report or be subject to a recoupment of the difference between 90 percent of funds received through the HCS and ICF/IID Medicaid payment rates and the provider's actual expenditures providing HCS and ICF/IID services to Medicaid recipients. On August 28, 2015, a letter of certification was submitted to the Legislative Budget Board and the Comptroller of Public Accounts that a system of spending accountability for the HCS and ICF/IID programs had been established as required by Riders 39 and 40.

Both the rate increases and the systems of spending accountability became effective September 1, 2015. For the HCS program, HHSC increased rates for Supervised Living/Residential Support Services (SL/RSS) and Day Habilitation (DH). SL/RSS increased between 0.76% and 1.08%, and DH increased by between 0.48% and 3.94% depending on consumer level of need. For the ICF/IID program, HHSC applied a 2.2 percent rate increase for all ICF/IID facility sizes and cost centers with an adjustment to the 2.2 percent increase figure to remain within appropriations. The resulting percent increase was 2.02 percent. Interested parties can access the HCS and ICF/IID payment rates at the following link: <https://www.hhsc.state.tx.us/rad/long-term-svcs>.

Providers were given the option of not receiving the September 1 rate increases, which would exempt them from the 90 percent spending requirements; 34 HCS and 14 ICF/IID providers opted out. Providers that elected to receive the September 1 rate increases will have their 2015 Cost Reports evaluated to determine if the 90 percent spending requirements were met.

### **Recruitment and Retention**

2016-2017 General Appropriations Act, H.B. 1, 84<sup>th</sup> Legislature, Regular Session, 2015 (Article II, HHSC Rider 89) appropriated funds for the development of recruitment and retention strategies for community attendants to address the projected shortage of attendants. As part of the 2015 cost report process, HHSC collected data on attendant hourly wages, benefits and turnovers. In addition, HHSC conducted an on-line survey of providers who submit cost reports to gather data on initial wages paid to attendants, basis for wage increases (e.g. training, length of employment, merit-based), opportunities for wage enhancements (e.g. bilingual, high needs consumers, remote areas), estimated time to fill vacancies and average length of employment of direct care workers. Results of data analysis should be complete in the summer of 2016, and will be used to develop recruitment and retention strategies.

## SECTION IX: MISCELLANEOUS

The 84<sup>th</sup> Legislature passed several bills that promote independence and support rights of individuals who have been appointed guardians.

S.B. 1881, 84<sup>th</sup> Legislature, Regular Session, 2015, modified §1357 of the Estates Code to implement the Supported Decision-Making Agreement Act. This act provides a less restrictive alternative to guardianship for adults with disabilities who need assistance with decisions regarding daily living, but who are not considered incapacitated persons for purposes of establishing a guardianship. Supported decision-making is a process of supporting and accommodating an adult with a disability to enable the individual to make life decisions without impeding the self-determination. Supported decision-making can be used to make decisions related to where to live, what services, supports, and medical care the individual wants to receive, with whom the individual wants to live with, and where the individual wants to work.

S.B. 1664, 84<sup>th</sup> Legislature, Regular Session, 2015 amended the Education Code to establish the Texas Achieving a Better Life Experience (ABLE) program. The purpose of the ABLE program is to encourage and assist individuals and families in saving funds to support individuals with disabilities to maintain health, independence, and quality of life, and to provide secure funding for qualified disability expenses on behalf of designated beneficiaries with disabilities that will supplement, but not supplant, benefits provided through private insurance, the Medicaid program under Title XIX of the Social Security Act, the supplemental security income program under Title XVI of the Social Security Act, the beneficiary's employment, and other sources. The Texas ABLE savings plan account is established as a trust fund outside of the state treasury and is administered by the Prepaid Higher Education Tuition Board.

S.B. 1882 84<sup>th</sup> Legislature, Regular Session, 2015, amended §1151.351 of the Estate Code to establish a bill of rights for persons for whom a guardian has been appointed. The bill contains 24 specific rights including:

- to have a copy of the guardianship order and letters of guardianship and contact information for the probate court that issued the order and letters;
- to have a guardianship that encourages the development or maintenance of maximum self-reliance and independence in the ward with the eventual goal, if possible, of self-sufficiency;
- to be treated with respect, consideration, and recognition of the ward's dignity and individuality;
- to reside and receive support services in the most integrated setting, including home-based or other community-based settings, as required by Title II of the Americans with Disabilities Act (42 U.S.C. Section 12131 et seq.);
- to financial self-determination for all public benefits after essential living expenses and health needs are met and to have access to a monthly personal allowance;
- to receive timely and appropriate health care and medical treatment that does not violate the ward's rights granted by the constitution and laws of this state and the United States;

- to complain or raise concerns regarding the guardian or guardianship to the court, including living arrangements, retaliation by the guardian, conflicts of interest between the guardian and service providers, or a violation of any rights under this section;
- to self-determination in the substantial maintenance, disposition, and management of real and personal property after essential living expenses and health needs are met, including the right to receive notice and object about the substantial maintenance, disposition, or management of clothing, furniture, vehicles, and other personal effects;
- to personal privacy and confidentiality in personal matters, subject to state and federal law;
- to have the guardian, on appointment and on annual renewal of the guardianship, explain the rights delineated in this subsection in the ward 's native language, or preferred mode of communication, and in an accessible manner.

## GRANTS AND INNOVATIONS SUPPORTING PROMOTING INDEPENDENCE

### **2013 Lifespan Respite Care: Increasing Integration and Sustainability**

*Funding Source:* Administration for Community Living (ACL)

*Purpose:* DADS will use this grant funding to partner with the Texas Respite Coalition and key stakeholders to fill critical gaps in caregiver services and strengthen the long-term integration and sustainability of the Texas Lifespan Respite Care Program (TLRCP).

*Funding:* The total federal funding is \$250,000 for 2013-2015. Total state funding is \$83,333 for 2013-2015.

*Grant Period:* August 1, 2013 - October 31, 2015

*Key Objectives:*

1. Increased integration of caregiver training and outreach at Texas aging and disability resource centers (ADRCs).
2. Training for faith-based organizations about best practices for developing volunteer respite care services.
3. Outcome evaluation for respite services provided by contracted providers through the TLRCP.
4. Development and implementation of a Respite Summit in June 2014, to engage community stakeholders in raising awareness of and planning for a better coordinated approach to providing statewide respite services.

*Additional Information:*

- A Request for Proposals (RFP) was issued in February 2015 to procure training for faith-based and volunteer organizations on how to develop respite care programs. A contract for these services is expected to be executed in July 2015.
- DADS is conducting brief educational sessions on respite care for ADRCs during their monthly scan call. Sessions have thus far provided information on state and nonprofit

resources for respite care. DADS is also developing materials to assist ADRCs in conducting outreach on respite to Hispanic families.

### **2014 Lifespan Respite Care: Developing a Sustainable System of Respite Care**

*Funding Source:* Administration for Community Living (ACL)

*Purpose:* DADS will use this funding over a three-year period for outreach to low income and Hispanic/Latino population of caregivers, expand faith-based respite, develop an emergency respite pool and augment respite care for caregivers receiving services through the Care Transitions Program.

*Funding:* The total federal funding is \$351,000 for 2014-2017. Total state funding is \$117,810 for 2014-2017.

*Grant Period:* September 2014-August 2017 (36 months)

*Additional Information:*

- DADS entered into contracts with three ADRCs to provide respite services to caregivers in need of urgent or emergency respite care. Respite care will be available to caregivers who do not qualify for other state respite care programs and need emergency or urgent respite as a result of illness, hospitalization or other circumstances that put the care recipient at risk of being left unattended. The respite services contract period continues through August 2015.
- DADS also entered into contracts with three ADRCs to provide respite services to caregivers caring for individuals participating in the Community Care Transitions Program (CCTP). Each ADRC will receive \$10,000 to provide respite to caregivers of individuals receiving CCTP coaching designed to prevent hospital readmission. Respite care will be available to individuals who do not qualify for respite through other state programs. The contract period for these services continues through August 2015.
- An RFP to procure training for faith-based and volunteer organizations on how to develop a respite care program was posted in February 2015. The contracting process for this RFP should be complete by July 2015.

### **Texas Lifespan Respite Care Program**

*Funding Source:* Legislative Appropriation for 2014-15 Biennium

*Purpose:* DADS is using the funds to award grants via contracts with four providers to increase the availability of respite in Texas for caregivers caring for individuals of any age with any chronic health condition/or any disability and to increase caregivers' awareness of respite care services.

*Funding:* The total state general revenue funding is \$1,000,000 for 2014-2015.

*Grant period:* July 2014-August 31, 2015

*Key objectives:*

1. Caregivers are connected with respite service providers.
2. Information about available respite is maintained and provided to caregivers.
3. Increase evidence based caregiver training for caregivers of adults with Alzheimer's or dementia.

*Additional Information:*

- DADS initiated contracts with four ADRCs to provide respite services for the TLRCP. The contactors are Care Connection ADRC, Central Texas Aging and Disability and Veteran’s Resource Center, Coastal Bend ADRC, and East Texas ADRC. These ADRCs increase the availability of respite to caregivers, conduct public awareness and outreach events about respite care, and educate caregivers about the benefits of and access to respite care.
- These ADRCs complete surveys to report to DADS on caregiver inquiries about and receiving respite services plus caregiver satisfaction with respite services. As of May 2015, nearly 375 caregivers had received respite services and supports. Among these caregivers, over 300 caregivers (83 percent) have received respite services through the providers. Regarding caregivers’ satisfaction with respite services, 96 percent of caregivers rated their respite services as very good or excellent. Respite services were seen as helpful to 99 percent of caregivers. In addition, 97 percent of caregivers reported that receiving respite services left them feeling less stressed.

**Aging and Disability Resource Center (ARDC) Program Development**

*Funding Source:* Federal Administration on Aging (AoA) and ACL

*Purpose:* The purpose of this grant is to strengthen sustainability of the ADRC program.

*Funding:* \$138,894

*Grant Period:* September 30, 2013 – December 29, 2015

*Key objectives:*

1. Administer a request for applications process for sustainability projects. The process will result in proposals from ADRC partners to obtain assistance, administer training, or develop other research to support the following activities:
  - a. The development of managed care organization contracts;
  - b. The development of Medicaid administrative claiming processes; or
  - c. The development of new sustainable funding sources.
2. Complete ADRC sustainability webinars. The ADRCs funded through the request for applications process will discuss the success of their sustainability projects and any limitations to replication. The ADRCs will provide any templates they develop to the other ADRCs for future use.
3. Deliver the person-centered thinking training to ADRC staff. The aim of person-centered thinking training is to better promote the person-centered model by creating expertise within the ADRC structure.

*Additional Information:*

Through this grant opportunity, DADS is providing Person Centered Thinking Trainer Certification to ADRC staff across the state. The training is an in-person and involved experience conducted by the Institute for Person Centered Practices. The training certification will promote the person-centered model by creating expertise within the ADRC structure. The ADRC candidates are currently in the mentorship phase of their candidacy and have completed all coursework. Once the training is fully completed, participating staff will be certified trainers with capacity to train others in person-centered thinking. Two ADRCs are in the process of

finishing their proposed sustainability projects funded through the request for applications process.

### **ADRC No Wrong Door Program**

*Funding Source:* Federal Administration on Aging (AoA) and ACL

*Purpose:* Transforming State LTSS Access Programs and Functions into a No Wrong Door System for All Populations and All Payers.

*Funding:* \$225,000

*Grant Period:* September 30, 2014 – September 29, 2016

#### *Key Objectives*

The Department of Aging and Disability Services (DADS), in collaboration with the Health and Human Services Commission (HHSC), the Department of State Health Services (DSHS) and the Department of Assistive and Rehabilitative Services (DARS) received a grant award from the Administration for Community Living (ACL) to enter into a strategic planning process focused on planning for the aging and disability resource center (ADRC) role within the No Wrong Door (NWD) system. The grant project, “Building a Strategic Plan for the Successful and Sustainable Operation of the Texas ADRC No Wrong Door System”, required the development of a three-year strategic plan for the ADRCs.

In fiscal year 2015, DADS entered into an agreement with Leavitt Partners, Inc., to provide strategic planning services for the grant. In August 2015, DADS hosted five in-person listening forums throughout the state as well as two statewide webinars. There was good representation at each event, with some forums having upward of 70 attendees. DADS also gathered stakeholder feedback from a number of other venues, including an ADRC State Advisory Committee meeting, an ADRC Coalition meeting, and a designated email address. Through the listening forums, DADS obtained substantive and comprehensive insight on improvements to ensure the success of the ADRC role in the no wrong door system.

The forums helped shape the preliminary vision, mission and value statements, which were vetted and refined by the ADRC Strategic Planning Committee. DADS and Leavitt Partners incorporated this information into a three-year strategic plan for the ADRC program. DADS is in the process of finalizing this strategic plan by the end of the grant period.

### **ADRC Statewide Expansion**

*Funding Source:* State General Revenue

*Purpose:* Expansion of the Aging and Disability Resource Centers

*Funding:* N/A

*Grant Period:* N/A

In September 2014, DADS expanded access to ADRC services by increasing the number of ADRCs from 14 ADRCs to 22 ADRCs allowing individuals to access ADRC services in all 254 Texas counties. In January 2015, DADS implemented a single ADRC toll-free number, which is advertised on the DADS website and connects individuals to the ADRC in their area. An

individual may call the ADRC using the toll-free number and complete the same LTSS Screen with assistance. To promote the number, DADS launched a successful media campaign in January 2015 and a follow-up campaign later in the year. During the follow-up campaign there were nearly 70 news stories aired and published. In January the toll-free number received a little over 1,000 calls, which increased to approximately 3,000 calls each month.

In September 2015, DADS in collaboration with HHSC and DSHS launched the Long-term Services and Supports (LTSS) Screen. The LTSS screen is a single questionnaire to determine an individual's LTSS needs. The LTSS screen generates referrals to organizations that may be able to assist the individual with their needs. Individuals are able to complete the screen themselves, either anonymously or by creating a credentialed account via the "Your Texas Benefits" website.

## CONCLUSION

As in the original (2001) and the subsequent revised Promoting Independence Plans, the Health and Human Services Commission (HHSC) is committed to a continuing relationship with the Promoting Independence Advisory Committee (PIAC) and all of its stakeholders who participate on many health and human services workgroups and advisory committees. HHSC Executive Commissioner Traylor will continue to determine the number of members of the Committee and appoint members who represent the health and human services agencies, individual and family advocacy groups, related workgroups, and service providers. With the support of the Department of Aging and Disability Services (DADS), the PIAC will continue to monitor the state's progress implementing the existing and previous plans and make recommendations to HHSC in order to ensure community options for individuals with disabilities.

HHSC is committed to meeting the spirit and goals of the Promoting Independence Initiative (Initiative), the Plan and the Supreme Court's *Olmstead* decision. The state is in an ongoing process to offer community options so individuals may choose to live in the most integrated setting. The primary philosophy of the Initiative is that each individual exercise the principles of self-determination in choosing where he or she wants to receive long-term services and supports. The state has made significant progress offering Texans community-based alternatives to institutional placement thanks to a significant increase in legislative appropriations during the past six legislative sessions. The challenge for future legislative sessions and those working in the area of long-term services and supports is how the state will continue to meet its obligation under *Olmstead* and yet also meet the realities of sustaining community long-term services and supports programs for the future.

Even with all the funding and policy commitments, a large number of individuals still do not have a community choice and remain on an interest list for Medicaid waiver services.<sup>53</sup> HHSC

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<sup>53</sup> As of March 31, 2015, there are 101,090 individuals (unduplicated count) on the Interest Lists. Interest List data may be found on the DADS website at: <http://www.dads.state.tx.us/services/interestlist/>.

and DADS have included Exceptional Items with their Legislative Appropriations Requests for additional funding to meet the goals of the Initiative. In addition, HHSC has detailed the costs of increasing reimbursement to long-term services and supports providers and direct service employees in its *Health and Human Services System Consolidated Budget Fiscal Years 2016-2017*. HHSC is also recommending in this *2014/2015 Plan*, 27 new funding/policy directives (contingent upon legislative funding and/or policy direction).

HHSC would like to thank the Governor's Office and the Legislature for their ongoing commitment to the Initiative. Their foresight and willingness to support long-term services and supports systems change has made Texas' response to the *Olmstead* decision one of the leaders in the nation.

HHSC would also like to thank all members of the Committee and state agency staff, who have dedicated their time, resources, knowledge, abilities, and work in developing of this *2014/2015 Revised Texas Promoting Independence Plan* and the Promoting Independence Initiative. HHSC would like to thank those members of the public who responded to its invitation for comment at each Committee meeting.

The health and human services agencies will continue to further its work with individuals, advocates, providers, and agencies to improve the system of services and supports for individuals with disabilities. With everyone working toward the same goal, we will continue to make a difference, make the principles of self-determination a reality, and provide individuals the choice to receive needed services in the most integrated setting.

# APPENDICES

**Appendix A**  
**2014 Promoting Independence Advisory Committee Membership List**

**Dennis Borel**

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**Rachel Hammon**

Executive Director  
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**Cindy Adams**

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**Appendix A**  
**2014 Promoting Independence Advisory Committee Membership List**

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**Appendix A**  
**2014 Promoting Independence Advisory Committee Membership List**

**Agency Leads**

**Nancy Walker**

Texas Health and Human Services Commission

**Jon Weizenbaum**

Texas Department of Aging and Disability Services

**Trina Ita**

Texas Department of State Health Services

**Glenn Neal**

Texas Department of Assistive and Rehabilitative Services

**Jennifer Sims**

Texas Department of Family and Protective Services

**Terri Richard**

Texas Department of Housing and Community Affairs

**Clint Winters**

Texas Workforce Commission

**DADS PIAC Liaison**

**Kristi Jordon**

Texas Department of Aging and Disability Services

**Appendix B**  
**Executive Order GWB 99-2**

THE STATE OF TEXAS EXECUTIVE DEPARTMENT, OFFICE OF THE GOVERNOR-  
AUSTIN, TEXAS EXECUTIVE ORDER GWB 99-2

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 United States 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 C**  
**Executive Order RP-13**

**Executive Order RP13 - April 18, 2002**

**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

**Appendix C**  
**Executive Order RP-13**

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.

**Appendix C**  
**Executive Order RP-13**

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

**Appendix D**  
**Promoting Independence Advisory Committee**  
**2014 Recommendations**

**Community Services**

1. Increase funding to reduce waiver interest lists by 10 percent annually.

Waiver interest lists means that individuals who need community services are not receiving them. This waiting for services could result in ongoing deterioration of medical and functional well-being and being institutionalized. Community services, on average, are significantly less expensive than institutional services. While there is progress in reducing interest lists for individuals who would otherwise enter a nursing facilities any wait time is not acceptable. Individuals with IDD continue to wait as long as twelve years for services.

2. Texas should amend the Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), and Medically Dependent Children Program (MDCP) waivers to diversion slots for individuals who are at imminent risk for institutionalization due to a crisis.

Texas currently has diversion slots for individuals at imminent risk of institutionalization in the Community Based Alternatives/ Star+, and Home and Community-based Services waivers. There is no equivalent diversion protocol for individuals at imminent risk of institutionalization in CLASS, DBMD, and MDCP waivers.

3. Texas needs to eliminate Special Provision 43 subsection (b)(1)(iii)(b) of the 2014-15 General Appropriations Act(Article II, Special Provision, Section 43, Senate Bill 1, 83rd Legislature, Regular Session, 2013).

Section 43 states that general revenue can be used to support an individual to exceed a waiver cost cap if the person's health and safety cannot be met under the individual cost limit. Section 43(b)(1)(iii)(b) however, denies the ability of the individual to use the general revenue if the state determines that there is another living arrangement, like a nursing facility, that can meet the individual's needs.

4. Implement Community First Choice (CFC) and officially name the Promoting Independence Advisory Committee as the CFC Development and Implementation Council.

HHSC must implement CFC as soon as possible. CFC is a necessary program for helping all individuals with disabilities regardless of age to remain in the community. While CFC will help all individuals regardless of disability it will be significantly important to individuals with IDD who have no state plan program currently available to them. One of the federal requirements for CFC is the establishment of an advisory group (the Development and Implementation Council), consisting primarily of consumer, family and advocate members. The purpose of the CFC Council is to provide important input and guidance to the

State regarding analysis and feasibility of the Community First Choice

**Appendix D**  
**Promoting Independence Advisory Committee**  
**2014 Recommendations**

option.

**Children's Initiatives**

5. Allow all SSI children and young adults under the age of 21 who meet the medically necessary level of care for nursing facility and are at the Social Security Income (SSI) level of income to automatically receive the MDCP waiver level of services in StarKids without being on an interest list.

This recommendation mirrors the current STAR+ policy. Individuals who meet the medically necessary criteria for nursing facility placement and are at the SSI level of income automatically receive STAR+ waiver services without being on an interest list. This precedent should be equivalent for children served through StarKids

**Managed Care Initiatives**

6. Invest in community care ombudsman.

This proposal creates of an independent Medicaid community care ombudsman, who will be charged with the following responsibilities:

- Assist consumers who have lost Medicaid benefits in getting them reinstated, as indicated.
- Assist consumers who have complaints or concerns in resolving such issues through in-plan grievance procedures, as needed.
- Educate consumers about their rights and explain process of appealing care decision at state level, as needed.
- Assist consumers in requesting hearings, as needed.
- Assist consumers in preparing for hearings, as needed.
- Provide disenrollment counseling, as needed.

To ensure effective advocacy and coordination of services, the Medicaid community care ombudsman must have access to the Health and Human Services Commission (HHSC) Contract Management, Managed Care Organization (MCO) leadership, and the Centers for Medicare and Medicaid Services (CMS). CMS is providing states the opportunity to apply for federal funding to support the creation of a managed care ombudsman. HHSC has indicated that it has no plans to apply for the funds. It is recommended that HHSC take advantage of all reasonably available resources to create an independent ombudsman.

7. HHSC needs to establish more accountability and measurable objectives as it expands its managed care delivery system for long-term services and supports (LTSS).

**Appendix D**  
**Promoting Independence Advisory Committee**  
**2014 Recommendations**

Given the increase in the number of individuals with cognitive disabilities entering the managed care delivery system, HHSC needs to increase accountability for LTSS services in STAR+, specifically for service coordinators. This accountability covers: readiness review; ongoing reporting of performance measures and benchmarks; and adequacy of its provider network.

**Behavioral Health**

8. HHSC and the Department of Aging and Disability Services (DADS) will develop and implement strategies to improve the mental health and wellness of people with intellectual and developmental disabilities (IDD) receiving publicly funded physical health, mental health and/or long term services and supports.

Under this proposal, it is recommended that the strategies must include, but not be limited to:

- Expanding awareness and use of trauma-informed care and positive behavior support.
- Development of crisis behavior intervention for both children and adults with IDD.
- Addressing the workforce shortage of professionals with expertise and experience serving the mental health needs of this population.
- Identifying and promoting the use of state of the art mental health treatment for individuals with IDD including in-home modeling and mentoring.

9. HHSC and the Department of State Health Services (DSHS) will identify and implement changes needed to expand the use of certified peer specialists in the provision of mental health services in Texas.

Under this proposal, it is recommended that the development of peer specialists as part of mental health services should include, but not be limited to:

- Expanding Medicaid reimbursement opportunities for peer support services.
- Expanding opportunities for consumer operated service programs.
- Revising supervision requirements in order to expand the types of service settings able to provide peer support services.

Rules will be developed relating to peer certification and supervision requirements and other issues identified by the executive commissioner as necessary to promote health and safety in peer specialist services. Development of the rules will include input from certified peer specialists and other stakeholders.

10. Develop relocation services for individuals with serious and persistent mental illness

In order to increase opportunities for recovery, DSHS must develop and implement a program to provide relocation and transition for individuals leaving state psychiatric facilities and those with frequent hospital readmissions services (similar to those available to

**Appendix D**  
**Promoting Independence Advisory Committee**  
**2014 Recommendations**

individuals leaving other institutions including nursing facilities and state supported living centers). DSHS needs to look at the lessons learned from other relocation/transition services programs as well as the unique needs of individuals experiencing serious mental illness (SMI) when developing the design of the program.

**Relocation Services Initiatives**

11. Increase the number of relocation/diversion specialists and establish a dashboard with specific metrics indicating the status of relocation/diversion specialist activities.

In order to increase the number of relocations back into the community and decrease admissions to institutional settings, the state of Texas should increase the number of relocation specialists. Additionally, relocation specialists should also focus on diverting individuals from institutional settings. It is very important that benchmarks and metrics be established to determine the degree of success that relocation/diversion specialists are having with relocation/diversion activities. The state needs to establish a public dashboard in order to be transparent and share this data.

12. DADS needs to develop benchmarks/metrics for its State Supported Living Center (SSLC) relocation specialists.

DADS currently does not have specific goals/benchmarks/performance measures for the number of individuals to relocate out of SSLCs into the community. DADS should increase the accountability of current relocation specialists in SSLCs and implement goals addressing the number of people to be relocated from SSLCs.

**Housing Initiatives**

13. Increase targeting in all housing programs for individuals with disabilities at the SSI level of income administered/funded through the Texas Department of Housing and Community Affairs (TDHCA).

A number of TDHCA programs could focus more on the SSI level of income. TDHCA's Low Income Housing Tax Credit is the largest production program at TDHCA but is one of the hardest to design to reach the lowest income without utilizing the other gap financing. With the demand for housing assistance for individuals with disabilities, it is critical that the maximum amount of resources be allocated for this assistance.

**Appendix D**  
**Promoting Independence Advisory Committee**  
**2014 Recommendations**

14. Change legislation that would allow for the use of TDHCA federal HOME funds to provide housing opportunities for people with disabilities wherever they would want to live in Texas.

Current statute restricts the commitment of HOME funds to a 5 percent funding limit for programs that serve people with disabilities.

15. Establish a set-aside for Tenant Based Rental Assistance (TBRA) to serve those households with an individual with a disability on the Project Access waitlist.

The state of Texas is committed to moving individuals from institutional settings. Affordable housing has been identified as the primary barrier to living in the community. Currently, there is a significant wait list for Project Access voucher due to a reduction in funding. Waiting for a housing voucher is preventing individuals from relocating to a community setting but they could be assisted through the HOME TBRA Program. The funds for the HOME program set-aside for people with disabilities were exhausted in December 2013 so a set-aside to secure funds to move individuals out of institutions is needed.

16. Increase funding for Texas Department of State Health Services' housing voucher program to serve more individuals in the community to provide stable housing options for individuals experiencing mental illness.

The current funding allocated by the 83rd legislative session will not address the number of individuals with mental illness who require housing assistance.

17. Use a portion of the Texas Department of Agriculture (TDA) Community Development Block Grant (CDBG) funding allocation to address the housing needs of low-income people with disabilities in rural communities;

TDA's CDBG program's primary objective is to develop viable communities by providing decent housing and suitable living environments, and expanding economic opportunities principally for persons of low- to moderate-income. The state has traditionally used CDBG funding for infrastructure improvements; Currently the state does not use a portion of its annual federal allocation (CDBG funding) for affordable housing development or to remove architectural barriers to people with disabilities even though this is an acceptable and desired way of allocating CDBG funds.

**Appendix D**  
**Promoting Independence Advisory Committee**  
**2014 Recommendations**

19. Reclassify TDHCA's Amy Young Barrier Removal Program as a separate category of 'home modification' program that would be exempt from the Single Family (SF) Umbrella Rules then its current status as a 'rehabilitation' activity. The current classification results in a refocus of the program away from barrier removal and has eliminated manufactured housing as a type of housing that can have barriers removed.

Affordable and accessible housing has been identified as a barrier to living in the community and individuals with disabilities need home modifications to allow them to remain in their homes instead of institutions. The state of Texas has indicated a commitment to providing services to individuals with disabilities to remain in the community.

The Amy Young Barrier Removal Program has been modified to require non-barrier removal items to be addressed focusing more of the funds away from the critical modifications needed and raising the funds available for each home. These changes have resulted in less households being assisted so many more individuals with disabilities are waiting across the state for much needed assistance to live more independently. In addition, many low income individuals with disabilities reside in one of the approximately 750,000 manufactured homes in Texas that are now excluded from assistance leaving more facing barriers to living independently.

**Employment Services**

20. HHSC should develop specific guidance for Service Coordinators / Case Managers as to how to provide information on employment that includes information about how Employment First information is provided, when the information is provided and the frequency with which it is repeated.

In order to fully inform and support individuals with disabilities about their employment options and maintain consistency in services delivery, it is important that specific guidance be developed for Service Coordinators / Case Managers as to how to provide information on employment. The goal of the guidance should be to provide reliable and accurate information on employment and work supports to encourage waiver recipients who want to work to pursue their goal. Additionally, the guidance should provide that prevocational and supported employment service options, including career planning, be reviewed and considered as a component of an individual's person-centered services and supports plan no less than annually, more frequently as necessary or as requested by the individual. These services and supports should be designed to support successful employment outcomes consistent with the individual's goals.

**Appendix D**  
**Promoting Independence Advisory Committee**  
**2014 Recommendations**

21. Texas should provide payments for customized or supported employment services on an individualized budget that reflects the needs of the person and where they are in the process of employment.

The current rate setting codes and methodology do not provide the flexibility that is needed to implement sound employment services with sustainability. Incentives for obtaining quality outcomes in employment should be built into contracts for both MCOs and the direct support providers.

**Workforce and Provider Stabilization**

22. HHSC, DADS and the Department of State Health Services (DSHS) should seek an increase in legislative appropriations in an amount necessary to raise the base wage for entry-level direct-support workers (DSWs) in home and community-based services (HCBS) programs. Initial efforts should focus on programs with the lowest paid DSWs. Additional requests should fund increased wages to DSWs on a graduated scale based on scope of work.

The PIAC subcommittee on DSWs continues to find that the state faces serious challenges meeting current and future needs for a stable and adequate direct-support workforce. The demand for DSWs in Texas is expected to increase substantially over the next decade due to numerous factors, including the aging baby boom generation, aging family caregivers, and the increasing prevalence of disabilities. Meanwhile, retaining DSWs has long been a challenge and job turnover rates are high statewide. Low pay is a significant factor in recruitment and retention.

Evidence indicates that increased wages positively influence recruitment and retention. DSWs are the foundation of the community-based long-term services and supports system. Higher wages contribute to a more stable workforce and improved service quality. A significant decline in recruitment and retention will likely lead to a shortage of available community services, resulting in increased hospitalization and institutionalization.

The 83rd Legislature (2013) did increase wages to establish a floor for DSWs at \$7.86/hour. This amount is barely above minimum wage and significantly below the standard for a living wage.

23. Increase provider and managed care reimbursement in order to attract and sustain provider capacity and network readiness.

**Appendix D**  
**Promoting Independence Advisory Committee**  
**2014 Recommendations**

Increasingly, the state is losing providers of direct services, direct service workers, physicians, licensed nurses and other professional who provide long-terms services and supports 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 does not have sufficient contracts with specialists and providers who can serve these individuals. It is critical for the provider base and managed care systems to have an adequate direct service worker and network system in place to serve all in individuals in a community-based setting.

**Miscellaneous**

24. Require Community Living Options and Information Process (CLOIP) for all individuals residing in private ICFs/IID.

Currently, individuals residing in private ICF/IID are not required to have a full CLOIP process. By having the Local Authority provide the CLOIP process for all individuals, the state ensures consistency and accuracy across programs and all individuals with IDD given a full measure of their possible residential options.

25. Decrease the amount of time an individual in a private nine or more bed Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID) has to wait for an HCS slot.

Currently, individuals residing in a nine or more bed private ICF/IID may have to wait up to twelve months for an HCS Promoting Independence Priority slot.

26. Implement recommendations developed as a result of developing the SSLC Long-Term Plan as required by the 2014-15 General Appropriations Act (Article II, Department of Aging and Disability Services, Rider 39, Senate Bill 1, 83rd Legislature, Regular Session, 2013).

Rider 39 requires a ten-year SSLC Long-Term Plan.

27. The State of Texas should tie employment opportunities for individuals with disabilities to its economic development programs, including businesses that receive incentives.

Any business receiving state assistance and/or incentives as part of economic development should be required to learn of and explore possibilities of hiring people with disabilities. This shall include training in the business case for employing people with disabilities and required engagement with the Texas Department of Assistive and Rehabilitative Services and other placement programs.

**Appendix D**  
**Promoting Independence Advisory Committee**  
**2014 Recommendations**

28. Create reciprocity of paratransit approvals among Texas communities. Remove the 21 day cap for use of paratransit in community visited. Make a paratransit approval valid statewide and remove limit on the use in the visited community. Encourage the use of mainline transportations systems when possible and the development of mainline systems everywhere.

Individuals with disabilities require pre-approval to use paratransit in their home community. When traveling to another community, documents establishing eligibility must be submitted. The visited community limits the number of days per year that paratransit may be used to 21. This can be inadequate for individuals conducting ongoing business, health care treatments or advocating to the Legislature. House Bill 1545 (83rd Legislature, Regular Session, 2013) authorizes a study of this issue. In addition, when possible, the state should encourage the use of mainline transportation and work to make mainline transportation accessible and available everywhere.