IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

ERIC STEWARD, by his next friend and mother, Lilian Minor, *et al.*,	§	
Plaintiffs,	§	
v.	§	
CHARLES SMITH, Governor, *et al.*,	§	
Defendants.	§	
	§	CIV. NO. 5:10-CV-1025-OG
THE UNITED STATES OF AMERICA,	§	
Plaintiff-Intervenor,	§	
v.	§	
THE STATE OF TEXAS,	§	
Defendants.	§	

PLAINTIFFS' AND THE UNITED STATES' EXPERT DISCLOSURE AND DECLARATION FOR KATHY E. SAWYER

I declare under the pains and penalties of perjury under the laws of the United States and in compliance with Fed. R. Civ. P. 26(a)(2)(B) that this document and the attached is true and correct and that I am submitting this disclosure regarding my work as an expert consultant in the above case.

1. I have been retained by the Plaintiffs and the United States as a joint expert in the *Steward v. Smith* litigation.

2. My report, which is attached, contains a complete statement of all of my opinions as well as an explanation of the basis and reasons for those opinions.

3. My report describes the facts, data and other information I considered in forming my opinions.

4. There are no exhibits prepared at this time to be used as a summary of or support for my opinions.

5. My attached curriculum vitae states my qualifications and lists all publications I have authored within the past ten years.

6. Within the last four (4) years, I have submitted a declaration as an expert in the following matter: *U.S. v. Georgia*, Civ. Action No. 1:10-CV-249-CAP (submitted Jan. 19, 2016)

7. My compensation in this litigation is $200.00 per hour for preparation of reports and statements, and for deposition or testimony, plus expenses. My compensation is not dependent on the outcome of this litigation.

This information is accurate and complete to the best of my knowledge, information and belief.

Signed and dated:

March 30, 2018

Kathy E. Sawyer

CERTIFICATE OF SERVICE

I certify that on this 30th day of March, 2018, a true and correct copy of the foregoing Plaintiffs' and the United States' Expert Disclosure and Declaration of Kathy E. Sawyer was delivered via electronic mail and Federal Express to the attorneys for defendants at the addresses below:

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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

ERIC STEWARD,
by his next friend and Mother, Lillian Minor, *et al*.,

Plaintiffs,

v.

CHARLES SMITH,
Executive Commissioner of the
Texas Health and Human Services Commission, *et al*.,

Defendants.

_____ Case No. SA-5:10-1025-OG

THE UNITED STATES OF AMERICA;

Plaintiff-Intervenor,

v.

THE STATE of TEXAS;

Defendant.

EXPERT REPORT OF KATHY E. SAYWER
Submitted March 30, 2018

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Attachments:

I. Introduction

My name is Kathy E. Sawyer, MSW, ACSW and I am an Independent Consultant with extensive experience in the management and review of government systems serving persons with intellectual and developmental disabilities. My professional work experiences that qualify me to serve as an expert in this case are summarized below.

II. Professional Experience and Methodology

A. Expert's Professional Experience and Qualifications

From January 1999 to February 2005, I served as Commissioner of the Alabama Department of Mental Health and Mental Retardation, with a budget of over $600 million in state and federal dollars, including Medicaid funding through the Home and Community Based Waiver Program. In this capacity, I was responsible for all state operated residential facilities, including four intermediate care facilities (ICFs) for persons with intellectual disabilities.[1] In addition, I was responsible for the overall administration of the Department's contracted and certified community-based programs, including those providing residential, day habilitation, and vocational services for persons with intellectual disabilities. Under my leadership, the state significantly expanded community-based services in the areas of housing, behavioral supports, and other specialized services. These service expansions, among other accomplishments, led to the settlement and termination of the 32-year-old *Wyatt v. Stickney* class action lawsuit in 2003.[2] Following the termination of the *Wyatt* case, I directed the consolidation and closure of eight of

[1] Intermediate Care Facilities, created under the Social Security Act, are a Medicaid option that funds institutions (four or more beds) for individuals with intellectual disabilities, and requires that these institutions provide active treatment.

[2] *Wyatt v. Stickney* (M.D. Ala.), filed in 1971, is a federal class action lawsuit that first established the constitutional right to treatment for persons involuntarily committed to state institutions serving persons with mental illnesses.

Alabama's 14 in-state facilities, including three of the ICFs, and successfully transitioned hundreds of individuals to community-based settings throughout Alabama.

In 2005, I was retained by the Office of the Mayor for the District of Columbia as a consultant in *Evans v. Fenty*, a long-standing class action involving individuals with intellectual and developmental disabilities. I served in various capacities including being appointed Interim Director of the District's Mental Retardation and Developmental Disabilities Administration. As Interim Director, I led the transition of the Administration to a full cabinet level agency, the Department of Disabilities Services. In that role, I directed the establishment of the Department's independent personnel, contract, procurement, budget and finance offices, among others. Further, during my tenure, systems to ensure health, safety, and delivery of quality services were newly established and/or significantly transformed, including service coordination, incident management, and high-risk health management systems. I also led the expansion of the District's Home and Community Based Waiver Program for persons with intellectual disabilities, which drastically increased services but also transitioned the District from being primarily dependent on state and local funding to a community service system that is mostly federally funded through the Medicaid waiver.

In 2010, the United States District Court for the District of Columbia appointed me the Independent Compliance Administrator in *Evans v. Fenty.* In this capacity I was responsible for guiding and directing the defendants' compliance with the court's orders, which set forth seventy-one criteria in nine compliance areas: Individual Habilitation; Residential, Vocational and Day Services; Staff Training; Personal Possessions; Restricted Control Procedures; Protection from Harm Procedures; Case Management; Quality Assurance; and Adequate Budget.

Under my direction, defendants achieved full compliance with all of the court's orders and the 43-year-old case was terminated in January 2017.

Currently, I am a consultant with the Developmental Disabilities Division of the Alabama Department of Mental Health. Attached as Attachment A is a copy of my curriculum vitae for a more detailed listing and description of my professional work experiences and qualifications.

B. Focus and Methodology of Review

This report describes my findings, both positive and negative, from my review of the Texas Intellectual and Developmental Disabilities Service System. Areas reviewed are those I deem to be critical to compliance with federal laws pertaining to serving people with intellectual and developmental disabilities and related conditions in the most integrated setting to meet their needs, including the Americans with Disabilities Act. Critical areas include: organizational structure and staffing; systemic funding, planning, and development; service planning and coordination; sufficient provider capacity to serve individuals in the community; mechanisms to ensure that individuals with IDD and their LARs are able to make an informed choice whether to remain in a nursing facility or transition to the community; and quality assurance/ improvement systems designed to monitor, evaluate and improve performance.

The report specifically examines the effectiveness of Texas's diversion and transition services in preventing unnecessary institutionalization of individuals with IDD in nursing facilities. The population focused on in this report is persons over 21 years of age with intellectual or developmental disabilities or related conditions (IDD) who are Medicaid-eligible (individuals, people, or persons with IDD) and who: currently reside or are at risk of residing in nursing facilities.

The report seeks to answer the following questions:

a. Are there systemic issues with Texas's developmental disability service delivery system that lead to the unnecessary segregation of individuals with IDD in nursing facilities?
b. Are the system's resources (including funding and waiver slots) and service capacity sufficient to meet the diversion and transition needs of individuals with IDD in nursing facilities?
c. Does Texas have policies, procedures, practices, and information sufficient to allow individuals with IDD to make an informed choice on whether to leave nursing facilities?
d. Does Texas adequately plan for the needs of individuals with IDD in nursing facilities?
e. Does the system have effective quality assurance mechanisms including quality improvement and assurance strategies that: identify important quality indicators; collect relevant data; monitor and evaluate performance; enforce corrective action, when indicated; and effectuate change that leads to improved outcomes for individuals with IDD in nursing facilities?
f. Does Texas have an effective *Olmstead* Plan that individuals with IDD who can benefit from, and do not oppose, community living can transition from nursing facilities to the community?

In reaching the findings and conclusions opined on in this report, I have relied on information obtained from meetings with counsel for Plaintiffs and Plaintiff-Intervenor and review of a variety of documents, as provided by Plaintiffs and the Plaintiff-Intervenor.

Documents reviewed include: HHSC policies, procedures, and regulations; staffing and organizational charts; performance contracts and reports; funding requests and budget appropriations; and waiver and other service planning, enrollment, and assessment reports. Transcripts of state officials' depositions were also reviewed and served as a major source of information for this report. Attached as Attachment B is an index of all facts, data, and other information considered in reaching the opinions set forth in this report.

III. Critical Components of a Community Service System Serving Persons with IDD

One of the first steps in assessing a system is to determine if the system has all of the components necessary to successfully achieve its purpose. In my opinion, the ultimate purpose or goal of community systems serving people with IDD is to provide services that meet the individual's needs and choices in settings that are safe and fully integrated in communities. The following are components I have found, in my experiences, to be critical for service systems to be effective in serving persons with IDD in the community.

To begin with, there must be a commitment to a core set of values that embrace and actively promote the rights of individuals with IDD, especially the rights to informed choice, to be safe, and to be protected from harm. In carrying out this commitment, the system must recognize the special needs and limited life experiences of persons with IDD and thereby, develop systems and services that not only protect these rights, but aggressively create opportunities for individuals to exercise these rights. The system's commitment to these core values is extremely important and must be evidenced in performance of all of its critical functions, such as: system strategic planning; funding and resource development; service planning, coordination, and delivery; monitoring and oversight; and compliance enforcement.

A. Planning

Planning is critical in order to ensure the system accurately identifies the needs of those to be served and utilizes this information to ensure adequate resources to effectively meet these needs. For systems serving persons with IDD, it is important that this planning occurs on two levels: the individual level and the system level. Individual level planning, oftentimes referred to as "individual service planning," is that which is conducted to assess the unique needs, strengths, preferences, etc., of the person being served. These assessed needs and preferences are then used by interdisciplinary service teams to develop service plans that guide the development, coordination, and delivery of services to the person. System level planning utilizes the aggregate results of all individual assessed needs, as well as other information and data sources, to develop systems of services needed for all persons in the target population. Both system level and individual level planning are critical for systems of this nature in order to ensure adequate and appropriate service capacity to achieve desired goals and outcomes.

B. Funding and Resource Development

The system's level and adequacy of funding are important and determine whether the system has sufficient resources to develop and provide the service capacity to meet individuals' needs in the community. A combination of local, state, and federal funding sources is typically used to provide the vast array of services needed to meet the special needs of this population. It is common in these systems to find a heavy reliance on federally funded services and programs to serve individuals with IDD. The federally funded services utilized for home and community-based settings are those of the State's Medicaid Plan, and services and supports through Home and Community Based (HCBS) Waivers through the Centers for Medicare and Medicaid (CMS). These waivers are extremely important, as they enable states to receive federal matching funds to

provide an array of community-based services and supports that facilitate the community integration of people with IDD. The importance of waivers is even greater for rural areas and states where the availability and access to very specialized services is limited and, without federal funding, would not be considered cost effective.

C. *Service Planning, Coordination, and Delivery*

Service planning, coordination, and delivery are major components of community service systems for people with IDD. In general, these elements of an IDD service system ensure that the individual's needs have been properly assessed and identified; that all services and supports needed to meet the individual's needs in community integrated settings have been identified and secured; and that barriers to community placement and integration have been identified and, if necessary, strategies to address these barriers have been implemented. An effective service planning, coordination, and delivery system is required for successful diversion and transition of people from institutional settings, and for ongoing provision of supports and services to prevent re-institutionalization.

D. Service Capacity

Building adequate service capacity is another critical component of IDD service systems. The service capacity required is typically determined by results of both individual and system level assessments and planning, as described earlier in this report. The results of these assessment and planning efforts identify the type, level, location and quantity of resources needed to adequately meet the basic and specialized individual needs of people with IDD, consistent with their individual preferences and choices. The system's service capacity must include an array of services and supports typically required for people with IDD, including: residential, habilitation, transportation, employment, clinical, medical, adaptive supports, home

modifications, wheelchair accessible providers and programs, and others. The availability of specialized clinical, nursing, medical and adaptive services and supports is critically important in order to have an adequate service capacity for this population.

E. Community Integration and Inclusion

Full community integration and inclusion of people with IDD is the recognized practice in the field and should be the ultimate goal of states' community service systems for persons with IDD. Unlike the deinstitutionalization movement of earlier decades, which simply sought to move people with IDD out of large institutions and place them in smaller community residential settings, current standards recognize the importance of providing people with IDD opportunities to fully integrate into their communities of choice for all aspects of their lives, including residential, employment, recreational and others. This is particularly true for states, like Texas, that participate in CMS HCBS waiver programs. In March 2014, CMS issued final rules requiring that settings funded by HCBS waivers be integrated in and promote participation and full access in communities. States have until March 2022 to fully comply with the new settings requirements. As noted later in this report, Texas relies heavily on these HCBS waivers and thus, is directly impacted by these requirements.

F. Quality Assurance and Improvement

Comprehensive quality assurance mechanisms, with continuous quality improvement strategies, are a necessary component of systems serving this population. The Quality Assurance/Improvement mechanisms are essential to protect individuals from harm, promote choice and customer satisfaction, validate that services are provided at a level and in a manner that is compliant with the system's expressed standards and regulations, including binding federal regulations, and improve the quality and availability of services where deficiencies are

identified. An effective Quality Assurance/Improvement system must include: measurable performance indicators for all providers of services, including agency and contract personnel and providers; periodic monitoring and oversight of service delivery; collection, analysis, and utilization of performance data; and use of corrective actions to improve deficient performance. Corrective action strategies to enforce compliance are usually progressive and include among other elements: training, technical assistance, and issuance of sanctions, including termination.

IV. Standards and Accepted Practices in the Field

In evaluating the effectiveness of Texas's IDD system in preventing unnecessary institutionalization of people with IDD in nursing facilities, I used various standards and guiding principles, including Title II of the ADA; regulations and agency guidance concerning Title II; rules, assurances, and standards as promulgated by CMS, including the rules regarding the HCBS waiver program; Texas's regulations, policies, procedures, quality assurance measures, LIDDA Performance Contract requirements, and other documents developed to comply with Title II of the ADA; professional standards and accepted practices in the field of intellectual and developmental disabilities concerning ensuring integration; and my experience in directing service systems for people with IDD.

A. Assessment

There must be an accurate, reliable, and professionally acceptable method for assessing all habilitative needs of people with IDD. While there are a range of validated assessment instruments used by public IDD systems, it is essential that a standardized assessment instrument and process be used consistently by trained staff, in order to determine functional strengths and needs in all habilitative areas. A comprehensive functional assessment process, implemented by trained IDD professionals, is the well-accepted standard in virtually all IDD systems.

Information generated by these assessments are used both to determine needed services on an individual level and determine system capacity demands on a statewide level.

B. Informed Choice and Transition Planning

In order to ensure that people with IDD are not unnecessarily segregated, they must be given an informed and meaningful choice about where to live. For individuals to have such a choice, they must be given information about a range of living options. The information they are given must be detailed, concrete, and individualized. Similarly, the living options they are presented must address their needs, preferences, and previous experiences. To make an informed choice, individuals must receive information about various alternative services with detailed information about how each service would meet their needs. This standard has been accepted by Texas as well: Texas rule and the Performance Contract require service coordinators to discuss a range of community living service and support options with residents of nursing facilities at their first visit and every six months.[3]

The importance of the process of educating individuals about living options is particularly pronounced for people with IDD who have limited abilities to understand complex information. Often people with IDD need to receive information in a concrete way. For example, while it is likely important for all individuals to see options for where they may live, it is particularly important for people with IDD to see potential living arrangements, try living in potential settings for a short period of time, and speak with individuals who have moved. It is also important, during this process, for there to be an individual such as a service coordinator or other person who has knowledge and experience about available community services and the

[3] One exception to this rule is that LIDDAs are only required to discuss community living options with individuals who refuse service coordination at their first visit and annually thereafter.

transition process who is trusted by the individual and can assist the individual in making a decision. Texas's policies recognize these standards as well. The LIDDA Performance Contract requires that the service coordinator facilitate visits to community programs and offer educational activities and information to individuals in nursing facilities and their families. Important and effective educational opportunities noted by the State in the Performance Contract include peer-to-peer programs, in which individuals can speak with others who have moved into the community, and similar family-to-family programs for individuals' families.

This process of educating individuals about living options and planning for their transition needs to begin early—ideally before an individual ever enters into an institution. Planning for an individual's transition from an institution like a nursing facility into the community should be integrated into the assessment and person-centered planning process from the beginning. Individualized Service Plans (ISPs) should include basic information about an individual as well as that person's goals, objectives, needs, and services. Importantly, it should also include a vision statement for what the individual's life in the community would look like as well as practical, individualized living options and goals for the individual. Person-centered planning should focus on the individual's barriers to community living and the team's efforts to address those barriers, including any concerns of the individual or family members tied to prior community placements. This is reflected in Texas policy, which requires concerns and barriers to be listed and addressed. ISPs must be individually-driven and formulated through the person-centered planning approach, which is a well-established professionally accepted standard in the field.

Ultimately, to ensure individuals with disabilities are not unnecessarily segregated, it is crucial that they have access to individualized community living arrangements that address their

needs and preferences, including the full array of medical, behavioral, adaptive, and other supports they need. There must be a detailed plan for the person's transition that will enable them to move from an institution to the community safely.

C. System Planning

As mentioned above, in addition to individual planning, it is important for a state to have reliable information about the strengths, needs, and preferences of the individuals it serves in institutional settings, in order to adequately plan to serve individuals with IDD in the community. The state must utilize the aggregate results of individually-assessed needs to make determinations of needed services and develop systems of services. In conducting system planning, it is essential for a state to consider and address existing problems, barriers, gaps, and deficiencies in the system, and to consider the needs of particular populations that may be difficult to serve. For example, to effectively plan to serve the population of individuals with IDD in nursing facilities, the system must consider the unique needs of individuals with high medical or behavioral support needs, assess whether the system is currently meeting those needs, and respond if the system is not meeting those needs. It is also essential that the system assess and plan for the number of people who will be at risk of institutionalization and who will be interested in transitioning out of institutions, to determine the needed amount of available resources, provider capacity, and Medicaid waiver slots.

D. Training

It is essential to a functioning system that all people who work with individuals with IDD receive training about intellectual and developmental disabilities and communication strategies for people with IDD. Further, training must include strategies to meet the habilitative needs of people with IDD and methods to develop and implement an ISP. Having qualified staff who are

trained in both IDD service issues as well as the specific services that are provided to individuals whom they serve is a well-accepted standard in public IDD service systems. It is accepted practice in the field that training be competency-based.

E. Quality Assurance

It is essential that individuals who lead the system and who enact the policies within a system are aware of, and engaged in, the system's quality assurance and improvement activities. Key personnel at many levels of an agency's decision-making chain must know how the system is performing and whether it is achieving its goals. Without this knowledge, they are unable to know whether performance is failing and are unable to improve for the benefit of the people they serve. Virtually all IDD service systems are expected to have an effective quality management and improvement program that measures performance, identifies deficiencies or gaps, takes corrective action, and then determines if that corrective action has effectively resolved the problem. This sequence, often referred to as a QA/QI feedback loop, is the well-accepted standard for public IDD systems.

V. Findings

My review of the Texas system found that, although on paper, many of the critical components of a service system as described in the foregoing pages appear to exist, there are nevertheless significant gaps. Among significant gaps noted are a lack of: (1) planning that clearly identifies and addresses the needs of individuals with IDD in nursing facilities and at risk of admission to nursing facilities; (2) policies and procedures for people with high medical needs that ensure their ability to live safely in community-based settings; (3) an appropriate outreach, education, and informed choice process; (4) adequate waiver slots to serve individuals with IDD in nursing facilities or at risk of admission to nursing facilities; (5) strategies and actions to

address continuing barriers that prevent individuals from living in the community, including a lack of provider capacity; and (6) an adequate quality assurance system with improvement plans and strategies, and enforcement mechanisms. Finally, I found that Texas does not have an effective *Olmstead* Plan that prevents unnecessary segregation. These findings are described in the following pages and provide responses to exploratory questions posed earlier in in this report.

A. Deficiencies in Texas's Intellectual and Developmental Disabilities Services Delivery Lead to the Unnecessary Segregation of Individuals with IDD in Nursing Facilities

1. HHSC's Organizational Structure, Functions, and Staffing Reveal Significant Deficiencies

Authority and responsibility for the provision of services to individuals with IDD in nursing facilities or at risk of admission to nursing facilities are primarily delegated to Local Intellectual and Developmental Authorities (LIDDAs) in each service area of the state. In addition, Texas contracts directly with a number of other providers for home and community based waiver services. Thirty-nine LIDDAs currently operate in the state by contract with the former Texas Department of Aging and Disability Services (DADS), which was abolished September 1, 2017, and its functions transferred to the Texas Health and Human Services Commission (HHSC). The abolishment of DADS was prompted by a Sunset review and later, mandated by Senate Bill 200 of the 84th Texas Legislature. The Sunset review cited DADS' failure to regulate providers and take enforcement actions, even for serious and repeat offenses; fragmented monitoring and management of contracts by hundreds of staff across the agency; agency operations occurring in silos; and a need for more support in the community for persons with complex behavioral and medical needs.

Although statutory authority and responsibility was transferred from DADS to HHSC, LIDDAs remain contractually obligated for intake and eligibility determinations, individual service planning, service coordination, monitoring service delivery, resource development and allocation with the LIDDA service area, and oversight of local IDD services. HHSC is responsible for systemic policy and planning, funding, contract management, remediation of systemic deficiencies, and monitoring of LIDDAs and other providers for program and fiscal compliance.

This review found that the organization's recent transformation and restructuring has not fully realized the intended goals of a more streamlined and efficient system. Depositions of staff reveal that there continue to be silos and failures to share relevant data and other information across units. This is especially noted with the oversight of LIDDAs and enforcement of program compliance. The impact of these continued failures is evidenced by the state's level of compliance with their own performance outcomes, which is described in more detail later in this report.

2. Texas Underutilized its Medicaid Waiver Slots and Currently Lacks a Sufficient Number of Waiver Slots to Serve All Individuals with IDD in Nursing Facilities Who Would Benefit and Not Oppose Placement in the Community

Texas has underutilized its Medicaid-funded waiver slots and failed to take sufficient action to meaningfully increase waiver slot utilization for individuals with IDD in, or at risk of entering, nursing facilities. Currently, as discussed below, Texas has insufficient diversion and transition slots to meet the projected needs of individuals with IDD who are in, or at risk of entering, nursing facilities.

The Medicaid Home and Community-based Services (HCS) waiver program is the state's primary source of funding for diverting and transitioning people with IDD from nursing

facilities. In addition, the State funds General Revenue services, provided by or through LIDDAs. Among the various services provided through the Medicaid waiver program for persons already living in the community are: residential assistance; physical therapy; speech and language pathology; occupational therapy; employment assistance and supported employment; day habilitation; nursing; and behavioral support.

For the past several years, the Texas legislature has directed certain appropriations for HCS waiver slots for the specific purposes of avoiding admission to nursing facilities (diversion slots) and moving persons with IDD from nursing facilities into community-based settings (transition slots). These legislative appropriations are deemed as exceptional items in budget requests and are noted in the State's *Olmstead* plan, entitled the "Promoting Independence Plan." In 2014, Texas conducted a process to identify the number of people with IDD in nursing facilities, which it used to support a request for transition and diversion Medicaid-funded waiver slots. As a result of this process, Texas funded a total of 510 waiver slots (150 for diversion and 360 for transition) for fiscal years (FY) 2014-15. Based upon Texas's estimates of need, DADS increased its legislative request for waiver funding for FY 2016-17—asking for a total of 1300 slots (600 for diversion and 700 for transition).[4] Similarly, for FY 2018-19, HHSC's legislative appropriations request included 700 slots to transition individuals from nursing facilities and 600 slots for diversion purposes.

State officials determined the initial request for 1300 slots (600 for diversion and 700 for transition) for FY 2018-19 based upon the estimated need and demand. Based upon this analysis, HHSC determined that this appropriations request for 1300 additional diversion and transition waiver slots was appropriate. However, HHSC received appropriations for only 150

[4] The 700 transition slots were divided into 680 slots for adults and 20 slots for children.

transition slots and 150 diversion slots in FY 2018-19, which began on September 1, 2017. This is less than a quarter of the requested number of waiver slots and less than half the number of diversion and transition slots utilized in the last biennium.

The tables below illustrate the allocations and utilization of the transition and diversion waiver slots for the past three biennia. The FY 2018-19 biennium is ongoing, so the numbers of waiver slots enrolled are not yet available.

Table 1- Transition Waiver Slots

	FY 14-15	**FY 16-17**	**FY 18-19**
Initial Request	360	700	700
Allocated	360	680	150
Enrolled	145	403	

Table 2- Diversion Waiver Slots

	FY 14-15	**FY 16-17**	**FY 18-19**
Initial Request	n/a [5]	600	600
Allocated	150	600	150
Enrolled	140	382	

As shown in these charts, the number of transition and diversion slots allocated for the FY 2018-19 biennium—and thus available for individuals with IDD in nursing facilities or at risk of entering them, as of September 1, 2017—is significantly lower than either the slots

[5] It appears from my review that DADS did not initially request diversion waiver slots for individuals at risk of placement in nursing facilities for the FY 2014-15 biennium but later allocated diversion slots from the HCS interest list.

requested for that biennium or the slots enrolled in the previous biennium. In addition, according to State officials, the number allocated for FY 2018-19 is further reduced because any person who was in the enrollment process but not finally made a waiver participant as of August 31, 2017 has to be counted against the FY 2018-19 numbers, thereby reducing the available slots for the next biennium by two-thirds of all transition slots and almost half of all diversion slots. Accordingly, HHSC has only 50 appropriated transition slots available for the entire biennium for individuals with IDD in nursing facilities, and only 79 appropriated diversion slots available to prevent nursing facility placement for people with IDD.

The State's documents indicate, and the State's administrators confirm, that they had planned to use slots that were vacated as a result of attrition ("attrition slots") to make up for this huge deficit. But State officials, although they have tried to make some projections, were unable to predict how many people would vacate their slots to create attrition slots each month. In addition, the State has prioritized other target groups for attrition slots, so the first available attrition slots will go to people at risk of placement in other institutions (not including nursing facilities). Nursing facility diversion is listed as the second priority, and individuals who would like to transition out of nursing facilities are third on the priority list. Thus, the 79 slots for diversion and 50 slots for transition available for individuals with IDD for FY 2018-19—both numbers well below HHSC's own projected need—are all that is guaranteed to be available for individuals with IDD in, or at risk of entering, nursing facilities.

Further complicating matters was HHSC's decision to divide up the allocated transition slots so that they would not be released until FY 2019, resulting in no allocated transition slots available in FY 2018. Thus, unless an individual who wants to transition from a nursing facility in FY 2018 can be placed into an unpredictable and unforeseeable vacancy in a current waiver

program, they will have to wait at least until FY 2019 to leave the nursing facility and receive community waiver services. The prospect of waiting up to a year to transition makes it far less likely that an individual will in fact leave the nursing facility.

The data pertaining to slot allocations raises several concerns about the state's methods for planning and assessing needs, particularly for purposes of funding and building service capacity necessary to meet the needs of individuals with IDD in or at risk of admission to nursing facilities. Historically, the annual enrollment or utilization of transition waiver slots is less than the number of slots allocated by the Legislature in each of the fiscal years for which data are available. In the first biennium (FY 2014-15) approximately 40% of the slots allocated were utilized, and in FY 2016-17 there was enrollment of only 59% of the slots. Similar concerns are noted about the use of diversion slots. Though in the first biennium, 93% of the slots were used, in the second biennium (after a significant increase in the number of slots allocated), approximately 63.67% of the available slots were used. As discussed below in Section V.A.4, a number of barriers to community placement for people with IDD exist in Texas; these barriers may lead to underutilization of waiver slots. In summary, Texas has underutilized and failed to enroll individuals for reasons that may well not reflect either the needs or preferences of individuals with IDD or their families. This underutilization of waiver slots may have contributed to the dramatic and unjustified reduction in recent appropriations for new waiver slots.

The reduction in slots for FY 2018-19 is especially concerning because, according to the State's own data, utilization of slots gradually but significantly increased over time between spring 2014 and August 2017. The data indicate that the demand for waiver slots has increased.

Assuming this trend continues, the decrease in slots starting on September 1, 2017, comes at a time when need for the slots is likely greater than before.

At the same time, the State failed to conduct a careful and meaningful analysis to determine the reasons for the underutilization of waiver slots during the 2016-17 biennium. In my experience, where service utilization rates are lower than expected, it is essential for the State's IDD service system to do a comprehensive analysis of the problem to understand why it occurred and then, based upon that information, develop and implement appropriate measures to address the problem. Key staff testified that, to their knowledge, HHSC did not do this analysis. Had HHSC done the needed analysis, it could have developed and implemented corrective measures such as a review and revision of the Community Living Options (CLO) process, increased training for service coordinators, and increased opportunities for individuals in nursing facilities to visit community programs, participate in community activities, and explore trial placements for individuals with IDD in nursing facilities who might be interested in transitioning. Each of these strategies might well have resulted in a significant increase in the utilization of both transition and diversion waiver slots. But none of these approaches appear to have been taken. In addition, HHSC directly, or through the LIDDAs, also could have done targeted outreach to individuals in nursing facilities who previously received community services, or to individuals in nursing facilities who are appropriate for community placement.

HHSC also could have focused its efforts on particular LIDDAs that were not performing as well as others. The State's data indicate that two LIDDAs utilized zero diversion slots during four entire fiscal years, and four LIDDAs only used one diversion slot during that time period. Similarly, the data indicate that four LIDDAs used four or fewer transition slots from FY 2014 through FY 2017. This information is concerning because it indicates that some LIDDAs were

poorly performing for four entire years. Yet, I have seen no evidence that HHSC analyzed what led to this performance issue or took action to address it.

Instead of analyzing reasons for underutilization and implementing improvements, before the Legislature allocated slots, HHSC provided it with lower projections of needed slots for FY 2018-19 than it originally requested: 450 transition slots (compared to the originally requested 700) and 350 diversion slots (compared to 600). Key HHSC officials testified at their depositions that they were unaware of any efforts to meaningfully investigate the reasons for the utilization rates or of any significant steps to improve them, and leadership of HHSC, including the Commissioner, did not notify the Legislature about the reasons for underutilization and/or advocate to the Legislature for an appropriation of the number of slots it originally requested.

Although HHSC adopted a "contingency plan" to use attrition slots to make up for the slot deficit, this plan is insufficient to address the problem for several reasons. First, HHSC staff testified that there would be no transition slots available for FY 2018. Consequently, as reported by HHSC staff and administrators, anyone seeking a slot will likely end up on a waiting list for attrition slots; people on the waiting list for attrition slots would likely remain unnecessarily in the nursing facility until such time that their name reaches the top of the list. Further, it is speculative whether the plan can be successfully implemented because of the uncertainty about the numbers of attrition slots that will actually become available each month. Even if attrition slots were to become available, HHSC administrators stated that it is uncertain whether any slots would be used by people with IDD in nursing facilities, given the prioritization system the State implemented and which placed nursing facility residents behind other groups. Further, HHSC administrators testified that there have been no efforts to analyze how long a person would have to be on the attrition slot waiting list to get a waiver slot.

The number of slots allocated by the Legislature and available on September 1, 2017 to individuals with IDD in, or at risk of entering, nursing facilities is inadequate to allow qualified individuals with IDD to avoid unnecessary institutionalization, as demonstrated by the State's own data. For example, the number of transition slots utilized in FY 2016-17 (403) is more than two-and-a-half times greater than the Legislature's allocation of 150 for FY 2018-19, and is more than eight times greater than the number of transition slots actually available to individuals during the FY 2018-19 biennium. That some attrition waiver slots could potentially be used to make up for this shortfall does not adequately address the deficit, particularly given the uncertainty of available attrition slots, the competition for these slots among members of other priority populations, and the trend of increasing demand. In further support of this finding, even State officials acknowledged that the number of appropriated waiver slots was less than what they estimated would be needed to meet the demand and that they were concerned about the lack of sufficient allocated slots.

3. Texas Failed to Analyze Relevant Data and Information to Increase Waiver Slot Utilization Before Discontinuing Its Former Auto-Release of Waiver Slot Policy

In June 2017, the State discontinued the use of its "auto release" policy that proactively provided for the immediate release of an HCS waiver slot upon an indication of an individual's interest in transitioning to the community. Under the auto release policy, the release was followed by the Service Coordinator making personal contact with the individual and/or their LAR to further explore their interest in transitioning to the community. This policy, if appropriately implemented, could have proactively facilitated the timely transition of individuals with IDD in nursing facilities into the community. It built upon information obtained in the PASRR evaluation process and eliminated the need for an individual to make an affirmative

request for a transition slot as part of the subsequent Community Living Options process. Unfortunately, the State discontinued the auto-release of waiver slots in June of 2017.

The number of persons for which waiver slots were released under this policy was reported by the State to be significantly higher than those who later opted to pursue community services after meeting with the Service Coordinator. In fact, only 26% of people who expressed an interest in transitioning to the community as reflected in the PASRR evaluation ultimately accepted a waiver slot. This is significant, particularly given that the trigger for the automatic release of the slot was a PASRR evaluation indicating that the person expressed an interest in moving to the community. This should have prompted the state to conduct a closer review of the reasons that slots were not used, if promoting community integration is indeed the goal of the system. Exploring whether the person and his LAR had a personal contact with the Service Coordinator, what information was provided about community service options, and whether visits to community options were made are among those elements that should have been closely examined in order to potentially improve, as opposed to completely abandoning, the process.

HHSC, however, did not make reasonable efforts to address the auto release waiver decline rate to try to improve the acceptance (also known as the "take-up") rate. Although HHSC required service coordinators to document whether they ever met with individuals and their LARs and offered them waiver slots when the auto-release process was triggered, there was very little aggregate information collected by HHSC's IDD Services Division containing the reasons for the declines other than the simple, unsupported categorization that the nursing facility met the individual's needs. And there was no evidence that I could find demonstrating that this information was reviewed, analyzed, and used to address the reasons for a person declining the auto-released waiver slot. HHSC administrators also testified that they were unsure whether

HHSC conducted any analysis of the LIDDAs that had the highest number of auto-released waiver slot declines. If HHSC had tracked and analyzed this information and taken action to address it rather than simply abandoning the auto-release process, HHSC would have likely significantly improved the auto-release waiver slot acceptance rate.

4. Individuals with IDD in Nursing Facilities and at Risk of Admission to Nursing Facilities Face Numerous Systemic Barriers to Transitioning to and Remaining in the Community, Including a Lack of Service Provider Capacity

Diversion and transition activities are reported to HHSC quarterly by LIDDAs in two separate reports. LIDDA PASRR quarterly reports include, among other information, staff training, the number of individuals in each LIDDA's catchment area who transitioned or diverted from nursing facilities, and barriers to diversion or transition for particular individuals. Enhanced Community Coordination (ECC) reports include information about the activities conducted by Enhanced Community Coordinators at each LIDDA, including information about barriers to diversion and transition for individuals with IDD in nursing facilities. Through my review of LIDDA PASRR quarterly reports and ECC reports, I found a number of systemic barriers that prevented the timely transition of persons from nursing facilities to community-based settings. If used properly to address these barriers, these reports would be a valuable source of information for the State's quality assurance system and would provide critical planning information for actions to address systemic deficiencies or service capacity gaps. However, as described in a separate section of this report, HHSC fails to adequately use the information contained in these reports to identify and address systemic problems and to improve the system. Many LIDDAs reported the same barriers numerous times, and one LIDDA reported that "[a]ll previously identified barriers continue to be present."

I reviewed more than 200 individual LIDDA PASRR quarterly reports and the compilation "All LIDDA" reports from fiscal year 2016 and the first three quarters of fiscal year 2017. According to the LIDDA quarterly data, there were a number of particular barriers that affected individuals' ability to move to the community from nursing facilities. At least 12 LIDDAs—more than 30 percent—notified the State that a lack of medical supports for people with high medical needs or a lack of provider capacity to serve people with high medical or other needs was a persistent barrier. Many LIDDAs also stated that a more general lack of provider availability, including a lack of wheelchair accessible residential settings and a lack of providers in particular areas of the state, was another barrier. Other barriers included lack of cooperation from nursing facilities or community providers, and a need for adaptive or medical equipment or home modifications. Many of these barriers, such as a lack of adaptive or medical equipment, appeared for the same person in multiple reports and over multiple quarters.

I also reviewed more than 135 ECC reports from fiscal years 2016 and 2017. As an initial matter, I note that the requirements for the ECC reports appear to have changed during FY 2016. In addition to making review of trends more difficult, the new format encourages less discussion of barriers. Specifically, in the old reporting format, LIDDAs were asked to write a general description of barriers for individuals, but the new reporting format asks only about whether there were "delays" of three particular types of services: medical, nursing, or nutrition management. Consequently, it was much more likely after the new format that ECC reports would contain no discussion of barriers preventing transition. In fact, many LIDDAs left blank all sections of the report asking about delays. Some LIDDAs appeared to only report about individuals who had successfully transitioned, with no apparent review of barriers facing individuals who were currently in nursing facilities. In addition, I found no evidence that the

State follows up with LIDDAs that report no barriers or delays for individuals who would like to transition but have not yet transitioned.

The barriers that LIDDAs did report in the ECC reports were concerning. At least 14 LIDDAs—over 35%—reported a lack of available and adequate community providers, especially for people with complex medical needs. At least seven LIDDAs reported a lack of provider capacity in particular areas of the state. As in the LIDDA quarterly reports, a lack of adaptive or medical equipment was a significant barrier noted by multiple LIDDAs. Other LIDDAs noted a lack of access to medications upon transition. Finally, nursing facility resistance, difficulties with provider communication or cooperation, and issues with Medicaid upon transition were cited as additional barriers to transition by multiple LIDDAs. For most of these barriers, some LIDDAs repeatedly reported them as barriers over the course of multiple quarterly reports.

The barriers identified by the LIDDAs were further supported by additional documentation from HHSC staff, who identified barriers to individuals getting their needs met in the community, based upon a review of ECC reports and other data and in person visits. This analysis and documentation was a required component of the annual QSR report. Barriers identified by HHSC staff included a lack of providers who can meet the needs of individuals, including a lack of availability of providers with homes that are wheelchair accessible and a lack of availability of providers in particular areas of the State. HHSC staff deposition testimony further reinforced that a lack of availability of providers in particular areas of the State is a barrier. As in the LIDDA reports, HHSC staff also identified community provider and nursing facility cooperation, a lack of medical or adaptive equipment, and Medicaid issues at transition as barriers.

Similarly, in a provider survey that was conducted by a state provider association, half of the waiver providers surveyed noted that there were difficulties in arranging for nursing services in the HCS program, and more than half noted difficulties in arranging for physical therapy, occupational therapy, day habilitation, behavioral services, and psychiatric services. Difficulty in finding professionals willing to accept the reimbursement rates for services was frequently mentioned by providers as a reason for those difficulties, and the lack of service availability in rural areas was also noted by some providers.

I find these frequently-identified barriers to be significant and likely to delay or prevent the transition of individuals with IDD from nursing facilities to the community. Medical supports and equipment, adaptive equipment, and home modifications are critical in allowing individuals who need them to function in any setting. Similarly, having a provider who can safely care for individuals with high medical needs is essential to an individual with those needs. Without these services and supports available in the community, individuals will not be able to transition to the community and will remain isolated and unnecessarily segregated in nursing facilities.

The frequently-identified barrier that there is a lack of providers in particular areas of the State is also problematic. In my experience, individuals who are transitioning out of institutions will often want to move to areas that they are familiar with or in which their family resides. One ECC Report I reviewed acknowledged this, saying "[s]everal individuals in [nursing facilities] would move out if they could remain in their current county to stay close to family and friends." A lack of provider capacity in areas where people want to move is a barrier to transitioning and may serve to keep individuals in nursing facilities unnecessarily.

It is also important for providers of community-based services to be able and willing to accommodate individuals' needs for services. If providers cannot do so, it will prevent individuals' transition to the community. For this reason, I find that the frequently-identified barrier of provider cooperation is significant and concerning. Nursing facility resistance is also deeply problematic, because nursing facilities control much of the daily lives of individuals who live in them. Their resistance to individuals moving to the community is likely to be a significant barrier.

Medicaid issues upon transition are also a cause for concern. Many LIDDAs reported a delay in HHSC switching individuals into the correct Medicaid type (institutional versus community) upon transition. This issue would likely lead to essential services and supports being delayed and potentially prevent placement in the community.

The frequently-identified barriers to individuals diverting or transitioning from nursing facilities are significant and are likely to lead to delays in or prevention of community placement for individuals with IDD in nursing facilities. The State should already have acted to remediate these barriers, but as discussed below, the State has failed to address these barriers through its quality assurance system.

5. Texas Has Failed to Adequately Plan for and Address the Needs of Individuals with IDD Who Have High Medical Needs

Texas has recognized that individuals with IDD who have high medical needs can, and should, have the opportunity to reside and participate in the community. Likewise, Texas has acknowledged that it lacks sufficient provider capacity, services, and resources to meet the needs of individuals with IDD who have high medical needs in the community. Multiple sources have identified the lack of service capacity in the community for individuals with IDD who have high medical needs as a barrier for individuals with IDD in nursing facilities, as well as those at risk

of admission to these facilities, that can thus prevent them from remaining in or returning to their communities.

Although Texas has recognized the need to better serve individuals with high medical needs, the State has failed to implement service plans and other procedures that would facilitate and expand community-based services to this population, thus leaving nursing facilities as the most convenient alternative. This failure is illustrated by recent actions taken by HHSC to indefinitely suspend an initiative to enhance community services for certain individuals with IDD in the HCS waiver program. Specifically, the Legislature allocated funding for the 2016-17 biennium to enhance the service capacity for people with IDD who have high medical needs in the ICF and HCS waiver programs, including funding for higher support staffing ratios, medically trained and supervised direct service professionals, and increased community-based nursing and care coordination. However, the enhanced services were only developed and implemented for individuals in the ICF program, but not the HCS program. Therefore, individuals with IDD who are receiving services from the HCS program, or who could divert or transition from nursing facilities into the HCS program, cannot access the enhanced services. Although there were attempts to implement these enhanced services for individuals in the HCS waiver program during the fall of 2016 and winter of 2017, these efforts, including instituting proposed rules and a proposed waiver amendment, were unsuccessful. In addition, in July 2017, HHSC staff recommended that the initiative to enhance provider reimbursement for people with high medical needs not go forward because the Legislature did not appropriate funding for this initiative for the 2018-19 biennium, along with the concomitant concern that the cost of implementing this initiative would exceed the cost of an appropriation. The initiative was therefore never implemented. As a result, individuals in nursing facilities, or at risk of entering

these facilities, who have high medical needs will not get the benefit of providers in the community who are receiving a higher reimbursement to provide the additional services and supports needed to care for them, which increases the likelihood that they will face unnecessary segregation in nursing facilities instead of living in the community. The initiative, if implemented, likely would have reduced the barrier of lack of provider capacity and likely would have allowed more individuals in nursing facilities to transition to more integrated settings.

In my professional experience, persons with IDD in nursing facilities or at risk of placement in nursing facilities often have complex medical needs that must be addressed if they are to enjoy safe and successful lifestyles in community settings. These needs may range from increased nursing monitoring to special adaptive equipment or environmental modifications that accommodate their special needs. In order to ensure that individuals with high medical needs are served successfully in the community, state IDD systems must ensure comprehensive assessments of these individuals' medical and healthcare needs; provide enhanced monitoring of them by nursing and other trained professionals; and provide working healthcare plans that are easily understood by non-medical personnel such as direct care staff, among others. Funding is necessary for these types of initiatives, including higher staffing ratios, medically trained direct care staff, and other aspects. It is extremely important to provide competent and sufficient levels of staffing and environments that are safe for persons with high medical needs. Failure to do so may result in poor quality healthcare plans, failure to timely recognize and address health and medical needs, and failure to adequately support persons with high medical needs in integrated community settings.

Texas's failure to take these steps has significantly increased the likelihood that individuals with IDD with high medical needs will be at greater risk of institutionalization,

including institutionalization in nursing facilities. It also creates barriers to those individuals with IDD who are in nursing facilities who wish to transition to the community.

B. Texas Fails to Ensure that Individuals and/or Their LARs Have the Information They Need to Make an Informed Choice Whether to Leave a Nursing Facility

The commitment to the prevention of unnecessary institutionalization and promotion of community integrated living for individuals with IDD is articulated in the written HHSC mission, values, and goals, as well as in the state's Promoting Independence Plan. Texas espouses two primary strategies to accomplish this using appropriated Medicaid-funded HCS waiver slots: diverting individuals from nursing facility placements and transitioning individuals in nursing facilities to community placements. These strategies are to be carried out by the LIDDAs that are responsible, through contracts with HHSC, to plan, develop, coordinate, and deliver IDD services in each of the 39 service areas.

LIDDAs are responsible for assigning diversion coordinators for persons at risk of nursing facility admission, whose role is to identify available community living options, services and supports appropriate for each person. For individuals with IDD in nursing facilities deemed PASRR eligible, LIDDAs must assign service coordinators to facilitate the development of the individual's service plan, coordinate needed services, monitor the delivery of all services identified in the plan, and provide information and education about community living options.

HHSC has adopted the "Community Living Options" ("CLO") process which is guided by HHSC instructions, requiring LIDDA service coordinators to provide individuals with IDD residing in nursing facilities with information and opportunities to explore community living options through education, community visits, and other activities. Service coordinators are required to provide CLO information to most individuals with IDD in nursing facilities at least once every six months. They are required to document their CLO efforts on a specific HHSC

form, and the outcome of the CLO process must also be documented in the individual's Individual Service Plan (ISP) that addresses the "Transition Plan to the Community."

There are three "phases" of the Transition Plan: Phase I during which the service coordinator asks the individual or their LAR whether they want to transition to the community or remain in the nursing facility; Phase II during which a transition plan is developed that is supposed to include opportunities for the individual and their LAR to visit community providers among other related activities; and Phase III during which the individual transitions to the community. According to the HHSC instructions that guide LIDDA service coordinators, only Phase I is required for all individuals. If the person or their LAR does not indicate during Phase I that they wish to leave the nursing facility, the service coordinator does not proceed to Phase II. As a result, a concrete description of what community living actually would look like, including where the person might live, with whom, and what community activities and supports would be available is never developed unless the individual or his/her LAR affirmatively declares that their choice is to leave the nursing facility. For most individuals, community exploratory activities are not offered unless the individual expresses an interest in transition. Such an approach does not take into consideration the fact that individuals with IDD in nursing facilities often have been in facilities for years without the chance to see or even envision life in community settings. Instead, many may have become accustomed to isolated and segregated lifestyles in nursing facilities. These types of lifestyles often leave individuals with IDD and their families (who also may lack recent information about community services) fearful of being abused, neglected or otherwise mistreated if placed in the larger community. Whether expressed or not, these fears must be anticipated and addressed with sensitivity by those who provide services.

As discussed earlier in this report, the system must be sensitive to individuals' limited life experiences and proactively assert exploratory community opportunities first, in order to ensure that the choice whether to remain in the nursing facility is an informed one. Initial efforts must not only include providing educational materials about community options, but also include opportunities that gradually expose individuals and their families to community integrated activities. Once these efforts have taken place, then individuals and their families can make informed decisions about community integrated services. HHSC's CLO and transition planning policies and procedures do not allow for individuals to make an informed choice whether to transition from the nursing facility because they usually are not provided with important information until they decide that they want to transition to the community. If the State were to improve its CLO process by ensuring that individuals and/or their LARs have all of the information and direct experience that they need prior to deciding whether to leave the nursing facility with supports and services, including requiring opportunities to visit community placements, participate in community activities, attend provider fairs, and meet with other individuals with IDD who have transitioned to the community and their families to learn more about the transition process and living in the community, it is my opinion that the State would significantly increase transitions to the community for individuals with IDD in nursing facilities.

C. Texas Fails to Adequately Plan for the Needs of Individuals with IDD in, or At Risk of Being Admitted to, Nursing Facilities.

Texas does not adequately assess gaps in care and other services to identify the needs of individuals with IDD in nursing facilities. When planning and developing community-based services for persons with IDD in nursing facilities or at risk of residing in nursing facilities, service systems must take into account that many of these individuals have high and complex medical needs and some may have significant behavioral support needs that require specific

services and supports beyond those needed to address their IDD. To begin with, the planning must include very comprehensive healthcare needs data about these individuals. This data and information must be based on current clinical and functional assessments such as medical evaluations, physical assessments, medication reviews, occupational assessments and other aspects of a comprehensive functional assessment. This data must then be used in developing residential and day services, transportation, and all other services and supports individuals with IDD will require to live and function effectively in community settings. In addition, planning must include enhanced monitoring of persons in community settings, by professionals trained and qualified to assess their special needs. The latter provides a safety net to ensure their needs are being properly addressed and treated in these settings.

My review of documents, including HHSC staff and administrators' depositions, found that there is insufficient comprehensive analysis conducted of gaps in the Texas service system in order to meaningfully plan for and develop community-based services so that individuals with IDD can successfully transition from nursing facilities, or avoid admission to nursing facilities. For example, although HHSC administrators acknowledge that community integration is an issue that is a challenge for the State, the Associate Commissioner for HHSC's Intellectual and Developmental Disabilities and Behavioral Health Services testified that she was unaware of any specific initiative or written plan to improve practices related to community integration for individuals with IDD.

Additionally, although a lack of community provider capacity has been widely identified by stakeholders and HHSC administrators and staff as a barrier to individuals with IDD transitioning from, and avoiding admission to, nursing facilities, my review also revealed that HHSC has not adequately identified systemic provider capacity issues. For example, HHSC

does not do any systemic evaluations to determine whether there is sufficient provider capacity to meet the needs of individuals with IDD in the HCS waiver program. Instead, HHSC mostly identifies and responds to HCS waiver provider capacity issues on an individual client case-by-case basis.

Similarly, according to state officials, HHSC does not systemically evaluate whether there is sufficient provider capacity to meet the needs of individuals with high medical and/or complex behavioral needs or for geographic areas throughout Texas. Texas officials rely on receipt of complaints of inadequate or insufficient HCS providers as indicators of gaps in services for individuals with IDD in nursing facilities. These complaints reportedly are submitted through the Ombudsman or Consumer Rights offices or received from various advisory committees, stakeholder groups, etc. but are not adequately systematically analyzed or aggregated.

This approach to assessing needs and gaps in services fails to take into account information collected and reported by sources such as All-LIDDA and Individual LIDDA Quarterly and Enhanced Community Coordination reports. While not perfect, these reports are very relevant, since they are based on first-hand knowledge and actual experiences and were developed to specifically identify and track needs and gaps in services. Thus, these reports should be primary sources of data and information used and analyzed in evaluating service capacity and gaps in services. They provide quarterly reporting of actual experiences in delivering services, including identifying barriers and other problems encountered in diverting and transitioning persons with IDD from nursing facilities.

Similarly, documents and depositions revealed that Texas has failed to identify individuals at risk of admission to nursing facilities. It has failed to gather data and other

information about the assessed needs of those currently residing in nursing facilities. This lack of basic information about individuals with IDD makes it extremely unlikely that HHSC will be able to develop service capacity appropriate and needed to divert and/or transition individuals with IDD from nursing facilities.

D. Texas Fails to Provide Adequate Oversight, Improvement, and Enforcement of Its Developmental Disability Service System.

An effective IDD quality assurance (QA) system is essential to ensure that individuals with IDD are getting the services that they need so that they can transition to and/or remain safely in the community and avoid unnecessary institutionalization. An integral part of such a system is a focus on diversion and transition of individuals from institutions, including nursing facilities. An effective quality assurance system with this focus should include: measurable performance indicators for providers responsible for services and supports necessary to meet the needs of persons they serve, and specifically for individuals with IDD in nursing facilities; regular monitoring and oversight of service delivery; collection and analysis of performance data; and use of this data to implement corrective actions that will improve deficient performance and achieve desired outcomes.

While Texas engages in some quality assurance activities that relate to diversion and transition of individuals with IDD from nursing facilities to the community, I did not find an actual comprehensive quality assurance, quality improvement or quality management plan. The quality assurance activities reviewed were not often integrated or coordinated, did not result in adequate identification and resolution to systemic problems, and did not provide for sufficient continuous improvement. Specifically, in my review, I found significant deficiencies in Texas's IDD QA system, including HHSC's failure to adequately: 1) track and analyze key data to identify systemic problems and use such information to effectively resolve them; 2) enforce

contract and regulatory provisions and hold LIDDAs accountable for service delivery; 3) use the QSR results to fully identify gaps in community services and improve performance to achieve compliance standards; and 4) train LIDDA service coordinators and other LIDDA staff who serve individuals with IDD in nursing facilities or at risk of entering these facilities.

1. Texas's Quality Assurance System Does Not Adequately Address Diversion and Transition of Individuals with IDD from Nursing Facilities.

As illustrated below Texas does not use data for key metrics in order to identify and correct problems in the system relating to diversion and transition of individuals with IDD in nursing facilities or at risk of admission to nursing facilities and to engage in continuous improvement of the overall system. These deficits include the lack of sufficient quality assurance and performance improvement in the areas of informed choice and waiver utilization.

a. HHSC does not adequately analyze and address whether individuals with IDD in nursing facilities have made an informed choice to stay in the nursing facility.

HHSC does not meaningfully monitor and analyze the necessary metrics to determine whether individuals with IDD have made an informed choice to remain in nursing facilities. This failure is illustrated by the fact that HHSC does not track the reasons a person or their LAR has decided to stay in a nursing facility for those individuals for whom a waiver slot has been automatically released, as well as for others. Relatedly, HHSC does not monitor or track the number of individuals who take tours of community programs each quarter or what programs they visit, and HHSC does not examine what difference such tours make in their choice to stay or leave a nursing facility. Similarly, there is no evidence that information collected, reviewed, or aggregated concerning the types of education provided to individuals with IDD and their families about community living options and related topics are examined to determine what types of

information are or are not useful in making transition decisions, and what impact the entire process has on promoting informed choice. HHSC also does not identify areas or types of interventions that have been successful in informing individuals and overcoming initial reluctance about moving to the community with supports and services. Additionally, HHSC does not examine the number of people who initially opposed community placement but subsequently changed their minds, as well as the information and experience that was instrumental in making a different decision. HHSC also does not use data or take actions to analyze and reduce the number of people who return from the community to a nursing facility. All of these metrics are key to fully analyzing and ensuring that individuals with IDD in nursing facilities are making truly informed choices regarding whether to return to the community or stay in the nursing facility. Because HHSC does not analyze these metrics, it cannot have a comprehensive understanding of transition issues, cannot make reliable statements or planning decisions on transition demand and capacity, and cannot effectively promote informed choices to access community services or remain in nursing facilities.

b. HHSC does not adequately analyze and address the under-utilization of waiver slots.

Another significant deficit in the QA system that relates to diversion and transition of individuals with IDD in nursing facilities is Texas's failure to track the necessary information to accurately and comprehensively understand the utilization, and in Texas's case, its under-utilization, of Medicaid-funded waiver slots for individuals with IDD in nursing facilities. As explained in Section V.A.2, above, the State under-utilized its allocated nursing facility waiver slots for diversion and transition. It is essential for the State's IDD service system to do a comprehensive analysis of that problem to understand why it occurred and then, based upon that information, develop and implement appropriate measures to address the problem. However,

there was little evidence that the state conducted a careful and meaningful analysis of the under-utilization of waiver slots for the FY 2016-17 biennium. Obvious sources of information critical and available for this type of analysis are the LIDDA PASRR and the Enhanced Community Coordination reports. As discussed in Section V.A.4, these reports cite barriers encountered in both diverting and transitioning individuals from nursing facilities. However, there was little evidence that these barriers were meaningfully examined or that sufficient corrective actions were taken to modify policies and/or seek necessary funding to address these barriers. For example, although barriers pertaining to lack of family support and cooperation can be addressed by education, the number of such sessions reported in LIDDAs' quarterly reports were few.

A related problem is that HHSC does not monitor and track barriers to placement for those individuals who have not expressed an interest in leaving the nursing facility and for whom no waiver slot has been released. Additionally, unless discovered in onsite review by the Contract Accountability Office (CAO), HHSC does not track, monitor, or assess whether barriers that have been identified through the CLO process are subsequently addressed.

Another example of the State's failure to analyze the utilization of waiver slots is the State's abrupt discontinuation of its auto-release waiver slot policy. Texas should have conducted a closer review of the reasons for the change in individuals' decision regarding transition. Exploring whether the person and his LAR had a personal contact with the service coordinator, what information was provided about community service options, and whether visits to community options were made are just some of the factors that should have been explored to potentially improve, as opposed to completely abandoning, the process.

The State's failure to sufficiently analyze and use key data to address waiver utilization also is evidenced by the lack of information and oversight of the CLO process. My review of

this process found that Texas does not actively pursue transition of individuals with IDD in nursing facilities to the community and does not sufficiently implement the goal of community living for individuals with IDD in nursing facilities if the individual initially does not express an interest in community living. The State only minimally tracks the reasons why individuals with IDD or their LARs decline community services, and there was no evidence that the State aggregates and analyzes that information to determine the reasons for declining community service options. The State should gather and analyze this information in order to better understand and address why individuals and/or their LARs have declined waiver slots and how to better overcome barriers to diversion and transition of individuals with IDD in nursing facilities, so that it can increase waiver utilization. Finally, the State's data from the LIDDAs on their use of transition and diversion slots could have and should have been used to address under-utilization of waiver slots but it was not used in this manner.

2. Texas Does Not Use the Results of the QSR to Meaningfully Identify Gaps in Community Services and to Improve Performance.

I also found that Texas does not use the Quality Service Reviews (QSRs) to meaningfully identify and address gaps in community services. The PASRR Quality Service Review Process (QSR) was initiated in January 2015 by mutual agreement of the parties under the *Steward* Interim Agreement. This process measures performance in six mutually agreed upon Outcomes covering: 1) diversion, 2) nursing facility specialized services, 3) transition, 4) community services, 5) service coordination and 6) service planning.

An additional Outcome (Outcome 7) was reportedly developed to require a quality assurance and management system that included an incident management system to ensure persons served are safe and protected from harm. However, this Outcome was never reviewed, as the State failed to provide the QSR reviewer the necessary data and other information to

review performance in this area. The exclusion of this Outcome is extremely alarming and speaks to the State's overall commitment to protection of people with IDD. In all of my related experiences with systems serving persons with IDD, incident management and prevention systems that are integrated with the IDD services systems are considered critical components of an effective quality assurance and management plan. These systems are important for vulnerable populations as they require the immediate reporting and investigation of any and all alleged incidents of abuse, neglect, and mistreatment of persons served. Further, these systems require that corrective and preventative actions are promptly taken to reduce and, if possible, eliminate the occurrence of such incidents to ensure the safety and general well-being of persons with IDD.

Since the QSR process and tool were developed solely for individuals with IDD in this case and addressed by this report, my review examined the 2016 results and their comparison with prior year (2015) and the 2017 results (as of August 31, 2017). Results for five Outcomes and related Outcome Measures that are relevant to my report were reviewed including: Diversion (Outcome 1); Transition (Outcome 3); Community Services (Outcome 4); Service Coordination (Outcome 5) and Service Planning (Outcome 6) and are set forth are shown in the tables in Attachment C to this report.

Outcome 1 measures the system's performance in preventing the unnecessary placement and institutionalization of persons in nursing facilities where community services have been determined to be an appropriate and available alternative. Although HHSC's overall compliance was 74% in 2016 and 73% for 2017 (as of August 31, 2017), the State's compliance with certain key Outcome Measures associated with this Outcome was significantly lower.

For example, Outcome Measure 1-3 evaluates whether:

> The PASRR Level II evaluation confirms whether the individual has ID or DD and if so, appropriately assesses whether the needs of the individual can be met in the community

> an accurately identifies, based on the information available, the specialized services the person needs if s/he is admitted to a NF. A report of the reviewer's decision is shared with the individual and his/her LAR.

Compliance with this Outcome Measure by the end of 2016 had dropped from the previous year from 41% to 29%. The results for this Outcome Measure in 2017 were not much improved—and nine percent lower than the score in 2015—at 32%.

Another example of a key Outcome Measure in which the State's performance has dropped is Outcome Measure 1-9. This assesses:

> For members of the Target Population living in the community who can be diverted from NF admission, the SC or other LIDDA staff identify, arrange, and coordinate all community options, services, and supports for which the individual may be eligible and that are necessary to enable the individual to remain in the community and avoid admission to a NF. Services and supports will be consistent with an individual's or LAR's informed choice.

The results for this Outcome Measure went from 56% compliance in 2015 to 33% compliance in 2016 and in 2017 (as of August 31, 2017).

For Outcome 3, which measures the system's performance in successfully moving persons from nursing facilities to community-based settings, the State's performance was very poor, as it achieved only an overall compliance rate of 44% in 2016 and 46% compliance in 2017 (as of August 31, 2017). And for certain key Outcome Measures related to this Outcome, the State's overall compliance was significantly lower.

For example, Outcome Measure 3-8 evaluates whether, for individuals residing in nursing facilities,

> The individual has an ISP that includes all of the services and supports, including integrated day activities, she needs to achieve his/her goals, maximize his/her potential, and participate in community activities. The NF member receives all of the specialized services identified in the ISP, including alternative placement assistance and opportunities to learn about community options such as opportunities to visit community programs, in the frequency, intensity, and duration specified in the ISP. The SPT monitors the provision of all specialized services.

Compliance with this Outcome Measure dropped from 19% in 2015 to 12% in 2016 and remained at 12% compliance in 2017. See Table 2, Attachment C.

Similarly, Outcome Measure 3-12 measures whether:

> Any individual whose SPT recommends continued placement in NF has a plan that documents the reason for the decision and describes the steps the team will take to address the identified barriers to placement in the most integrated setting. The plan is implemented as designated by the SPT and in the timeframes the team established.

Compliance with this Outcome Measure went from a mere 11% compliance in 2015 to 0% in 2016 and remained at 0% in 2017 (as of August 31, 2017). Other similar examples of low and significant declines in compliance for Outcome 3 are set forth in Table 2 in Attachment C.

The number of areas measured by the QSR for which there was a decline in performance compared to 2015 is alarming. As set forth in Attachment C, of the 35 Outcome Measures that I reviewed, performance had declined since 2015 for 20 measures. Improvement was found for only 15 measures.

For example, Outcome Measure 6-7 which evaluates whether

> Individuals in the TP [target population] who live in the community have a SPT whose members include those people who are specified in program rules. The SPT is responsible to develop the ISP, ensure the ISP is implemented, and monitor that all services and supports in the plan are provided to the individual.

Texas's compliance with this Outcome Measure dropped from 35% in 2015 to 14% in 2016 and then to only 7% in 2017 (as of August 31, 2017). In another example, Outcome Measure 4-19 measures whether "[a]n individual who has an identified risk of behavior or medical crisis has a crisis plan in his/her ISP that focuses on crisis prevention." Texas's compliance with this Outcome Measure fell from 25% in 2015 to 13% in 2016 and then to just 8% in 2017 (as of Aug. 2017).

The fact that the system had low, and often declining, performance on a number of important measures, across all areas reviewed, reveals that the system has failed to adequately

assess, identify, plan and provide needed community services and supports for individuals to move to and live successfully in community integrated settings. The State's poor performance on the Outcomes and Outcome Measures pertaining to community services, service planning, and service coordination also evidences the need for training service coordinators.

Although the QSR has identified important deficits in Texas's delivery of services to individuals with IDD in or at risk of admission to nursing facilities, Texas has not adequately used this important information to make needed changes. The information is not shared throughout all relevant parts of HHSC for use in planning and to bring about any needed systemic reforms. According to the testimony of a several of HHSC administrators, including, notably, high level HHSC officials, the QSR results, including data and other information, are not routinely shared across offices. For example, the Associate Commissioner for Intellectual and Developmental Disabilities and Behavioral Health Services testified that she was not familiar with the QSR reports, that she never reads them, and does not know what information that HHSC reports to the QSR reviewers. Similarly, the Associate Commissioner of Long-Term Care Regulatory Services stated that she also never reads the QSR reports and is unaware whether anyone who works in Long-Term Care Regulatory Services reviews these reports. Additionally, the CAO director testified that she does not review most of the QSR reports and that the results of the reports are not incorporated as part of the CAO's oversight of the LIDDAs.

With few exceptions, such as establishing work groups, using Money Follows the Person funds to pay for home modifications for a few individuals, and some improved educational materials and information, there was scant evidence of specific meaningful and continuous improvement strategies that both addressed and corrected problems found consistently over several years by the QSRs. With relatively minor exceptions, the documentation shows that this

information has not been effectively used and sufficient actions are not taken to address these findings of deficient and non-compliant performance. Further, the State's failure to use its own QA tool was continuing through September 1, 2017. As of that date, even the final 2016 QSR report had been delayed and was not yet released. Reportedly, no information was publicly or even internally available on the 2017 QSR.

Additionally, barriers to community living are reported by LIDDAs in quarterly LIDDA and Enhanced Community Coordination reports. However, it appears these reports are not carefully reviewed and utilized by staff. For example, inconsistent data or errors in data found in these reports are not timely identified and corrected. Even when significant barriers have been reported, initiatives undertaken in response to barriers are minimal, and they are not sustained or continuously tracked to ensure positive results and improvement through a meaningful quality assurance process.

LIDDAs also report quarterly on the number of admissions, diversions, and transitions from nursing facilities. These reports also include data and other information about barriers, LIDDA staff training, and community education efforts. These reports appear to be the most standardized methods used by the state to track LIDDA performance. However, these reports do not appear to be reviewed carefully nor utilized by staff in developing specific sustainable improvement strategies. Even the Contract Accountability and Oversight unit, which is the unit that aggregates the reports and is tasked with overseeing LIDDA performance, does not take action based on these reports or even review them.

These deficits in Texas's quality improvement system result in Texas not adequately improving performance with respect to diversion and transition of people with IDD in nursing facilities and the provision of community services to people with IDD.

3. HHSC Does Not Adequately Enforce Contract and Regulatory Requirements and Hold LIDDAs Accountable for Compliance with Service Requirements for Individuals with IDD in Nursing Facilities.

There are several ways in which Texas oversees LIDDAs in their responsibilities to serve individuals with IDD in nursing facilities and those at risk of being admitted to nursing facilities. Monitoring and oversight of LIDDAs' performance is primarily the responsibility of the Performance Contract Unit and the Contract Accountability and Oversight (CAO) Unit in the IDD Services Division of HHSC. The LIDDA Performance Contract serves as the contractual agreement setting forth specific requirements of the LIDDA, including performance measures and outcome targets. Remedies and sanctions to enforce compliance are also included as a part of the contract. LIDDAs must also comply with Texas's relevant regulations. On site reviews are conducted by CAO staff, using a standardized tool, to monitor the LIDDA's compliance with eight (8) indicators that measure compliance largely with procedural requirements, as opposed to actual consumer outcomes. In addition, LIDDA compliance with PASRR and related requirements are assessed by Texas's QSRs. When a LIDDA is found to be out of compliance with its contractual or statutory requirements, Texas can, pursuant to the terms of the LIDDA contracts and HHSC policy, require LIDDAs to develop and implement corrective action plans (CAPs), which can be followed by a CAP compliance review conducted by HHSC. Texas can also issue other sanctions to LIDDAs that are out of compliance, including monetary penalties. Despite having these mechanisms to monitor and enforce LIDDA compliance, however, the implementation of these mechanisms falls short of what is needed to adequately hold LIDDAs accountable for fulfilling their obligations to ensure that individuals with IDD are appropriately diverted and/or transitioned from nursing facilities to the community.

There are some important responsibilities of the LIDDAs that relate to the provision of services, including diversion and transition services and particularly the informed choice process,

which the Director of the CAO testified that HHSC does not monitor. For example, the CAO director testified that HHSC does not monitor whether the LIDDA offers community visits and related activities to individuals if they have not affirmatively requested such experiences. The CAO director also testified that HHSC also does not require reporting on and does not monitor what specific types of individual and family education is provided. Thus, even if, for example, some individuals need accommodations in communication or learning about community options, need direct experiences in the community to make an informed choice, or would benefit from speaking with other individuals who have successfully transitioned, if the LIDDA does not provide those accommodations, opportunities, or supports, they are not held accountable by the State for not facilitating an adequate informed choice process.

There are also significant disparities between the LIDDAs with respect to the types, amounts, and frequency of the education and training that LIDDAS provide to individuals and families. Under HHSC's LIDDA contract, LIDDAs are required to provide an educational activity, such as a presentation or other information at least semi-annually. As shown in Attachment D, some LIDDAs provided almost no educational sessions for individuals and families, while others provided several opportunities during the first three quarters of fiscal year 2017. The State's own data show, as set forth below in Table 1, that some LIDDAs have reported that no individuals or families received education or information for the first three quarters for 2017 (January 1, 2017-Aug. 31, 2017), either as a result of the LIDDA failing to provide such opportunities or nonattendance at offered activities.

Table 3: Number of LIDDAs that reported that no individuals or families received education or information for all three Quarters of FY 2017 as a result of a failure to provide such opportunities or lack of attendance.

Number of LIDDAs reporting that no individuals or families received educational or information for Q1 of FY 2017	Number of LIDDAs reporting that no individuals or families received educational or information for Q2 of FY 2017	Number of LIDDAs reporting that no individuals or families received educational or information for Q3 of FY 2017	Number of LIDDAs reporting that no individuals or families received educational or information for all three first quarters of FY 2017
16 out 39 (41%)	14 out 39 (35.8%)	17 out of 39 (43.5%)	7 out of 39 (17.9%)

Because HHSC does not require the LIDDAs to provide any particular type of educational activity and instead gives the LIDDAs wide latitude to provide any of these activities that they see fit, there are significant inconsistencies with the types and amounts of information being provided to individuals and their LARs that would enable them to make informed decisions whether to remain in the nursing facility—with some individuals and LARs not being offered any such education.

The State has delegated virtually all service planning, service delivery, and transition activities to the LIDDAs through its contract with the LIDDAs. However, the State fails to collect or oversee many of the LIDDA contract requirements. Even when it does conduct reviews, collect information, or assess performance of the LIDDAs, the State fails to adequately

hold the LIDDAs accountable when problems are identified or appropriately take enforcement actions when problems are not rectified.

4. HHSC Does Not Ensure that LIDDA Service Coordinators and Other LIDDA Staff Receive Competency-Based Training to Meet the Needs of Individuals with IDD in Nursing Facilities.

Adequate and comprehensive competency-based training of LIDDA staff is essential to ensuring that individuals with IDD are successfully diverted and transitioned from nursing facilities and can remain safely in the community and avoid readmission to nursing facilities or other institutional settings.

Review of the LIDDA performance contract and other policies, procedures, and standards found very minimal training requirements for LIDDA and nursing facility staff relevant to community integration or availability of community-based services. While there was evidence of training requirements for service coordinators found in the LIDDA performance contracts, these requirements were found to be minimal and primarily limited to new employee training. Most post-employment training is provided by LIDDAs but is inconsistent across the LIDDAs, since there are no minimum state requirements regarding frequency, duration, content, or competency evaluation. For example, a review of the "All-LIDDA" quarterly reports reveals that during FY 2017 Q1-Q3, the most recent period for which LIDDA training data was available, 7 LIDDAs failed to provide any staff training for at least one quarter during this period and one of these 7 LIDDAs failed to provide any staff training for two of the three quarters reported for 2017.

The range of the amount of time that LIDDAs devote to staff training also varies widely, with some training being remarkably short. For example, one LIDDA reported that it spent only a total of 15 minutes to provide training on two PASRR-related topics. Another LIDDA reported spending just an hour to cover five different PASRR-related topics. Several LIDDAs reported

spending no more than an hour to cover 3 topics and did not provide any training to service coordinators during the first three quarters of FY 2017.

The tables in Attachment D reflect the inconsistent application of training requirements across LIDDAs. The failure to establish minimum training requirements, especially competency-based training, results in a workforce with varying levels of qualified and competent staff. This leaves the system and its service recipients at risk of failure.

E. Texas's Olmstead *Plan Is Ineffective in Ensuring that Qualified Individuals with IDD in Nursing Facilities and Those At Risk of Admission to these Facilities Can Live in the Most Integrated Setting.*

The Texas "Promoting Independence Plan" is the State's *Olmstead* Plan, which describes how Texas plans to comply with the Supreme Court's decision in *Olmstead v L.C.* The Promoting Independence Plan has been revised several times. Unless otherwise noted in this report, I am referring to the 2016 Revised Texas Promoting Independence Plan, published in August 2017.

The ultimate goals of *Olmstead* planning are to eliminate unnecessary segregation of people with disabilities, including intellectual and developmental disabilities, and to ensure people receive services in the most integrated settings appropriate to their needs. Based on my experience, I would expect that a plan to eliminate unnecessary segregation of individuals with disabilities would clearly identify specific groups of individuals who are in specific types of segregated settings, like nursing facilities and ICFs, for whom the State is planning to ensure greater integration. Each group and/or segregated setting should then be given priority focus in a state's plan to deinstitutionalize individuals with IDD. I would also expect that for each group of people and segregated setting, there would be specific, measurable goals that would address the expected outcomes, including the projected number or percentage of people who will move to

the community and timeframes in which each outcome would be accomplished. Further, in promoting *Olmstead* goals, the state should also have as part of its plan goals that limit unnecessary admission to these segregated settings.

Having clear measurable goals and timelines are important elements of a plan and are necessary to determine whether the desired change has occurred. In essence, to be successful, a plan must be methodical, with a specific end goal as well as measurable benchmarks.

It is positive that the state has a published *Olmstead* Plan, which to some degree has incorporated input from a broad cross section of stakeholders. However, my review of the "Promoting Independence Plan" found it included little to no information or requirements specific to individuals with IDD in, or at risk of being admitted to, nursing facilities. Much of the Plan is focused on issues that generally do not affect individuals with IDD in nursing facilities. And in discussing trends in transitions and expenditures over time, the Plan does not set forth numbers broken down by type of disability or type of institution.

The Plan also does not contain sufficient goals or timelines that demonstrate the State's commitment to deinstitutionalization of individuals with IDD in nursing facilities. There are no listed goals in the Plan for reducing the population of individuals with IDD in nursing facilities, and state officials testified that they had no goals for reducing the number of people with IDD who are living in nursing facilities. Similarly, there are no measurements of success for reducing institutionalization of individuals with IDD in nursing facilities. Not only does HHSC not state any goals for this population, it also does not state the current numbers of adults with IDD in nursing facilities in the Plan, although there is a table for the number of *children* in institutions, including children in nursing facilities.

The failure of HHSC to include goals for individuals with IDD in nursing facilities, accompanied with testimony from State officials that the State does not plan for the future service needs of these individuals, indicates that the Promoting Independence Plan does not demonstrate the State has a commitment to ensure that individuals with IDD in nursing facilities will be provided with services that allow them to live in the most integrated setting appropriate to their needs.

I also found that in some instances, the State did not fulfill its priority activities described in the Promoting Independence Plan. For example, the 2014-2015 Plan noted that "[s]ince the original plan, the [Promoting Independence Advisory Committee]'s top priority has been full funding for community-based services so that all interest lists are eliminated." However, as the 2016 Revised Plan acknowledged, the State did not fund any reduction of the interest list for fiscal years 2018-2019. This failure to follow through on a self-described priority in the Plan indicates that the Plan is not being effectively implemented. Similarly, although one of the Plan priorities has been to fund needed waiver slots, the 2016 Revised Plan acknowledged that many fewer slots for individuals diverting and transitioning from nursing facilities were appropriated by the Legislature than were requested. Tellingly, the Plan was modified to reflect what was appropriated, rather than what was needed to ensure that individuals with IDD in nursing facilities can live in the community.

Until recently, Texas had a Promoting Independence Advisory Committee (PIAC), whose purpose was "to assist HHSC in developing a comprehensive, effectively working plan to ensure appropriate care settings for persons with disabilities." Over the course of many years (more than a decade), the PIAC made recommendations to be considered for inclusion in the Promoting Independence Plan, such as increasing funding to reduce waiver interest lists. However, in 2017,

for unexplained reasons, the State abruptly discontinued the PIAC. Although an informal workgroup was subsequently formed to meet occasionally on similar issues, it was unclear from state officials what the specific tasks of the new workgroup would be. It is important that when planning to reduce segregation of individuals with IDD that input of critical stakeholders is taken into account. This input should be received and considered in a formal way, to ensure that stakeholders who are involved with implementing the plan or who may be affected by the plan are genuinely engaged. However, HHSC disbanded its formal method for taking stakeholder opinions into account, which in my opinion will be detrimental to its ability to effectively reduce segregation of individuals with IDD in nursing facilities.

Overall, the Promoting Independence Plan represents, at best, an articulation of Texas's intent to commit to eliminating unnecessary institutionalization and to promoting community integration of individuals with disabilities. However, to be an effective plan that leads to change, critical elements such as clear identification of the target populations and settings, measurable goals, timeframes for implementation, benchmarks and inclusion of input from stakeholders must be incorporated. Without these elements, meaningful change and progress are unlikely.

VII. Conclusion

In conclusion, my review of the Texas IDD service system for individuals with IDD residing in nursing facilities, and those at risk of admission to nursing facilities, found a few positive, and a number of negative, attributes. Among the positives are: 1) Texas's utilization of Medicaid waivers to maximize local dollars to provide a variety of waiver services for some individuals with IDD; 2) the Texas *Olmstead* Plan and other documents articulate a commitment on paper to certain principles and values that are important such as serving and promoting community integration and inclusion of individuals with IDD; and 3) for the most part, Texas's

IDD service system included components, such as service coordination, that I have found critical in coordinating and delivering services to individuals with IDD.

However, despite these positive aspects, I found glaring and disturbing deficiencies in Texas's IDD service system including the failure to adequately execute and implement the plans, principles, and goals that are expressed in the State's plans, policies, procedures, and other publications.

Among the most noted failures of the system that I found are the following: 1) failure to assess the needs of people with IDD to more accurately project and address their needs, such as how many waiver slots are needed each year to divert and transition individuals from nursing facilities, among other important service needs; 2) failure to use the data and other information routinely collected and reported by LIDDAs describing barriers, services gaps, etc., to address these problems and concerns; 3) failure to ensure that individuals with IDD in nursing facilities or at risk of nursing facility placement and/or their LARs have the information they need to make an informed choice about where they will live; 4) failure to share and use data and other information generated by the QSR to improve performance although the QSR monitoring system was specifically designed and agreed to by the parties to be used for this purpose; 5) failure to recognize that persons with IDD living in nursing facilities, or at risk of admission to nursing facilities, are likely to have complex, high medical needs that must be planned for and accommodated in less restrictive, community integrated settings and 6) failure to have a comprehensive and integrated quality assurance and management plan with mechanisms that proactively and continuously evaluate the system's performance and make adjustments as needed to improve performance.

In summary, it appears that many of the concerns and problems cited by the Texas Legislature's Sunset Review remain relevant and have not been fully resolved. Further, it appears that providing services to individuals with IDD in, or at risk of admission to, nursing facilities, especially services intended to successfully divert and transition persons with IDD from nursing facilities, has not been a focus of HHSC. Individuals with IDD in, or at risk of admission to, nursing facilities appear to have not been given priority attention in planning, developing services, monitoring and evaluating performance, or even simply addressing documented problems. Unfortunately, the HHSC culture seems to be reactive, as opposed to proactive, and responds when complaints have been filed against the system. As a result, the system by default, and those who depend on it for services, are left to rely on institutions that are convenient like nursing facilities, thus significantly diminishing the likelihood of community integration and inclusion of individuals with IDD.

Attachment A

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EDUCATION

Master of Social Work Degree (MSW), 1976**,** University of Alabama, School of Social Work, Tuscaloosa, Alabama

Bachelor of Science in Social Welfare Degree (BSSW), 1975**,** University of Alabama**,** School of Social Work, Tuscaloosa, Alabama, Graduated Cum Laude

Undergraduate Sociology Studies, 1971, Alabama State University, Sociology Department, Montgomery, Alabama

High School Diploma, 1971, Sidney Lanier High School, Montgomery, Alabama

PROFESSIONAL EXPERIENCE

(November 2017 – Present) Consultant
Serves as consultant for the Public Affairs Research Council of Alabama. Work includes guiding the Developmental Disabilities Division of the Alabama Department of Mental Health in developing a strategic plan for compliance with the Center for Medicare and Medicaid Services (CMS) Home and Community Based Services Rule

(December 2016 – Present) Expert Witness
Serves as Expert Witness for Plaintiffs in *Steward v. Smith* (Texas) Class Action Lawsuit. Conduct reviews of Texas State Medicaid Plan, Olmstead Plan, budgets and other documents related to services for persons with intellectual disabilities. Work is specific to the target population of such persons 21 years or older who are residing in nursing facilities or at risk of nursing facility placement.

(August 2010-January 2017) Independent Compliance Administrator
Appointed Independent Compliance Administrator by the United States District Court for the District of Columbia to guide and oversee the Department on Disability Services' compliance with exit criteria in the thirty-three-year-old *Evans v. Gray* Class Action Lawsuit. Case was settled and terminated January 2017.

(August –November, 2010) Expert Witness
Served as Expert Witness for the United States Department of Justice in *US Georgia*. Conducted site visits of Georgia State Psychiatric Hospital; reviewed

state Medicaid, Olmstead Plans and budgets relative to services for persons with intellectual disabilities and serious mental illnesses and provided expert testimony.

(June 2005 – Present) Independent Consultant
Provide consultation and technical assistance to clients in strategic planning, resource development, litigation management and community organization, primarily in governmental areas of intellectual and developmental disabilities, mental health and human services. Consulting contracts include:
Governor's Finance Office, State of Alabama (2005-2006)
Public Affairs Research Council of Alabama (2005-2006), (2008-2010) (2017)
Governor's Office and Department of Mental Health, State of Alabama (2008-2010)
Alabama Youth Justice Coalition, Southern Poverty Law Center (2005-2006)
Eli Lilly Co. (2005-2006) (2008-2010)
National Center for Women, Trauma and Violence (2005-2006)
Department on Disability Services, District of Columbia (2005-2008)
Franklin Resources Group (2006-2009)

(June 2006 –2007) Interim Director, Department on Disability Services, Washington, D.C.
Appointed by Mayor Anthony Williams and reappointed by Mayor Adrien Fenty to provide administrative oversight and supervision of the District's service system for persons with mental retardation and developmental disabilities. Managed system serving approximately 2000 District residents with a budget of approximately $83million. Assisted in the establishment of the agency as a cabinet level agency reporting to the Mayor of the District. Responsible for major service reforms and compliance initiatives in the federal litigation styled *Evans v. Fenty*.

(January, 1999-2005) Commissioner, Alabama Department of Mental Health and Mental Retardation
Appointed Commissioner in January 1999 by Governor Don Siegelman (D). Re-appointed Commissioner December 2002 by Governor-Elect Bob Riley (R). Responsible for the overall administration and management of the Department of Mental Health and Mental Retardation, including all state in-patient facilities and community contracted and certified programs for mental health, mental retardation and substance abuse services. Responsible for a budget of over $600 million, including state and federal revenues (Medicaid and Block Grant). Responsible for the settlement and termination of the 33-year *Wyatt v. Stickney* federal class action lawsuit and the consolidation and closure of eight of Alabama's 14 state institutions.

(1985 - 1999) Director of Advocacy Services, Alabama Department of Mental Health and Mental Retardation
Employed as Director reporting to the Commissioner. Responsible for designing and implementing a Statewide Internal Rights Protection and Advocacy Program for persons served by the department and its contracted programs.

(1977 - 1985) Regional Coordinator, Alabama Department of Mental Health and Mental Retardation
Employed in the Region I Catchment area of Alabama - thirteen (13) northern counties. Responsible for the development and administration of community based programs for persons with mental retardation.

(1976-1977) Child Protective Services Worker, Arizona Department of Economic Security
Provided protective services for abused, abandoned and neglected children. Coordinated interstate inquiries and court preparations for legal proceedings.

CERTIFICATIONS AND LICENSURES

Certified Public Manager, CPM - 1990, State of Alabama, Auburn University in Montgomery, Department of Public Administration

Executive Development Certificate, 1984, University of Alabama in Birmingham, Department of Health Services Administration

Licensed Private Independent Practice (PIP), 2007, Social Work Administration, Alabama Board of Social Work Examiners, License No. PIP. 71-402-C

Licensed Certified Social Worker (LCSW), 2007, Alabama Board of Social Work Examiners,
License No. 0402C

Academy of Certified Social Workers (ACSW), 2007, National Association of Social Workers, Inc.

Diplomate in Clinical Social Work (DCSW), 2000 National Association of Social Workers, Inc.

Qualified Mental Retardation Professional (QMRP), 1977, Alabama Department of Mental Health and Mental Retardation

PUBLICATIONS

Hinton, A. and Sawyer, K, Beyond Wyatt: Mental Health and Mental Retardation Issues Facing Alabama in the 21st Century, Alabama Issues, Peer Review, 2003

PROFESSIONAL AFFILIATIONS

(2005-Present) Member, Alabama Department of Human Resources Board of Trustees, Montgomery, Alabama.

(2010-2013) Trustee, Alabama State University Board of Trustees, Montgomery, Alabama

(2009-2012) Co-Chair, Mental Health Advisory Committee, Envision, River Region, Montgomery, Alabama

(2003-2005) Member, National Association of State Mental Health Program Directors Research Institute, Inc., Alexandria, Virginia

(2001-2005) Member, National Experts on Trauma and Violence,

(1994-1996) Mental Illness Advisory Committee, Alabama Disabilities Advocacy Program, Tuscaloosa, Alabama

(1994-1996) Chair, National Conference Committee, National Association of Social Workers, Inc. Washington, DC

(1993-1994) Member, Institute for the Advancement of Social Work Research Board, Washington, DC

(1992-1995) Member, Advisory Board, Social Work Department, Troy State University

(1992-1993) Member, Board of Directors, Certified Public Managers, State of Alabama

(1990-1993) Member, Competence Certification Commission, National Association of Social Workers, Inc., Washington, D.C.

(1989-2005) Alabama Association for Retarded Citizens, Inc. Montgomery, Alabama

(1987-2005) Alabama Alliance for the Mentally Ill (AAMI), Birmingham, Alabama

(1987-1990) Member, *Wyatt* Consultant Committee, Alabama Department of Mental Health and Mental Retardation

(1987-1990) Member, Advisory Board, School of Social Work, University of Alabama in Tuscaloosa

(1986-1989) Member, National Program Committee, National Association of Social Workers, Inc., Silver Springs, Maryland

(1978-1980) Member and Past President, Alabama Chapter, National Association of Social Workers, Inc.

CIVIC AND COMMUNITY AFFILIATIONS

(2010-Present) Member, Junior League of Montgomery Inc., Community Advisory Board

(2009-2010) Member, Montgomery Aids Outreach Board of Directors

(2008-2010) Co-Chair, Mental Health Regional Planning Committee, Envision, Montgomery, Alabama

(2005-2007) Member, Alabama Civil Justice Foundation Board

(2005-2006) Member, Leadership Montgomery Board of Directors

(1998) Member, Leadership Alabama, Class IX.

(1998) Chair, Welfare Reform Steering Committee, Day Street Baptist Church, Montgomery, Alabama

(1998-2005) Member, Board of Directors, Tukabatchee Area Boy Scouts Council

(1997) Member, **Joint Civilian Orientation Conference - 60**, United States Department of Defense-Pentagon, Washington D.C.

(1995 - 1999) Member, Board of Directors, Alabama Poverty Project Board

(1995 - 1997) Magnet School Advisory Committee, Montgomery County Board of Education, Montgomery, Alabama

(1996-1997) Member, **Beta Nu Omega Chapter**, Alpha Kappa Alpha Sorority, Inc.

(1995 - 1996) Member, Board of Directors, Landmarks Association, Montgomery, Alabama

(1992-1994) Member, Board of Directors, Success by Six, Montgomery, Alabama

(1988-Present) Assistant Director, Camp Sunshine for Girls and Boys

(1987-2008) Member, Leadership Montgomery, Inc., Montgomery, Alabama

(1992-1993) Past President, Leadership Montgomery, Montgomery, Alabama

(1992-1993) Member, Board of Directors, and Future Planning Chairperson, Junior League of Montgomery

(1990 - Present) Member, Junior League of Montgomery, Montgomery, Alabama

(1990-1993) Member, Board of Directors, United Way Montgomery Tri-County Area

(1990-1992) Member, Board of Directors, Montgomery Symphony

(1989-1991) Member, Board of Directors, Gift of Life Foundation, Montgomery, Alabama

HONORS

(2005-Present) The Kathy Sawyer Leadership and Advocacy Award was established by Minority Mental Health Consumers and is awarded annually at the Alabama Mental Health Consumers Conference.

(2008) Leadership Award, Leading Edge Institute, Birmingham, Alabama

(2007) Outstanding Leadership Award, Human Resources Development Institute, Chicago, Illinois

(2006) Mental Health Consumers, Outstanding Leadership Award, Mental Health Consumers of Alabama.

(2005) Lifetime Achievement Award, the Alabama Chapter of the National Association of Social Workers, Inc.

(2005) President's Award, the Council of Organizations Serving Deaf Alabamians

(2004) Legacy of the Dreamer Award, the Southern Christian Leadership Conference (SCLC)

(2004) ALLY Leadership Award, the People First of Alabama

(2004) Sustainer of the Year Award, the Junior League of Montgomery, Inc.

(2004) Citizen of the Year, the *Montgomery Advertiser*

(2004) Whitney M. Young, Jr. Service Award, Boy Scouts of America, Tuckabatchee Area Council

(2004) Eagle Award by the Minority Mental Health Consumers of Alabama

(2004) Outstanding Alumna Award, Theta Sigma Chapter of Alpha Kappa Alpha (University of Alabama)

(2004) Ann Denbo Lifetime Award, National Alliance for the Mentally Ill (NAMI) Decatur Chapter

(2004) Mental Health Issues Award, Montgomery Area Mental Health Authority

(2003) Dr. Mary Starke Harper Lecture Series Recognition

(2003) Civil Rights Pioneer Award, The University of Alabama

(2002) Hope Award, the Mental Health Consumers of Alabama

(2001) Outstanding Achievement in Government Award, Eli Lilly Reintegration, Eli Lilly Corporation

(2001) Government Service Legacy Award, Alpha Upsilon Lambda Chapter, Alpha Phi Alpha Fraternity

(2000) Outstanding Supportive Advocate Award, Mental Health Consumers of Alabama

(2000) Citizen of the Year Award, Montgomery Alumnae Chapter, Delta Sigma Theta Sorority, Inc.

(1999) Professional of the Year Award, Mobile Association for Retarded Citizens

(1999) Meritorious Award, *The Montgomery Tuskegee Times*

(1999) The Silver Beaver Award, Tuckabatchee Area Council, Boy Scouts of America

(1998-99) Achievement in Leadership Award, Mental Health Association in Montgomery

(1997) Women of Distinction Award, South Central Alabama Girl Scouts Council

(1996) Inductee, Sidney Lanier High School Hall of Fame, Montgomery, Alabama

(1996) Distinguished Service Award, Alabama Alliance for the Mentally Ill

(1994) Volunteer of the Year Award, Association of Junior Leagues of America

(1993) Respect Award, Mental Health Consumers of Alabama and DMH/MR Office of Consumer and Ex-Patient Relations

(1993) Social Worker of the Year, Alabama Chapter, National Association of Social Workers, Montgomery Unit

(1992) District IX State Employee Public Service Bishop Barron Award, State of Alabama Employee Association

(1992) Women of Achievement Award, The Montgomery Advertiser, Montgomery, Alabama

(1992) Image Trailblazer Award, Delta Sigma Theta Sorority, Inc., Montgomery Alumnae Chapter

(1991) Who's Who in Government Services

(**1991) Distinguished Leadership Award,** National Association for Community Leadership

(1990) Governor's Volunteer of the Year Award, State of Alabama

(1986) Who's Who in Human Service Professionals

(1976) Inductee, Omicron Delta Kappa Leadership Society, University of Alabama, Tuscaloosa, Alabama

(1975) Who's Who in Colleges and Universities, University of Alabama, Tuscaloosa, Alabama

(1974) Inductee, Mortar Board, Hypatia Chapter, University of Alabama, Tuscaloosa, Alabama.

Attachment B

Steward v. Smith
5:10-CV-1025-OLG
In the United States District Court
for the Western District of Texas
San Antonio Division

REPORT OF KATHY SAWYER
Attachment B:
Considered Materials

	DOCUMENT	BATES NUMBER
1.	Plaintiffs' Second Amended and Supplemental Complaint (ECF Doc. 173)	
2.	Plaintiffs' Motion for Preliminary Injunction (ECF Doc. 317)	
3.	Interim Settlement Agreement (ECF Doc. 180)	
4.	LIDDA Performance Contract FY16-17 with Attachment G	DefE-00001706-DefE-00001727; DefE-00001859-DefE-00001873
5.	LIDDA Performance Contract FY16-17 Amendment 2, September 1, 2016	DefE-00001785-DefE-00001846
6.	PASRR QSR 2015 ANNUAL REPORT of COMPLIANCE, Kathryn duPree, June 8, 2016	DefE-00000601
7.	2016 PASRR QSR Compliance Status Interim Report – DRAFT, Kathryn duPree	DefE-00096540
8.	Nursing Facility Transition Protocol	US00255959
9.	Nursing Facility Diversion Protocol	US00255960-255961
10.	All LIDDAs PASRR Quality Reporting, Q1 FY16	DefE-00000034
11.	All LIDDAs PASRR Quality Reporting, Q2 FY16	DefE-00000559
12.	All LIDDAs PASRR Quality Reporting, Q3 FY16	DefE-00000726
13.	All LIDDAs PASRR Quality Reporting, Q4, FY16	DefE-00055545
14.	PASRR Service Coordinator Participant Guide	DefE-00055401
15.	Form 1041, Individualized Service Plan/Transition Plan – NF (Effective August 2014), *available at* https://hhs.texas.gov/laws-	US00253775-253800

	regulations/forms/1000-1999/form-1041-individual-service-plantransition-plan-nf	
16.	Local Authorities Directory, TEX. HEALTH & HUMAN SVCS. COMM'N (Updated March 8, 2016), https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/local-intellectual-developmental-disability-authority-lidda/local-authorities-directory	US00253801-253820
17.	TEX. HEALTH AND HUMAN SVCS. COMM'N, 2014/2015 Revised Texas Promoting Independence Plan (May 2016).	US00253821-253890
18.	FY16-17 Slot Rollout	DefE-00045924
19.	FY16-FY17 LIDDA Performance Contract	DefE-00170241
20.	LIDDA Performance Contract Att. G	DefE-00170275
21.	LIDDA Performance Contract Att. K	DefE-00170295
22.	NF PASRR Related HCS Slots FY14-15, FY16-17	DefE-00193119
23.	NF Slots FY14-15	DefE-00206128
24.	Waiver Slot Enrollment Report – 04/2014	DEFP-00029805
25.	Waiver Slot Enrollment Report – 5/2014	DEFP-00029789
26.	Waiver Slot Enrollment Report – 06/2014	DefE-00031269
27.	Waiver Slot Enrollment Report – 09/2015	US00254621-254647
28.	Waiver Slot Enrollment Report – 10/2015	DEFP-00029645
29.	Waiver Slot Enrollment Report – 12/2015	US00254648-254674
30.	Waiver Slot Enrollment Report – 01/2016 (Slot Type 89)	DefE-00000036
31.	Waiver Slot Enrollment Report – 01/2016 (Slot Type 90)	DefE-00000037
32.	Waiver Slot Enrollment Report – 02/2016	US00254675-254709
33.	Waiver Slot Enrollment Report – 03/2016	US00254710-254747
34.	Waiver Slot Enrollment Report – 04/2016	DEFP-00029607

35.	Waiver Slot Enrollment Report – 05/2016	DEFP-00029588
36.	Waiver Slot Enrollment Report – 05/2016 (full report)	US00254748-254787
37.	Waiver Slot Enrollment Report – 06/2016	US-00254788-254827
38.	Waiver Slot Enrollment Report – 07/2016	US00254828-254859
39.	Waiver Slot Enrollment Report – 08/2016	DEFP-00029550
40.	Waiver Slot Enrollment Report – 10/2016	US00254860-254893
41.	Waiver Slot Enrollment Report – 02/2017	US00254894-254929
42.	Waiver Slot Enrollment Progress Report – 03/2017	US00254930-254941
43.	Letter from Jami Snyder, Texas State Medicaid Director, to Bill Brooks, Associate Regional Administrator, Medicaid and Children's Health, Center for Medicare & Medicaid Services, re: Transmittal Number 17-0020 amendment to the Texas State Plan for Medical Assistance (August 1, 2017).	US00254956-254982
44.	TEX. HEALTH & HUMAN SVCS. COMM'N, Application for Section 1915(b)(4) Waiver: Fee-for-service Selective Contracting Program (August 2017).	US00254942-254955
45.	All LIDDA Quality Reporting Q1 FY16	DefE-00000556
46.	"An Overview of DADS in our New Organization"	US00254983-255009
47.	DADS 2016-2017Interim-Structure Org Chart	US00255010-255012
48.	TEX. HEALTH & HUMAN SVCS. COMM'N, *HCBS Assessment Results, Intellectual and Developmental Disability Program External Assessment*, PowerPoint (August 1, 2017).	US00255013-255092
49.	Patty Ducayet, LMSW, Office of the State Long-Term Care Ombudsman Annual Report, State Fiscal Years 2013-2014, Tex. Health & Human Svcs. Comm'n (formerly Tex. Dept. of Aging & Disability Svcs.), November 2014, *available at* https://www.dads.state.tx.us/news_info/ombudsman/docs/13-14annualreport.pdf	US00255093-255104
50.	Office of the State Long-Term Care Ombudsman Annual Report, State Fiscal Years 2015-2016, Tex. Health & Human Svcs. Comm'n (formerly Tex. Dept. of Aging & Disability Svcs.), November 2016, *available at*	US00255105-255120

	https://www.dads.state.tx.us/news_info/ombudsman/docs/15-16annualreport.pdf.	
51.	Promoting Independence Advisory Committee Stakeholders Report 2014, Tex. Health & Human Svcs. Exec. Comm'r Promoting Independence Stakeholder Advisory Committee, September 2014, *available at* https://hhs.texas.gov/sites/default/files/basic_page/piac-2014-stakeholder.pdf	US0255121-255138
52.	Long-Term Services and Supports Quality Review, Biennial Summary Report 2015, Tex. Health & Human Svcs. Comm'n (formerly Tex. Dept. of Aging and Disability Svcs.), January 2015, *available at*, https://hhs.texas.gov/reports/2015/01/long-term-services-and-supports-quality-review-biennial-summary-report-2015-pdf	US00255139-255174
53.	Excerpts from Legislative Appropriations Request for Fiscal Years 2018-2019, Vols. I & II, Tex. Health & Human Svcs. Comm'n, September 12, 2016.	US00255175-255209
54.	Excerpt from Legislative Appropriations Request for Fiscal Years 2014-2015, Version 1, Tex. Health & Human Svcs. Comm'n, Administrators Statement, August 27, 2012.	US00255251-255259
55.	Excerpt from Legislative Appropriations Request for Fiscal Years 2014-2015, Version 1, Tex. Health & Human Svcs. Comm'n, Summary of Exceptional Items, August 23, 2012.	US00255260-255261
56.	Excerpt from Legislative Appropriations Request for Fiscal Years 2014-2015, Version 1, Tex. Health & Human Svcs. Comm'n, Summary of Total Requests, August 23, 2012.	US00255262-255266
57.	S.B. 1, Text of Conference Committee Report on Senate Bill No. 1, Art. II, 83rd Gen. Assemb., Reg. Sess. (Tex. 2013).	US00255267-255426
58.	Excerpt from Legislative Appropriations Request for Fiscal Years 2016-2017, Version 1, Tex. Health & Human Svcs. Comm'n, Administrators Statement, August 18, 2014.	US00255427-255436
59.	Excerpts from Legislative Appropriations Request for Fiscal Years 2016-2017, Tex. Health & Human Svcs. Comm'n, August 18, 2014.	US00255437-255462
60.	Excerpt from Legislative Appropriations Request for Fiscal Years 2016-2017, Organizational Chart, Tex. Health & Human Svcs. Comm'n, August 18, 2014	US00255463
61.	H.B. 1, Text of Conference Committee Report on House Bill No. 1 (and other bills affecting 2016-17 biennial appropriations), 84th Gen. Assemb., Reg. Sess. (Tex. 2015).	US00255464-255622
62.	TEX. HEALTH & HUMAN SVCS. COMM'N, Home and Community-based Services Waiver Slot Enrollment Plan for the 2018-2019 Biennium (September 2017), *available at* https://hhs.texas.gov/sites/default/files/documents/laws-	US00255623-255632

	regulations/reports-presentations/2017/Home_and_Community-based_Services_Slot_Enrollment_Plan_FY18-19.pdf	
63.	TEX. HEALTH & HUMAN SVCS. COMM'N (formerly Tex. Dept. of Aging & Disability Svcs.), Local Intellectual and Developmental Disability Authority Preadmission Screening and Resident Review (PASRR) Reporting Manual, (revised November, 2016), *available at* https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/resources/pasrr/pasrr-reporting-manual.pdf	US00255633-255645
64.	TEX. HEALTH AND HUMAN SVCS. COMM'N, 2016 Revised Texas Promoting Independence Plan (August 2017), *available at* https://hhs.texas.gov/reports/2017/09/2016-revised-texas-promoting-independence-plan	US00255646-255711
65.	Application for a 1915(c) Home and Community-Based Services Waiver (effective September 1, 2017), *available at* https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/hcs-waivers/hcs-waiver-amendment11.pdf	US00255712-255958
66.	ACCESS Quarterly LIDDA PASRR Reporting, FY16 Q1-Q4, FY17 Q1	DefE-00056597, DefE-00055546, DefE-00055552, DefE-00055558, DefE-00260846
67.	Alamo Local Authority LIDDA Quarterly PASRR Reporting, FY16 Q1-Q4, FY17 Q1-Q2	DefE-00056337, DefE-00055570, DefE-00055575, DefE-00055564, DefE-00260243, DefE-05344942
68.	Andrews Center LIDDA PASRR Quarterly Reporting; FY16 Q1, 4; FY17 Q1-Q2	DefE-00056342, DefE-00055581, DefE-00260552, DefE-05345481
69.	Austin Travis County Integral Care LIDDA PASRR Quarterly Reporting, FY16 Q1-Q4	DefE-00563498, DefE-00055626, DefE-00055623, DefE-00055634
70.	Betty Hardwick Center LIDDA PASSR Quarterly Reporting; FY16 Q1-Q4; FY17 Q1, Q3	DefE-00260223, DefE-00055678, DefE-00055684, DefE-00055670, DefE-00055663, DefE-00260399, DefE-05185559

71.	Behavioral Health Center of Nueces County LIDDA PASSR Quarterly Reporting FY16 Q1-Q4, FY17 Q1-Q3	DefE-00056358, DefE-00056540, DefE-00055657, DefE-00055651, DefE-00055645, DefE-00261173, DefE-05344916, DefE-05184886
72.	Bluebonnet Trails Community Services LIDDA PASRR Quarterly Reporting FY16 Q1-Q4, FY17 Q1-Q3	DefE-00056364, DefE-00055692, DefE-00055699, DefE-00055706, DefE-00261038, DefE-05344687, DefE-05183960
73.	Border Region LIDDA PASRR Quarterly Reporting FY16 Q1-Q4	DefE-00056370, DefE-00055713, DefE-00055719, DefE-00055725
74.	MHMR Authority of Brazos Valley LIDDA PASRR Quarterly Reporting FY16 Q1-Q4, FY17 Q2-Q3	DefE-00056415, DefE-00056025, DefE-00056030, DefE-00056036, DefE-00615929, DefE-00602185
75.	Burke LIDDA PASRR Quarterly Reporting FY16 Q1-Q4, FY17 Q1	DefE-00056377, DefE-00055733, DefE-00055739, DefE-00055746, DefE-00055753, DefE-00261188
76.	Camino Real LIDDA PASRR Quarterly Reporting FY16 Q1-Q4, FY17 Q1-Q3	DefE-00056383, DefE-00055759, DefE-00055756, DefE-00055771, DefE-03027032, DefE-05344867, DefE-00615172
77.	Center for Life Resources LIDDA PASRR Quarterly Reporting FY16 Q2-Q4	DefE-00055777, DefE-00055783, DefE-00055530
78.	Central Counties Services LIDDA PASRR Quarterly Reporting FY16 Q1-Q4, FY17 Q1	DefE-00056388, DefE-00055796, DefE-00055802, DefE-00055808, DefE-00260839

79.	Central Plains LIDDA PASRR Quarterly Reporting FY16 Q1-Q4, FY17 Q2-Q3	DefE-00056394, DefE-00055819, DefE-00055824, DefE-00055813, DefE-05345166, DefE-05185377
80.	Coastal Plains Community Center PASRR Quarterly Reporting FY16 Q1-Q4, FY17 Q1-Q3	DefE-00056400, DefE-00239803, DefE-00055829, DefE-00055834, DefE-00260263, DefE-05344803, DefE-05184890
81.	Community Healthcore LIDDA PASRR Quarterly Reporting FY16 Q1-Q4, FY17 Q1-Q2	DefE-00056405, DefE-00055839, DefE-00055845, DefE-00055850, DefE-00260408, DefE-05337055
82.	Concho Valley LIDDA PASRR Quarterly Reporting FY16 Q1-Q4, FY17 Q1	DefE-00056410, DefE-00056041, DefE-00056047, DefE-00056053, DefE-00261965
83.	Denton County MHMR Center LIDDA PASRR Quarterly Reporting FY16 Q1-Q4, FY17 Q1-Q2	DefE-00056425, DefE-00055868, DefE-00055856, DefE-00261061, DefE-00261061, DefE-05344949
84.	Emergence Health Network LIDDA PASRR Quarterly Reporting FY16 Q1-Q4, FY17 Q1	DefE-0005879, DefE-00055874, DefE-00056592, DefE-00055884, DefE-00261291
85.	Gulf Bend LIDDA PASRR Quarterly Reporting FY16 Q1-Q4, FY17 Q1	DefE-00056436, DefE-00055897, DefE-00055902, DefE-00055890, DefE-03026737
86.	Gulf Coast LIDDA PASRR Quarterly Reporting FY16 Q1-Q4, FY17 Q1-Q2	DefE-00056603, DefE-00055920, DefE-00055913, DefE-00055907, DefE-03027650, DefE-05408687

87.	The Harris Center LIDDA PASRR Quarterly Reporting FY16 Q1-Q4	DefE-00056476, DefE-00056059, DefE-00056065, DefE-00056072
88.	Heart of Texas Region MHMR Center PASRR Quarterly Reporting FY16 Q1-Q4, FY17 Q1	DefE-00056446, DefE-00056441, DefE-00055939, DefE-00055933, DefE-00055927, DefE-00260426
89.	Helen Farabee Center LIDDA PASRR Quarterly Reporting FY16 Q1-Q4, FY17 Q1	DefE-00055957, DefE-00056447, DefE-00055957, DefE-00055951, DefE-00055945, DefE-00260269
90.	Hill Country MHDD Centers PASRR Quarterly Reporting FY16 Q1-Q4, FY17 Q2	DefE-00056459, DefE-00055963, DefE-00055969, DefE-00055975, DefE-05338855, DefE-05338856, DefE-06011477
91.	Lakes Regional LIDDA PASRR Quarterly Reporting FY16 Q1-Q4, FY17 Q1-Q2	DefE-00056465, DefE-0005982, DefE-00055988, DefE-00055994, DefE-00260913, DefE-05344966
92.	Lifepath LIDDA PASRR Quarterly Reporting FY16 Q2-Q4, FY17 Q1-Q2	DefE-00055009, DefE-00055537, DefE-00056000, DefE-05032202, DefE-05345296
93.	Metrocare LIDDA PASRR Quarterly Reporting FY16 Q1-Q4, FY17 Q1-Q3	DefE-00056471, DefE-00056007, DefE-00056013, DefE-00056019, DefE-03027074, DefE-05344958, DefE-05185403
94.	Permian Basin Community Centers LIDDA PASRR Quarterly Reporting FY16 Q1-Q4, FY17 Q3	DefE-00056177, DefE-00056166, DefE-00056171, DefE-00056182, DefE-05186353

95.	Pecan Valley Centers for Behavioral and Developmental Healthcare LIDDA PASRR Quarterly Reporting FY16 Q1-Q4, FY17 Q2	DefE-00056534, DefE-00056149, DefE-00056155, DefE-00056160, DefE-05344960
96.	Spindletop LIDDA PASRR Quarterly Reporting FY16 Q1-Q4, FY17 Q1-Q3	DefE-00056546, DefE-00056194, DefE-00056188, DefE-00056200, DefE-03026584 DefE-05405301, DefE-05174636
97.	Star Care LIDDA PASRR Quarterly Reporting FY16 Q1-Q4, FY17 Q3	DefE-00056552, DefE-00056206, DefE-00056212, DefE-00056218, DefE-05186150
98.	MHMR of Tarrant County LIDDA PASRR Quarterly Reporting FY16 Q1-Q4, FY17 Q1	DefE-00261132, DefE-00056482, DefE-00056078, DefE-00056101, DefE-00260284
99.	Texana LIDDA PASRR Quarterly Reporting FY16 Q1-Q4, FY17 Q1-Q2	DefE-00056558, DefE-00056224, DefE-00056238, DefE-00056231, DefE-00260617 DefE-00602550
100.	Texoma LIDDA PASRR Quarterly Reporting FY16 Q1-Q4, FY17 Q1-Q2	DefE-00056564, DefE-00056276, DefE-00056270, DefE-00056264, DefE-00260348, DefE-00602591
101.	Tri-County Services LIDDA PASRR Quarterly Reporting FY16 Q1-Q4, FY17 Q1-Q2	DefE-00056570, DefE-00056288, DefE-00056282, DefE-00056294, DefE-03027006, DefE-05345003
102.	Tropical Texas Behavioral Health LIDDA PASRR Quarterly Reporting FY16 Q1-Q4; FY17 Q1, Q3	DefE-00056576, DefE-00056313, DefE-00056307, DefE-00056301, DefE-00260276 DefE-00665820

103.	Texas Panhandle LIDDA PASRR Quarterly Reporting FY16 Q1-Q4, FY17 Q1	DefE-00056587, DefE-00056244, DefE-00056254, DefE-00056259, DefE-00260415
104.	West Texas Center LIDDA PASRR Quarterly Reporting FY16 Q1-Q4; FY17 Q1, Q3	DefE-00056582, DefE-00223256, DefE-00056325, DefE-00056319, DefE-00056331, DefE-00260598, DefE-05185103
105.	Form 1039, Community Living Options (effective September 2014), *available at* https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1039-community-living-options	US00253559-253568
106.	Plaintiffs' and United States' Amended Notice of Deposition Pursuant to Fed. R. Civ. P. 30(b)(6)	
107.	DADS FY16-17 Performance Contract with LIDDAs	US00253569-253680
108.	TEX. HEALTH & HUMAN SVCS. COMM'N, Promoting Independence Plan Update FY17 Q1 (November 2016)	US00253681-253722
109.	HHSC IDD Services Unit Organizational Chart	DefE-00672453
110.	FY16-17 HCS PASRR Related Slots	DefE-00637504
111.	HCS Comparison of Allocated FY 16-17 and Proposed FY 18-19	DefE-00720175
112.	Transcript of the Deposition of Jennifer Cochran, September 14, 2017, Austin, Texas.	
113.	Exhibits Submitted at the Deposition of Jennifer Cochran (PX43-PX54), September 14, 2017, Austin, Texas.	
114.	2016 QI PASRR QSR Compliance Report, Kathryn DuPree	DefE-00000677
115.	Caseload Methodology Reports – Alamo Local Authority	DefE-00251180
116.	Caseload Methodology Reports – Austin Travis County Integral Care	DefE-00245941, DefE-00251640
117.	Caseload Methodology Reports – Bluebonnet Trails Community Centers	DefE-00245975
118.	Caseload Methodology Reports – Betty Hardwick Centers	DefE-00244770, DefE-00251310
119.	Caseload Methodology Reports – Behavioral Health Center of Nueces County	DefE-00245980

120.	Caseload Methodology Reports – Burke	DefE-00245836
121.	Caseload Methodology Reports – Camino Real	DefE-00245960, DefE-00251022
122.	Caseload Methodology Reports – Central Plains	DefE-00245953
123.	Caseload Methodology Reports – Coastal Plains	DefE-00245946
124.	Caseload Methodology Reports – Community Healthcore	DefE-00245852, DefE-00664324
125.	Caseload Methodology Reports – Heart of Texas	DefE-00246051
126.	Caseload Methodology Reports – Helen Farabee Centers	DefE-00250415, DefE-00244699
127.	Caseload Methodology Reports – Hill Country MHDD Centers	DefE-00245934
128.	Caseload Methodology Reports – Lakes Regional	DefE-00609745
129.	Caseload Methodology Reports – MHMR Authority of Brazos Valley	DefE-00609936
130.	Caseload Methodology Reports – MHMR of Tarrant County	DefE-00246086
131.	Caseload Methodology Reports – Pecan Valley	DefE-00244804
132.	Caseload Methodology Reports – Permian Basin Community Centers	DefE-00244848
133.	Caseload Methodology Reports – Tri-County Community Services	DefE-00244789, DefE-00251038
134.	Caseload Methodology Reports –West Texas Centers	DefE-00244851
135.	TEXAS COUNCIL FOR DEVELOPMENTAL DISABILITIES, 85TH Texas Legislature Final Budget Summary, http://www.tcdd.texas.gov/public-policy/texas-legislature/85th-legislature-final-budget/#Promoting_Independence	US00253723-253729
136.	Transcript of the Deposition of Judy Southall, October, 4, 2017, Austin, Texas.	
137.	Exhibits submitted at the Deposition of Judy Southall (PX80-PX95), October 4, 2017, Austin, Texas.	
138.	Transcript of the Deposition of Richard Miller, October 13, 2017, Austin, Texas.	
139.	Exhibits submitted at the Deposition of Richard Miller (PX201-PX217), October 13, 2017, Austin, Texas.	
140.	Transcript of the Deposition of Elizabeth Jones, October 17, 2017, Austin, Texas.	

141.	Exhibits submitted at the Deposition of Elizabeth Jones (PX245-PX264), October 17, 2017, Austin, Texas.	
142.	Order Amending Schedule (ECF Doc. 382)	
143.	TEX. HEALTH & HUMAN SVCS. COMM'N, Implementation of Acute Care Services and the Long-term Services and Supports System Redesign for Individuals with an Intellectual or Developmental Disability, September, 2017, https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2017/long-term/implementation-acute-care-ltss-redesign-sept-2017.pdf	US00253730-253774
144.	Transcript of the Deposition of Lona Carter, October, 2, 2017, Austin, Texas.	
145.	Exhibits submitted at the Deposition of Lona Carter (PX55-PX64), October 2, 2017, Austin, Texas.	
146.	Transcript of the 30(b)(6) Deposition of Anthony Jalomo, November 2, 2017, Austin, Texas.	
147.	Exhibits submitted at the 30(b)(6) Deposition of Anthony Jalomo (PX330-PX343), November 2, 2017, Austin, Texas.	
148.	Transcript of the Deposition of Anthony Jalomo, November 3, 2017, Austin, Texas.	
149.	Exhibits submitted at the Deposition of Anthony Jalomo (PX343-355), November 3, 2017, Austin, Texas.	
150.	Transcript of the Deposition of Linda Lothringer, November 6, 2017, Austin, Texas.	
151.	Exhibits submitted at the Deposition of Linda Lothringer (PX356-PX388), November 6, 2017, Austin, Texas.	
152.	Transcript of the Deposition of Judy Southall, November 7, 2017, Austin, Texas.	
153.	Exhibits submitted at the Deposition of Judy Southall (PX389-PX415), November 7, 2017, Austin, Texas.	
154.	Transcript of the Deposition of Martha Diase, November 1, 2017, Austin, Texas.	
155.	Exhibits submitted at the Deposition of Martha Diase (PX304-PX326), November 1, 2017, Austin, Texas.	
156.	Transcript of the Deposition of Jami Snyder, November 16, 2017, Austin, Texas.	
157.	Exhibits submitted at the Deposition of Jami Snyder (PX475-PX512), November 6, 2017, Austin, Texas.	
158.	Transcript of the Deposition of Richard Rees, October 3, 2017, Austin, Texas.	
159.	Exhibits submitted at the Deposition of Richard Rees (PX59-PX79), October 3, 2017, Austin, Texas.	

160.	ACCESS Enhanced Community Coordination Quarterly Reports, FY17 Q1, Q4	DefE-05336753, DefE-05174292
161.	Alamo Local Authority Enhanced Community Coordination Quarterly Reports FY16 Q1-Q4, FY17 Q1-Q3	DefE-00240684, DefE-00243259, DefE-00246151, DefE-00246152, DefE-00251850, DefE-00251851, DefE-00251852, DefE-00251853, DefE-00251854, DefE-00260786, DefE-00260787, DefE-00260788, DefE-00260789, DefE-00260790, DefE-05175489, DefE-06011233
162.	Andrews Center Enhanced Community Coordination Quarterly Reports FY16 Q2-Q3, FY17 Q1	DefE-00244263, DefE-00246057, DefE-00251844, DefE-00260551
163.	Austin Travis County Integral Care Enhanced Community Coordination Quarterly Reports Y16 Q1, FY17 Q1	DefE-00240845, DefE-05031417
164.	Behavioral Health Center of Nueces County, Enhanced Community Coordination Quarterly Reports, FY17 Q1-Q2	DefE-05031242, DefE-05407747
165.	Betty Hardwick Center Enhanced Community Coordination Quarterly Reports FY16 Q1, Q3, Q4; FY17 Q1, Q3	DefE-00240838, DefE-01353284, DefE-00260340, DefE-00260341, DefE-00260342, DefE-05185545
166.	Bluebonnet Trails Community Services Enhanced Community Coordination Quarterly Reports FY16 Q4, FY17 Q1-Q2	DefE-00252162, DefE-00260825, DefE-06011340
167.	Border Region MHMR Enhanced Community Coordination Quarterly Reports, FY16 Q1, Q3; FY17 Q1-Q3	DefE-00260023, DefE-00246204, DefE-00262966, DefE-05344454, DefE-05184366
168.	MHMR Authority of Brazos Valley Enhanced Community Coordination Quarterly Reports, FY17 Q1, Q3	DefE-00262628, DefE-06019192

169.	Burke Center Enhanced Community Coordination Quarterly Reports, FY16 Q1, Q4; FY17 Q1	DefE-00251673, DefE-00240564, DefE-05031239
170.	Camino Real Enhanced Community Coordination Quarterly Reports FY16 Q1-Q4, FY17 Q1-Q3	DefE-00240842, DefE-00243538, DefE-00246325, DefE-00253385, DefE-00260479, DefE-06011309, DefE-06018792
171.	Center For Life Resources, Enhanced Community Coordination Quarterly Reports, FY16 Q4, FY17 Q1	DefE-00263056, DefE-03022061
172.	Central Counties Services Enhanced Community Coordination Quarterly Reports, FY16 Q2, FY17 Q1-Q2	DefE-00243386, DefE-00260549, DefE-03026703, DefE-06011335
173.	Central Plains Enhanced Community Coordination Quarterly Reports, FY16 Q4, FY17 Q1-Q2	DefE-01356234, DefE-06009093, DefE-06009090, DefE-06011360
174.	Coastal Plains Community Center, Enhanced Community Coordination Quarterly Reports, FY17 Q1, Q3	DefE-00263093, DefE-06019164
175.	Community Healthcore, Enhanced Community Coordination Quarterly Reports, FY16 Q1-Q4, FY17 Q1-Q3	DefE-00240150, DefE-00243475, DefE-00245100, DefE-00245101, DefE-00250979, DefE-00260046, DefE-00260047, DefE-05407784, DefE-05173504
176.	Concho Valley Enhanced Community Coordination Quarterly Reports, FY17 Q1	DefE-06009190
177.	Denton County MHMR Center, Enhanced Community Coordination Quarterly Reports, FY16 Q3-Q4, FY17 Q1-Q2	DefE-00246157, DefE-00251612, DefE-00261376, DefE-00262994, DefE-06011303
178.	Emergence Enhanced Community Coordination Quarterly Reports, FY17 Q1	DefE-05031816
179.	Gulf Bend Center, Enhanced Community Coordination Quarterly Reports, FY16 Q4, FY17 Q1-Q2	DefE-00251838, DefE-00260596, DefE-06011477
180.	The Harris Center, Enhanced Community Coordination Quarterly Reports, FY16 Q2, Q4; FY17 Q1-Q2	DefE-00244184, DefE-00252465,

		DefE-00260834, DefE-06011477
181.	Heart of Texas Region MHMR Center, Enhanced Community Coordination Quarterly Reports FY16 Q3, FY17 Q1-Q2	DefE-00246327, DefE-00260425, DefE-05407390
182.	Helen Farabee Center, Enhanced Community Coordination Quarterly Reports, FY16 Q3, Q4; FY17 Q1	DefE-00245928, DefE-00252184, DefE-00260519
183.	Hill Country MHDD Centers, Enhanced Community Coordination Quarterly Reports, FY16 Q1-Q4, FY17 Q1-Q2	DefE-00240860, DefE-00243572, DefE-00245803, DefE-00251676, DefE-00251677, DefE-00260639, DefE-00260640, DefE-05338855, DefE-05338856, DefE-06011477
184.	Lakes Regional MHMR Center. Enhanced Community Coordination Quarterly Reports, FY16 Q2-Q4, FY17 Q1-Q2	DefE-00246321, DefE-00251241, DefE-00246322, DefE-00251243, DefE-00260210, DefE-00260211, DefE-00260212, DefE-06010417, DefE-06010418, DefE-06010419
185.	Lifepath Systems, Enhanced Community Coordination Quarterly Reports, FY16 Q4, FY17 Q1	DefE-00252649, DefE-00252657, DefE-00260627, DefE-00260940
186.	Metrocare Services, Enhanced Community Coordination Quarterly Reports, FY16 Q4, FY17 Q2-Q3	DefE-00251760, DefE-06011298, DefE-06137023
187.	Pecan Valley MHMR, Enhanced Community Coordination Quarterly Reports, FY16 Q4, FY17 Q1	DefE-00252099, DefE-00260582
188.	Permian Basin Community Centers, Enhanced Community Coordination Quarterly Reports, FY16 Q3-Q4, FY17 Q1-Q3	DefE-00252151, DefE-00246165, DefE-01879635, DefE-05337402, DefE-05178443
189.	Spindletop Center, Enhanced Community Coordination Quarterly Reports, FY 17 Q1-Q3	DefE-00260076; DefE-00260083,

		DefE-05405308, DefE-05174634
190.	Star Care, Enhanced Community Coordination Quarterly Reports, FY16 Q2, FY17 Q2	DefE-01350920, DefE-06011203
191.	MHMR of Tarrant County, Enhanced Community Coordination Quarterly Reports, FY Q1-Q4; FY17 Q1, Q3	DefE-00240854, DefE-00243563, DefE-00246060, DefE-00246073, DefE-01355863, DefE-00260807, DefE-00260803, DefE-05174235
192.	Texana Center, Enhanced Community Coordination Quarterly Reports, FY16 Q1, Q3, Q4; FY17 Q1-Q2	DefE-00240630, DefE-00245563, DefE-00260221, DefE-00253954, DefE-06010354
193.	Texas Panhandle, Enhanced Community Coordination Quarterly Reports, FY16 Q1, Q3, Q4, FY17 Q1	DefE-00259252, DefE-00253670, DefE-00260524, DefE-03015709
194.	Texoma Community Center Enhanced Community Coordination Quarterly Reports FY17 Q1-Q3	DefE-06009248, DefE-06011331, DefE-05174294
195.	Tri-County Behavioral Healthcare, Enhanced Community Coordination Quarterly Reports, FY16 Q2-Q4, FY17 Q1-Q2	DefE-00243515, DefE-00245995, DefE-00251044, DefE-00251045, DefE-00260388, DefE-00260387, DefE-06009100, DefE-05337955
196.	Tropical Texas Behavioral Health, Enhanced Community Coordination Reports, FY16 Q4, FY17 Q1	DefE-00251892, DefE-00260615
197.	West Texas Center, Enhanced Community Coordination Reports, FY16 Q4, FY17 Q1	DefE-00251186, DefE-00260544
198.	Enhanced Community Coordination All LIDDA Quarterly Report FY17 Q1	DefE-02018307
199.	All LIDDA PASRR Quarterly Reporting, FY17 Q1	DefE-00702109
200.	All LIDDA PASRR Quarterly Reporting FY17 Q2	DefE-02005170
201.	All LIDDA PASRR Quarterly Reporting FY17 Q3	DefE-02005171

202.	#89 NF Transition Snapshot 9/1/17	DefE-01958693
203.	Enhanced Community Coordination All LIDDA Quarterly Report FY17 Q3	DefE-02018300
204.	Enhanced Community Coordination All LIDDA Aggregate Quarterly Report FY17 Q1-Q3	DefE-02018301
205.	TEX. HEALTH & HUMAN SVCS. COMM'N, Home and Community-based Services Handbook, *available at* https://hhs.texas.gov/laws-regulations/handbooks/home-community-based-services-handbook	
206.	TEX. HEALTH & HUMAN SVCS. COMM'N, Home and Community-based Services Program Billing Guidelines, *available at* https://hhs.texas.gov/laws-regulations/handbooks/home-community-based-services-hcs-program-billing-guidelines	
207.	40 T.A.C., Part 1, Ch. 9, Subch. D: Home and Community-based Services (HCS) Program and Community First Choice (CFC), *available at* https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/long-term-care/hcs/TAC-Ch9-HCS-March202016.pdf	
208.	Transcript of the Deposition of Michelle Dionne-Vahalik, October 12, 2017, Austin, Texas.	
209.	Exhibits Submitted at the Deposition of Michelle Dionne-Vahalik (PX174-PX199), October 12, 2017, Austin, Texas.	
210.	Transcript of the Deposition of Michelle Dionne-Vahalik, December 19, 2017, Austin, Texas.	
211.	Exhibits Submitted at the Deposition of Michelle Dionne-Vahalik (PX659-PX683), December 19, 2017, Austin, Texas.	
212.	Transcript of the Deposition of Mendy Blevins, February 7, 2017, Austin, Texas.	
213.	Transcript of the Deposition of Stacey Lindsey, February 8, 2017, Austin, Texas.	
214.	Transcript of the Deposition of Sally Schultz, December 18, 2017, Austin, Texas.	
215.	Exhibits Submitted at the Deposition of Sally Schultz (PX663-PX658), December 18, 2017, Austin, Texas.	
216.	Transcript of the Deposition of David Cook, November 15, 2017, Austin, Texas.	
217.	Exhibits Submitted at the Deposition of David Cook (PX436-PX474), November 15, 2017, Austin, Texas.	
218.	TEX. HEALTH & HUMAN SVCS. COMM'N, Long-term Care Plan for Individuals with Intellectual Disabilities and Related Conditions (Final), Fiscal Year 2016-2017, November 2015, Updated September 2016, *available at* https://hhs.texas.gov/sites/default/files//idd-ltp.pdf	US00254196-254212

219.	40 T.A.C., Part 1, Ch. 17: Preadmission Screening and Resident Review, *available at* http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=40&pt=1&ch=17	US00254213-254232
220.	TEX. HEALTH & HUMAN SVCS. COMM'N, *PASRR Transition and Diversion for Individuals with IDD Residing in or Diverting from Nursing Facilities*, PowerPoint (September 6, 2017), *available at* https://hhs.texas.gov/sites/default/files//documents/doing-business-with-hhs/providers/resources/pasrr/pasrr-transition-diversion-aug-2017.pdf	US00254233-254269
221.	SUNSET ADVISORY COMM'N, Staff Report with Final Results, Department of Aging and Disability Services, (July 2015), *available at* https://www.sunset.texas.gov/public/uploads/files/reports/DADS%20Staff%20Report%20with%20Final%20Results.pdf	US00254270-254450
222.	S.B. 200, 84th Gen. Assemb., Reg. Sess. (Tex. 2015). *Available at* http://www.capitol.state.tx.us/tlodocs/84R/billtext/pdf/SB00200F.pdf#navpanes=0	US00254451-254607
223.	TEX. HEALTH & HUMAN SVCS. COMM'N (formerly Dept. of Aging and Disability Services), Information Letter No. 14-10 from Elisa J. Garza, Asst. Comm'r, Access and Intake, to HCS Providers and Local Authorities (April 1, 2014), *available at* https://www.dads.state.tx.us/providers/communications/2014/letters/IL2014-10.pdf	US0254608-254609
224.	TEX. HEALTH & HUMAN SVCS. COMM'N (formerly Dept. of Aging and Disability Services), Information Letter No. 16-11 from Michelle Martin, Dir., Ctr. For Policy and Innovation, and Elisa J. Garza, Asst. Comm'r, Access and Intake, to HCS Providers (April 22, 2016, revised July, 2016), *available at* https://www.dads.state.tx.us/providers/communications/2016/letters/IL2016-11.pdf	US00254610-254612
225.	TEX. HEALTH & HUMAN SVCS. COMM'N (formerly Dept. of Aging and Disability Services), Information Letter No. 16-40 from Jami Snyder, Assoc. Comm'r, to HCS Providers (December 21, 2016), *available at* https://www.dads.state.tx.us/providers/communications/2016/letters/IL2016-40.pdf	US00254613-254614
226.	TEX. HEALTH & HUMAN SVCS. COMM'N (formerly Dept. of Aging and Disability Services), Provider Letter No. 17-14/Information Letter No. 17-14 from Mary Henderson, Assoc. Comm'r, Regulatory Svcs.; Haley Turner, Dep. Assoc. Comm'r, IDD & BH Svcs.; Andy Vasquez, Dep. Assoc. Comm'r, Quality and Program Improvement, to LIDDAs, NFs, HCS Providers, TxHML Providers, CLASS Providers, DBMD Providers, STAR	US00254615-254618

	Plus Providers, ICFs/IID (July 3, 2017), *available at* https://www.dads.state.tx.us/providers/communications/2017/letters/IL2017-14_PL2017-22.pdf	
227.	TEX. HEALTH & HUMAN SVCS. COMM'N (formerly Dept. of Aging and Disability Services), Information Letter No. 17-16 from Victor Perez, Dir., Rate Analysis for LTSS to CFC Providers, FMSAs, HCS Providers, LIDDAs, and TxHML Providers (July 20, 2017), *available at* https://www.dads.state.tx.us/providers/communications/2017/letters/IL2017-16.pdf	US00254619-254620
228.	Transcript of the Deposition of Terry Hernandez, January 9, 2018, Austin, Texas.	
229.	Exhibits submitted at the deposition of Terry Hernandez (PX684-PX711), January 9, 2018, Austin, Texas.	
230.	Transcript of the 30(b)(6) Deposition of Deborah Mills, October 19, 2017, Austin, Texas.	
231.	Exhibits submitted at the 30(b)(6) deposition of Deborah Mills (PX265-PX275), October 19, 2017, Austin, Texas.	
232.	Transcript of the 30(b)(6) deposition of Dana Williamson, January 10, 2018, Austin, Texas.	
233.	Exhibits submitted at the 30(b)(6) deposition of Dana Williamson (PX712-PX749), January 10, 2018, Austin, Texas.	
234.	Transcript of the 30(b)(6) deposition of Cathy Belliveau, October 20, 2017, Austin, Texas.	
235.	Exhibits submitted at the 30(b)(6) deposition of Cathy Belliveau (PX276-PX303), October 20, 2017, Austin, Texas.	
236.	Transcript of the Deposition of Mary Henderson, November 14, 2017, Austin, Texas.	
237.	Exhibits submitted at the deposition of Mary Henderson (PX416-PX435), November 14, 2017, Austin, Texas.	
238.	Transcript of the deposition of Richard Rees, January 11, 2018, Austin, Texas.	
239.	Exhibits submitted at the deposition of Richard Rees (PX750-PX780), January 11, 2018, Austin, Texas.	
240.	Transcript of the deposition of Andy Vasquez, January 12, 2018, Austin, Texas.	
241.	Exhibits submitted at the deposition of Andy Vasquez (PX781-PX794), January 12, 2018, Austin, Texas.	
242.	Memorandum from Gary Jessee, Assoc. Comm'r for Medicaid and CHIP, Tex. Health & Human Svcs. Comm'n to Charles Smith, Chief Deputy Executive Comm'r, Tex. Health & Human Svcs. Comm'n (March 28, 2016), Subject: S.B. 7 System Redesign for Individuals with Intellectual and Developmental Disabilities Report.	DefE-01562423-DefE-01562479

243.	Email from Lona Carter, Tex. Health & Human Svcs. Comm'n, to Anthony Jalomo, Tex. Health & Human Svcs. Comm'n (August 8, 2017, 6:19 PM, CST), and attachment "QSR-Identified Barriers (Outcomes 4-8, 4-9)"	DefE-01940328 and DefE-01940329
244.	Tex. Health & Human Svcs. Comm'n, IDD-PES, Home and Community-based Services Suspension & Termination.	DefE-01970918
245.	Tex. Health & Human Svcs. Comm'n, IDD Waivers/Community Services/Hospice Utilization Review; HCS, TxHML, ICF-IID/Utilization Review (UR).	DefE-02824007
246.	Pending Policy Issues IDD SRAC	DefE-05121083
247.	ROUGH Transcript of the 30(b)(6) Deposition of David Cook, continued February 1, 2018, Austin, Texas.	
248.	ROUGH Transcript of the Deposition of David Cook, February 1, 2018, Austin, Texas.	
249.	ROUGH Transcript of the Deposition of Kathryn duPree, February 6, 2018, Austin, Texas.	
250.	ROUGH Transcript of Jon Weizenbaum, February 7, 2018, Austin, Texas.	
251.	ROUGH Transcript of Chris Adams, February 9, 2018, Austin, Texas.	
252.	Final Transcript of the deposition of Kathryn duPree, February 6, 2018, Austin, Texas.	
253.	Exhibits submitted at the deposition of Kathryn duPree (PX841-PX864), February 6, 2018, Austin, Texas.	
254.	Final Transcript of the 30(b)(6) deposition of David Cook, continued February 1, 2018, Austin, Texas.	
255.	Final Transcript of the deposition of David Cook, February 1, 2018, Austin, Texas.	
256.	Exhibits submitted at the deposition of David Cook (PX803-PX840), February 1, 2018, Austin, Texas.	
257.	Final Transcript of the deposition of Jon Weizenbaum, February 7, 2018, Austin, Texas.	
258.	Exhibits submitted at the deposition of Jon Weizenbaum (PX865-PX881), February 7, 2018, Austin, Texas.	
259.	Transcript of the deposition of Gary Jessee, February 8, 2018, Austin, Texas.	
260.	Exhibits submitted at the deposition of Gary Jessee (PX882-PX914), February 8, 2018, Austin, Texas.	
261.	Final Transcript of the deposition of Chris Adams, February 9, 2018, Austin, Texas.	
262.	Exhibits submitted at the deposition of Chris Adams (PX915-PX926), February 9, 2018, Austin, Texas	

263.	Slot Activity Report	DefE-05084303
264.	PX945 – documents included in Tabs 1 and 2 of documents reviewed by Haley Turner in preparation for February 21, 2018 30(b)(6) deposition.	
265.	ROUGH transcript of the 30(b)(6) deposition of Haley Turner, February 21, 2018, Austin, Texas.	
266.	ROUGH transcript of the deposition of Haley Turner, February 23, 2018, Austin, Texas.	
267.	Final Transcript of the 30(b)(6) deposition of Haley Turner, February 21, 2018, Austin, Texas.	
268.	Exhibits submitted at the deposition of Haley Turner (PX943-PX1016), February 21, 2018, Austin, Texas.	
269.	Transcript of the deposition of Dana Williamson, February 22, 2018, Austin, Texas.	
270.	Exhibits submitted at the deposition of Dana Williamson (PX1017-PX1038), February 22, 2018, Austin, Texas	
271.	ROUGH transcript of Sonja Gaines, February 27, 2018, Austin, Texas.	
272.	Final Transcript of the deposition of Haley Turner, February 23, 2018, Austin, Texas.	
273.	Exhibits submitted at the deposition of Haley Turner (PX1039-PX1063), February 23, 2018, Austin, Texas.	
274.	Final Transcript of the deposition of Sonja Gaines, February 27, 2018, Austin, Texas.	
275.	Exhibits submitted at the deposition of Sonja Gaines (PX1064-PX1092), February 27, 2018, Austin, Texas.	
276.	Enhanced Community Coordination 2016 Data Compilation	DefE-03749338, DefE-03749339
277.	Community Provider Survey	US00257595-257638; US0026213-261256
278.	TEX. HEALTH & HUMAN SVCS. COMM'N, Report of Funds Recouped from Local Intellectual and Developmental Disability Authorities in Fiscal Year 2016 (March 2017)	DefE-00734601
279.	TEX. HEALTH & HUMAN SVCS. COMM'N, Medicaid & CHIP Services Organizational Chart (October 7, 2016).	US00253891-253892
280.	TEX. HEALTH & HUMAN SVCS. COMM'N, Behavioral Health and IDD Services Dept. Organizational Chart (October 17, 2016).	PL0013190
281.	TEX. HEALTH & HUMAN SVCS. COMM'N, Health and Human Services System Organizational Chart	PL0053004
282.	TEX. HEALTH & HUMAN SVCS. COMM'N, Dept. of Aging & Disability Services Organizational Chart (March 14, 2017).	US00253893-253894

283.	TEX. HEALTH & HUMAN SVCS. COMM'N, *Medicaid & CHIP Services Post Transformation Structure*, Jami Snyder, Associate Commissioner, Medicaid & CHIP Services Dept., PowerPoint (October 27, 2016).	PL0052988
284.	TEX. HEALTH & HUMAN SVCS. COMM'N, HHSC IDD Services Organizational Chart (October 21, 2016).	PL0092787
285.	42 U.S.C. §§ 12131, *et seq.*	
286.	42 C.F.R. §§ 483.100, *et seq.*	
287.	FY18-19 LIDDA Performance Contract	DefE-01957456-DefE-01957658
288.	2017 QSR Results	US00257639
289.	HCS Diversion Slot Data – reorganized	US00257530
290.	HCS Transition Slot Data – reorganized	US00257531
291.	NF Diversion Slot List FY14-FY15	DefE-02195943
292.	NF Diversion Slot List FY16-FY17	DefE-01958694
293.	NF Transition Slot List FY14-FY15	DefE-01695363
294.	NF Transition Slot List FY16-FY17	DefE-01958693
295.	42 C.F.R. § 441.530, Home and Community-based Setting	
296.	Gov't of the District of Columbia Dept. of Disability Svcs., Policy No. 2014-DDA-POL009, Level of Need Assessment and Screening Tool (effective January 1. 2015).	US00261356-261358
297.	U.S. DEPT. OF JUSTICE, *DOJ Technical Assistance Guidance: Enforcement of the Integration Mandate, Title II of the ADA and Olmstead V.L.C., as it Relates to the Duties of Public Entities; Integrated/Segregated Settings and Informed Choice*, PowerPoint (October 29, 2014).	US00261359-261375

Attachment C

Table 1: Compliance with Outcome Measures for Outcome 1: Diversion

Outcome Measure No.	Measure	2015 Overall Compliance Score	2016 Overall Compliance Score	2017 Overall Compliance Score (as of August 31, 2017)
1-3	The PASRR Level II evaluation confirms whether the individual has ID or DD and if so, appropriately assesses whether the needs of the individual can be met in the community and accurately identifies, based on the information available, the specialized services the person needs if s/he is admitted to a NF. A report of the reviewer's decision is shared with the individual and his/her LAR.	41%	29%	32%
1-8	Individuals diverted from NF admission have access to information from DADS that describes the community services available to support them to live in the community.	94%	94%	83%
1-9	For members of the Target Population living in the community who can be diverted from NF admission, the SC or other LIDDA staff identify, arrange and coordinate all community options, services, and supports, for which the individual may be eligible and that are necessary to enable the individual to remain in the community and avoid admission to a NF. Services and	56%	33%	33%

	supports will be consistent with an individual's or LAR's informed choice.			
1-10	All individuals seeking admission to a NF who were identified through a PASRR Level II evaluation as having ID/DD, and who wish to remain living in the community, will receive support consistent with their choice, to participate with their Service Planning Team (SPT) in a planning process that identifies the community supports they need to remain in the community. The individual and the LAR are informed of community options that will meet the individual's needs."	54%	68%	82%
1-11	For individuals who are diverted from a NF placement, supports and services are made available to remain in the community, or to move to the community after a stay in a NF of fewer than 90 days. These supports and services recognize the needs and choices of the individual.	100%	100%	100%
1-19	The planning process used by the SPT includes assessments of medical, nursing, nutritional management, psychiatric, behavioral, therapy, independent living, community participation, integrated day activity needs, and a review of health related incidents.	Not a separate measure in 2015 but part of OM 1-10	48%	46%

Table 2: Compliance with Outcome Measures for Outcome 3: Transition

Outcome Measure No.	Measure	2015 Overall Compliance Score	2016 Overall Compliance Score	2017 Overall Compliance Score (as of August 31, 2017)
3-1	For individuals who have lived in a NF and who are moving or who have moved to the community, supports and services are made available to move to the community and to remain in the community. These supports and services recognize the needs and choices of the individual.	91%	98%	100%
3-4	Any NF member expressing an interest through the MDS Section Q process in speaking to someone about moving to the community is reported to the LA, which contacts the individual within 30 days of this notification to discuss community options.	73%	65%	71%
3-8	The individual has an ISP that includes all of the services and supports, including integrated day activities, s/he needs to achieve his/her goals, maximize his/her potential, and participate in community activities. The NF member receives all of the specialized services identified in the ISP, including alternative placement assistance and opportunities to learn about community options such as opportunities to visit community programs, in the frequency, intensity, and duration specified in the ISP. The	19%	12%	12%

	SPT monitors the provision of all specialized services.			
3-10	The SPT ensures that the ISP, including CLDP, is coordinated with the NFCPC and monitors the implementation of the CLDP.	30%	32%	31%
3-11	The individual has a Community Living Discharge Plan (CLDP), developed and implemented by SPT, which includes all of the activities necessary to assist the person to move to the community. The CLDP specifies the activities, timetable, responsibilities; services and supports the person needs to live in the most integrated setting. The CLDP is shared with the NF staff and providers of specialized services, and any responsibilities such staff and providers have to support its implementation are included in the NFCPC. The services and supports in the individual's CLDP are in place before the individual moves to the community. The SPT monitors and revises the CLDP as necessary.	44%	39%	47%
3-12	Any individual whose SPT recommends continued placement in a NF has a plan that documents the reason for this decision and describes the steps the team will take to address the identified barriers to placement in the most integrated setting. The plan is implemented as designed by the SPT and in the timeframes the team established	11%	0%	0%
3-13	The State monitors all individuals who have been discharged from the NF with frequency specified in the CLDP to determine if all supports and services specified in the CLDP are adequately provided to the individual and addresses any gaps in services to prevent crises,	61%	51%	65%

	re-admissions, or other negative outcomes. The individual will receive at least 3 monitoring visits during the first 90 days following the individual's move to the community, including one within the first 7 days.			

Table 3. Compliance with Outcome Measures for Outcome 4: Community Services

Outcome Measure No.	Measure	2015 Overall Compliance Score	2016 Overall Compliance Score	2017 Overall Compliance Score (as of August 31, 2017)
4-3	The ISP is based on assessments of the person's needs that appropriately identify these needs and recommend services and supports to address them. These assessments are completed by licensed and qualified staff within the timeframes established by the SPT. They include assessments of the medical, nursing, nutritional management, psychiatric, behavioral, therapy, independent living, community participation, and integrated day activity needs of the individual.	35%	35%	36%
4-4	The individual has an ISP that includes all of the services and supports, including integrated day activities, s/he needs to achieve his/her goals, maximize his/her potential, and participate in community activities. The Plan identifies the frequency, intensity, and duration of all services the Community Member receives. All services in the plan are implemented. The SPT monitors the provision of services.	52%	37%	40%
4-5	Each Community Member meets with his/her SC at least monthly to review his/her ISP and its implementation for the first 365 days after moving to a community program.	62%	43%	34%
4-7	For all Community Members, the SC inquires about recent Critical Incidents, increased physician visits, changes in the individual's health status, and medical crises and, if the person has experienced critical incidents or medical concerns, convenes the SPT to identify	70%	59%	53%

	all necessary modifications to the ISP. The SC notifies the provider if changes in the individual's health status have not been recorded in the record and ensures that this information is recorded in the record. The SC ensures the individual receives timely and ongoing medical, nursing, and nutritional management assessment. The SC works with the SPT to arrange for any additional services and support that are needed by the individual.			
4-12	The State will ensure that Community Members have access to the existing array of day activities in the most integrated settings appropriate to their needs and desires. Integrated day activities includes supported and competitive employment, community volunteer activities, community learning and recreational activities, and other integrated day activities.	26%	9%	18%
4-15	The State monitors all individuals who have been discharged from a NF with the frequency specified in the CLDP to determine if all supports and services specified in the CLDP are adequately provided to the individual, and addresses any gaps in services to prevent crises, re-admissions, or other negative outcomes. The individual will receive at least 3 monitoring visits during the first 90-days following the individual's move to the community, including one within the first 7 days.	60%	51%	65%
4-16	Community Members are given a choice of providers that have the capacity to meet their needs and can change service providers if they are dissatisfied with their services and supports, or their provider cannot meet their needs.	85%	80%	70%
4-19	An individual who has an identified risk of behavioral or medical crisis has a crisis plan in his/her ISP that focuses on crisis prevention.	25%	13%	8%

Table 4. Compliance and Outcome Measures for Outcome 5: Service Coordination

Outcome No.	Measure	2015 Overall Compliance Score	2016 Overall Compliance Score	2017 Overall Compliance Score (as of August 31, 2017)
5-2	All individuals in the TP have a Service Planning Team (SPT), convened and facilitated by the SC. The SPT meets at least quarterly to develop, review, and revise the Individual Service Plan (ISP) as indicated by the individual's changing needs and the SPT's assessment of the adequacy of the services and supports provided to the person to meet his/her individual needs. The SC facilities the coordination of supports and services for the individual.	38%	31%	29%
5-4	Each individual in the TP meets with his/her SC at least monthly to review his/her plan and its implementation while in the NF and/or for the first 180 days after moving to a community program.	53%	41%	32%
5-5	After an individual has been in his/her community for 180 days, the SC meets with him/her at frequency specified by the program. The SPT determines if more frequent face-to-face contact is needed based on an assessment of the individual's risk factors.	88%	94%	96%
5-6	At least quarterly, individuals who are in the NFs and their LARs receive education and information about community options that explain the benefits of community living, address	15%	21%	16%

	their concerns about community living, and that assist them to make informed choices about whether to move to the community. This information is provided by people knowledgeable about community services and supports and may include opportunities for individuals to visit community programs and talk to individuals with ID/DD living in the community and with their families.			
5-7	Upon admission to a NF and at least semi-annually the SC will provide each individual and LAR information about community services and supports. The SC will discuss this information to better enable the individual and LAR to make an informed decision about moving to the community. The SC discusses a range of community options and alternatives, facilitates visits to community programs, and addresses concerns about community living. The SC will use the CLO process designed by the State to provide community educational material.	48%	51%	58%
5-8	The individual has a Community Living Discharge Plan (CLDP), developed and implemented by the SPT, which includes all of the activities necessary to assist the person to move to the community. The CLDP specifies the activities, timetable, responsibilities; services and supports, the person needs to live in the most integrated setting. The CLDP is shared with the NF staff and providers of specialized services, and any responsibilities such staff and providers have to support its implementation are included in the NFCPC. The services and supports in the individual's CLDP are in place	44%	39%	47%

	before the individual moves to the community. The SPT monitors and revises the CLDP as necessary.			
5-9	For all community members, the SC inquires about recent Critical Incidents, increased physician visits, changes in the health status, and medical crises and, if the person has experienced critical incidents or medical concerns, convenes the SPT to identify all necessary modifications to the ISP. The SC notifies the provider if changes in the individual's record have not been recorded in the record and ensures that this information is recorded in the record. The SC ensures the individual receives timely and ongoing medical, nursing, and nutritional management assessment. The SC works with the SPT to arrange for any additional services and support that are needed by the individual.	66%	58%	49%

Table 5. Compliance and Outcome Measure for Outcome 6: Service Planning

Outcome No.	Measure	2015 Overall Compliance Score	2016 Overall Compliance Score	2017 Overall Compliance Score (as of August 31, 2017)
6-1	All individuals in the Target Population have a Service Planning Team (SPT), convened and facilitated by the SC. The SPT meets at least quarterly to develop, review, and revise the Individual Service Plan (ISP) as indicated by the individual's changing needs and the SPT's assessment of the adequacy of the services and supports provided to the person to meet his/her individual needs. The SC facilities the coordination of services and supports the individual receives.	38%	31%	29%
6-3	The ISP is based on assessments of the person's needs that appropriately identify these needs and recommend services and supports to address them. These assessments are completed by licensed and qualified staff within the timeframes established by the SPT. They include assessments of the medical, nursing, nutritional management, psychiatric, behavioral, therapy, independent living, community participation, and integrated day activity need of the individual.	31%	34%	34%
6-5	The individual has an ISP that includes all of the services and supports, including integrated day activities, s/he needs to achieve his/her goals, maximize his/her potential, and	19%	11%	16%

	participate in community activities. The NF member receives all of the specialized services identified in the ISP, including transition services and opportunities to learn about community options such as opportunities to visit community programs, in the frequency, intensity, and duration specified in the ISP. The SPT monitors the provision of all specialized services.			
6-7	Individuals in the TP who live in the community have a SPT whose members include those people who are specified in the program rules. The SPT is responsible to develop the ISP, ensure the ISP is implemented, and monitor that all services and supports in the plan are provided to the individual.	35%	14%	7%
6-8	Each individual in the TP meets with his/her SC at least monthly to review his/her plan and its implementation while in the NF or for the first 365 days of community placement.	53%	41%	32%
6-9	After the individual has been in his/her community for 365 days, the SC meets with him/her at the frequency specified by the program. The SPT determines if more frequent face-to-face contact is needed based on an assessment of the individual's risk factors.	87%	90%	71%
6-10	Any individual whose SPT recommends continued placement in a NF has a plan that documents the reasons for this decision and describes the steps the team will take to address the identified barriers to placement in the most integrated setting. The plan is implemented as designed by the SPT and in the timeframes the team established.	11%	0%	17%

Attachment D

Table 1

Excerpted from the LIDDA Quarterly PASRR Reporting
FY 2017 Q1
Staff Training (Question #3)
Community Education for Individuals and LARs (Questions #1 and 2)

LIDDA	# of Training Sessions /Topics	# of PASRR SC's Trained	# of Other LIDDA Staff Trained	# of Educational Opportunities Offered	# of Residents Participated	# of LARs Participated
1. Access	2	4	0	1	43	1
2. Alamo	3	18	6	0	0	0
3. Andrews Center	3	12	54	0	0	0
4. Austin Travis	3	0	30	0	0	0
5. Betty Hardwick	2	1	32	1	1	0
6. Nueces Co.	2	6	4	1	4	0
7. Bluebonnet	5	33	2	1	107	5
8. Border Region	4	3	15	2	8	1
9. Brazos Valley	2	7	16	2	11	0
10. Burke	4	16	65	0	0	0
11. Camino Real	5	5	20	2	11	0
12. Central Counties	4	6	5	0	0	0
13. Central Plains	1	0	1	0	0	0
14. Center for Life Resources	5	10	4	1	2	0
15. Coastal Plains	1	1	4	1	12	8
16. Community Healthcore	1	5	3	1	172	0
17. Concho Valley	5	0	18	2	1	0
18. Denton County	2	1	3	1	0	0

19. Emergence Health Network	3	3	5	1	2	3
20. Gulf Bend	3	4	15+	1	1	2
21. Gulf Coast	2	1	5	2	3	1
22. Harris Center	1	9	0	0	0	0
23. Helen Farabee	2	0	5	1	0	0
24. Hill Country	4	10	22	4	10	0
25. Heart of Texas Region	4	6	5	0	0	0
26. Lakes Regional	2	8	6	2	0	0
27. LifePath Systems	4	6	33	1	0	0
28. Dallas Metrocare	5	20	16	0	0	0
29. Permian Basin	3	3	0	4	23	0
30. Pecan Valley	0	0	0	0	0	0
31. Spindletop	0	0	0	3	11	1
32. Star Care	3	6	6	3	4	1
33. MHMR of Tarrant County	3	19	24	4	3	2
34. Texana	3	8	16	2	0	0
35. Texoma	4	6	15	5	5	1
36. Tri County	4	8	13	2	5	1
37. Tropical Texas	4	5	2	0	0	0
38. Texas Panhandle	0	0	0	0	0	0
39. West Texas Center	1	8	2	4	0	0

Table 2

LIDDAs Quarterly PASRR Reporting
FY 2017 Q2
Staff Training (Question #3)
and
Community Education for Individuals and LARs (Questions #1 and #2)

LIDDA	# of Training Sessions/ Topics	# of PASRR SC's Trained	# of Other LIDDA Staff Trained	# of Educational Opportunities Offered	# of Residents Participated	# of LARs Participated
1. Access	3	6	0	0	0	0
2. Alamo	3	19	8	1	2	1
3. Andrews	1	5	0	0	0	0
4. Austin Travis	2	2	46	0	0	0
5. Betty Hardwick	1	0	13	1	14	0
6. Nueces Co.	3	6	35	1	2	0
7. Bluebonnet	2	12	1	0	0	0
8. Border Region	3	2	13	2	10	2
9. Brazos Valley	2	7	2	3	15	4
10. Burke	0	0	0	3	126	12
11. Camino Real	3	4	0	0	0	0
12. Central Counties	3	4	2	0	0	0
13. Central Plains	3	0	0	1	0	0
14. Center for Life Resources	5	7	2	1	2	0
15. Coastal Plains	1	2	0	1	10	6
16. Community Healthcore	1	6	3	1	152	0
17. Concho Valley	5	0	7	2	1	0
18. Denton County	2	3	7	2	0	0

19. Emergence Health Network	4	6	11	1	1	0
20. Gulf Bend	4	10	39	0	0	0
21. Gulf Coast	4	7	11	2	1	0
22. Harris Center	2	9	0	1	0	2
23. Helen Farabee	0	0	0	1	0	0
24. Hill Country	5	13	26	1	1	0
25. Heart of Texas Region	5	17	2	0	0	0
26. Lakes Regional	2	0	15	0	0	0
27. Lifepath Systems	3	2	33	0	0	0
28. Dallas Metrocare	4	19	22	1	14	4
29. Permian Basin	3	3	0	4	23	0
30. Pecan Valley	5	15	0	1	5	0
31. Spindletop	0	0	0	2	17	1
32. Star Care	5	10	29	3	6	4
33. MHMR of Tarrant County	3	19	24	4	3	2
34. Texana	1	13	7	2	0	2
35. Texoma	3	9	26	5	8	0
36. Tri County	5	10	114	1	53	11
37. Tropical Texas	2	2	12	2	1	2
38. Texas Panhandle	3	4	1	1	18	1
39. West Texas Center	2	7	6	0	0	0

Table 3

LIDDAs Quarterly PASRR Reporting
FY 2017 Q3
Staff Training (Question #3)
And
Community Education for Individuals and LARs (Questions #1 and #2)

LIDDA	# of Training Sessions /Topics	# of PASRR SC's Trained	# of Other LIDDA Staff Trained	# of Educational Opportunities Offered	# of Residents Participated	# of LARs Participated
1. Access	2	4	0	1	36	0
2. Alamo	5	24	29	3	4	1
3. Andrews	3	12	54	0	0	0
4. Austin Travis	2	0	16	1	10	0
5. Betty Hardwick	2	0	1	0	0	0
6. Nueces Co.	7	27	1	2	3	0
7. Bluebonnet	3	16	1	1	100	10
8. Border Region	3	2	21	2	9	0
9. Brazos Valley	5	13	68	3	11	5
10. Burke	8	37	110	0	0	0
11. Camino Real	5	14	20	1	33	0
12. Central Counties	1	4	0	0	0	0
13. Central Plains	3	2	1	1	0	0
14. Center for Life Resources	5	10	4	1	0	0
15. Coastal Plains	1	0	0	1	21	17
16. Community Healthcore	1	6	2	1	161	131
17. Concho Valley	5	0	7	2	3	0

18. Denton County	2	2	7	2	0	0
19. Emergence Health Network	3	9	9	1	2	0
20. Gulf Bend	4	14	11	0	0	0
21. Gulf Coast	7	13	16	2	0	0
22. Harris Center	3	6	0	0	0	0
23. Helen Farabee	1	2	12	2	0	0
24. Hill Country	3	23	13	1	1	0
25. Heart of Texas Region	4	10	1	2	0	0
26. Lakes Regional	2	8	6	2	0	0
27. Lifepath	4	6	33	1	0	0
28. Dallas Metrocare	5	4	50	4	33	20
29. Permian Basin	4	4	0	5	3	0
30. Pecan Valley	5	4	0	1	6	5
31. Spindletop	4	1	4	2	28	1
32. Star Care	6	12	1	2	5	0
33. MHMR of Tarrant County	4	24	26	5	12	3
34. Texana	0	0	0	1	0	0
35. Texoma	4	9	22	5	9	0
36. Tri County	5	11	136	1	54	13
37. Tropical Texas	2	3	4	1	0	2
38. Texas Panhandle	3	6	2	0	0	0
39. West Texas Center	0	0	0	5	0	0