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

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

Plaintiffs,

v.

CHARLES SMITH, in his official capacity as the Executive Commissioner of Texas' Health and Human Services Commission, *et al.*,

Defendants.

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

THE UNITED STATES OF AMERICA,

Plaintiff-Intervenor,

v.

THE STATE OF TEXAS,

Defendant.

DECLARATION AND EXPERT DISCLOSURE OF RANDALL WEBSTER

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 the foregoing is true and correct and that I am submitting this disclosure regarding my work as an expert consultant in the above case.

1. 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.

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

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

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

5. Within the last four (4) years, I have not testified as an expert except in this case in conjunction with Plaintiffs' Motion for Preliminary Injunction.

6. I have been retained by the Plaintiffs and the United States as a joint expert in the *Steward v. Smith* litigation. My compensation in this litigation is $125/hour for my review, preparation of reports and statements, and for deposition or testimony, plus expenses. My compensation is not dependent on the outcome of this litigation.

Signed and dated:

Randall Webster 3/25/2018

Randall Webster

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' Declaration and Expert Disclosure of Randall Webster 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

_____

The United States of America
Plaintiff-Intervenor

v.

The State of Texas
Defendant

LOCAL INTELLECTUAL AND DEVELOPMENTAL DISABILITY AUTHORITY REPORT OF RANDALL WEBSTER

I. PURPOSE AND SCOPE OF REPORT

The Plaintiffs and United States requested that I, along with another developmental disability expert, Nancy Weston, conduct a review of the practices and processes of the Local Intellectual and Developmental Disability Authorities (LIDDAs) pertaining to the Pre-Admission Screening and Resident Review (PASRR) federal requirements for screening, evaluation, the provision of specialized services, and alternative placement for individuals with intellectual and developmental disabilities (I/DD) in nursing facilities (NF). I also reviewed LIDDA practices and processes pertaining to federal requirements for transition planning and community integration. The purpose of the review was to assess the LIDDAs' capacity and efforts to implement the recently redesigned PASRR program in Texas, and to assess Texas' and the LIDDAs' efforts to provide appropriate service and transition planning, to ensure informed and meaningful choice about services, and to transition individuals who did not oppose leaving the nursing facility and moving to the community. In addition, the review considered the capacity of community providers to serve individuals with I/DD who were at risk of entering, or already living in, nursing facilities.

LIDDAs are statutorily-created, quasi-public entities that are responsible for determining eligibility for services for individuals with I/DD, and then arranging, providing, and coordinating those services. The State of Texas, through its Department of Aging and Developmental Services (DADS) and now through its Health and Human Services Commission (HHSC), regulates, oversees, and funds thirty-nine separate LIDDAs. The State has delegated to the LIDDAs the responsibility for implementing the federally-mandated PASRR screening, evaluation, diversion, transition, and specialized service program requirements.

The scope of the LIDDA review was to determine if:

(1) the LIDDAs were properly identifying, screening, evaluating, and diverting persons with I/DD;

(2) the LIDDAs made professionally-adequate determinations of the need for specialized services that were based on comprehensive functional assessment of all relevant habilitative need areas;

(3) the LIDAAs provided, or ensured that the nursing facilities provided, all needed specialized services with the frequency, intensity, duration, and continuity to constitute a program of Active Treatment through an integrated service plan;

(4) the LIDDAs provided professionally-adequate service planning, coordination, and monitoring of services in nursing facilities;

(5) the LIDDAs provided professionally-adequate transition planning;

(6) the LIDDAs provided adequate, individualized information and meaningful options, in order to allow the individual with I/DD to make an informed choice about whether to enter or remain in the nursing facility, and were successful in transitioning individuals out of nursing facilities into the community; and

(7) the sampled provider network has the ability to meet the identified service needs of individuals in nursing facilities and capacity to provide residential services to people who chose to live in the community.

II. BACKGROUND AND EXPERIENCE

I have forty years of experience in the field of services to individuals with an intellectual and/or developmental disability, including twenty-three years as the Director of an Area Office for the Department of Developmental Disabilities (DDS) in Massachusetts. As the Area Office Director, I managed the provision and procurement of services to individuals with a developmental disability, including residential services, day services, employment services, respite services, emergency support services and family support services in the City of Fall River, Massachusetts and surrounding Towns. In that role, I also oversaw the functions of DDS service coordination program, which is available to

every individual in the service area, including both individuals receiving services in the community as well as individuals with an I/DD diagnosis who are placed in nursing facilities through the PASRR process.

I was appointed Assistant Commissioner for Field Operations for DDS from 2010 until my partial retirement in 2014. In addition to general statewide oversight, service design and delivery and policy development, I was responsible for ensuring that any citizen of the Commonwealth of Massachusetts with an Intellectual or developmental disability residing in a nursing facility was either placed into a community setting from a nursing facility or, if remaining in a nursing facility, was receiving services that met the federal standard for Active Treatment. I had a lead role in promoting and achieving substantial compliance with the federal court order in *Rolland v. Patrick,* a case in Massachusetts very similar to this one that required the timely placement of individuals who lived in nursing facilities into the community and/or the provision of Active Treatment to those who remained. As a result of that lawsuit, it has been the intention of the Department since 1999 to implement an aggressive PASRR compliance effort. Since the inception of that policy over 1,600 individuals were placed from nursing facilities into community 24/7 residential settings, settings staffed less than 24/7, or moved back to their families as the preferred service setting, rather than having to remain in a nursing facility and receive Active Treatment. Currently there are fewer than 250 individuals residing in nursing facilities at any one time in the Commonwealth with an I/DD diagnosis. Included in our PASRR compliance efforts has been and continues to be a very aggressive process to divert individuals from nursing facilities and the prompt placement of individuals approved through the PASRR process to return back to community living.

I continue to work as a part-time employee of DDS, with lead responsibility for a number of special projects including the transition of persons with DD and brain injuries from nursing facilities to the community, and the development of sufficient provider capacity to serve individuals with complex needs in the community.

A detailed description of my background and experience is set forth in my *Curriculum Vitae,* which is included in this Report as Attachment A.

III. METHODOLOGY

A. Documents Reviewed

In response to my request, documents were provided to me by Disability Rights Texas related to the State of Texas' PASRR design and compliance efforts, service and transition planning, diversion and transition numbers, informed choice, and community services. Additionally, I reviewed documents available on the HHSC/DADS website and on the websites of the LIDDAs I visited. The documents I reviewed included:

1. HHSC/DADS Performance Contracts with LIDDAs;
2. HHSC/DADS rules, proposed amendments to rules, requirements, bulletins, manuals, instructions, forms, and other materials concerning the PASRR Level I

screening and Level II evaluation, Community Living Options (CLO), Individual Service Plan (ISP), and other transition requirements, and IDD community and waver services;
3. LIDDA Quarterly Reports and statewide aggregate quarterly reports for all LIDDAs for various quarters of 2016 and 2017;
4. Lists of the number of PASRR clients associated with each LIDDA;
5. QSR Outcomes and Outcome Measures;
6. QSR Reports and data;
7. The deposition of a senior HHSC official;
8. DADS/HHSC Training Modules; and
9. Provider survey

A complete list of documents that I reviewed is set forth in Attachment B to this Report.

B. Programs Reviewed

Beginning on 1/30/17, I met with LIDDA staff in seven LIDDAs, with a focus on PASRR issues. In July, I conducted follow-up reviews with each of these LIDDAs with a focus on transition and community issues. During the second phase of my LIDDA review on July 24, 2017 to July 28, 2017 I met with an additional five LIDDAs about both PASRR issues and transition and community issues. It is my understanding that I was asked to focus on LIDDAs in order to assess, at a program level, the capacity and activities of the LIDDAs which are responsible for providing PASRR screening, evaluation, specialized services, service planning, diversion, transition planning, and community services to the individuals with I/DD in nursing facilities. The other disability professional evaluated thirteen additional LIDDAs, allowing us to separately assess two-thirds of all of the LIDDAs in Texas. Many of my findings are highly consistent across the LIDDAs I reviewed.

During my LIDDA reviews in January and February 2017 the LIDDA staff were, in every instance, very cooperative during the meetings, made their relevant staff available, and shared relevant information and their experiences concerning the PASRR program. During the second phase of my LIDDA review the LIDDAs again made their relevant staff available and were cooperative, but there was a distinct change in my interactions with LIDDA staff, likely related to the presence of numerous lawyers from HHSC, representatives from the Texas Office of the Attorney General, as well as the use of videotaping and/or audio taping of all meetings. Moreover, the transcripts do not accurately identify who made which statements in the meetings.

In the second phase of the LIDDA review I incorporated interviews with ten HCS providers, including a range of large and small, residential and nonresidential providers that served individuals in the LIDDA catchment area, in order to develop a sense of the provider capacity and capability to deliver residential services and LIDDA Specialized Services (SS).

The LIDDA meetings during each visit included groups of two (2) to fifteen (15) staff with various PASRR and transition responsibilities, including the LIDDA Diversion Coordinator, PASRR Service Coordinator, Enhanced Community Coordinator, Nursing Facility Service Coordinators, and in many instances senior staff from the LIDDA, as well as the lawyers and senior state officials during the second phase of my review, as noted above. The LIDDAs I reviewed were:

1. The Harris Center for MH and IDD in Houston, Texas
2. Texana Center in Rosenberg, Texas
3. Metrocare Services in Dallas, Texas
4. MHMR of Tarrant County in Fort Worth, Texas
5. Pecan Valley Centers for BDHC in Granbury, Texas
6. Heart of Texas MHMR in Waco, Texas
7. Community Health Core in Longview, Texas
8. Coastal Plains in Portland, Texas
9. Nueces County, Corpus Christi, Texas
10. Tropical Texas, Harlingen, Texas
11. Border Region, Laredo, Texas
12. Gulf Bend, Victoria, Texas

The providers I reviewed were:

1. Tejas Management
2. Hill Country
3. Premieant
4. Lifetime Living
5. JCE and Associates
6. Devereux
7. Tried and True
8. Abiding Choice
9. D&S
10. EduCare

The purpose of the meetings was to explore the practices, processes and experiences of the LIDDA and its PASRR and transition staff as they attempted to implement PASRR, service and transition planning, informed and meaningful choice, and diversion and transition requirements as detailed in Sections IV and Attachment G of the LIDDA Performance contract, as well as relevant HHSC and CMS PASRR rules, policies, and procedures.

C. Questions and Probes

In order to ensure that the meetings with LIDDA staff addressed the same basic issues, I, together with Nancy Weston, developed a series of probes or questions that covered each of the seven topics of the LIDDA review described in Section I of this Report. We used these probes to ensure that we both asked similar questions, gathered similar

types of information, and were in a position to make findings on similar topics. The probes were designed to ensure consistency in the LIDDA reviews that I and Nancy Weston conducted, although we recognized that there well might be differences in our actual findings at different LIDDAs.

The documents I reviewed, together with the onsite evaluations described above, allowed me to make a professional judgment about the LIDDAs' performance with respect to each of the seven questions that I addressed in this review. In making these judgments, I applied my knowledge and experience in the field of services to individuals with I/DD, including my understanding of the practices necessary to comply with federal requirements related to PASRR and community integration.

IV. STANDARDS

A. Scope

In conducting this review, I applied a range of standards to evaluate the programs and services provided by LIDDAs and HCS providers. First and foremost, I relied upon the statutory and regulatory requirements of the Medicaid Act (PASRR) and of Title II of the ADA (Integration Mandate), as well as the various interpretative guidelines and agency guidances concerning these federal requirements. Second, I considered Texas' rules, regulations, policies, and procedures that were developed to comply with federal legal requirements, including Texas' quality assurance programs and the Quality Service Review (QSR) process that Texas uses to evaluate compliance with these federal requirements. Third, I took into account well-accepted practices adopted by public entities and private providers in other states to implement federal requirements in an efficient and cost-effective manner. Fourth, I applied professional standards in the field of developmental disabilities concerning the habilitation for individuals with I/DD in nursing facilities and the community. Finally, I drew upon my decades of experience and expertise in serving individuals with IDD in facilities and the community.

B. The PASRR Program

The Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing facilities for long term care. PASRR requires that all applicants to a Medicaid-certified nursing facility be evaluated to determine if they have a serious mental illness and/or intellectual disability or related condition; need an institutional level of care which cannot be provided in a range of alternative settings; and need specialized services in order to provide a program of Active Treatment; and can obtain those specialized services in the nursing facility to which they seek admission. As explained by the Centers for Medicare and Medicaid Services (CMS):

> PASRR is an important tool for states to use in rebalancing services away from institutions and towards supporting people in their homes, and to comply with the Supreme Court decision, *Olmstead vs L.C.* (1999), under the Americans with

> Disabilities Act, individuals with disabilities cannot be required to be institutionalized to receive public benefits that could be furnished in community-based settings. PASRR can also advance person-centered care planning by assuring that psychological, psychiatric, and functional needs are considered along with personal goals and preferences in planning long term care.

https://www.medicaid.gov/medicaid/ltss/institutional/pasrr/index.html.

There are many federal requirements that govern the PASRR program. CMS issued regulations in the early 1990s, and issued subsequent guidance concerning the standards, procedures, and processes that each State must use for its nursing facility PASRR program. 42 C.F.R. Sec. 483.100-138. These regulations describe the process for identifying and screening individuals with I/DD and related conditions; the procedures and criteria for diverting individuals from nursing facility admission; the fifteen habilitative need areas that must be assessed in evaluating whether the individual would benefit from specialized services; the treatment standards that must be met in providing specialized services; the ongoing coordination and monitoring of nursing facilities and community providers to ensure that together, they deliver a consistent and continuous program of Active Treatment; and the State's authority and ultimate responsibility for ensuring that all of these requirements are met.

a. Screening and Diversion

The purpose of the Level I stage of the PASRR process is to determine if a person has or is suspected of having an I/DD diagnosis; the purpose of the Level II stage of the PASRR process is to confirm or deny the suspicion of I/DD and determine whether a nursing facility level of service and the provision of additional specialized services are needed, as well as whether the individual can be served in a community setting. The PASRR regulations list fifteen separate need areas which must be considered as a part of the Level II review. The PASRR must be completed by a qualified I/DD professional.

Olmstead and the Americans with Disabilities Act require that individuals avoid nursing facility or other institutional placements if they can be, and do not oppose being, served in the community. An effective PASRR program, operating consistent with the federal requirements described above, must include outreach and coordination to potential referral entities, like LIDDA Intake and Eligibility units, medical professionals, hospitals, rehabilitation facilities, assisted living facilities, and all publicly-funded residential programs to allow the PASRR program to prevent unnecessary admissions to a nursing facility.

This early and proactive approach allows the program to identify persons at risk of institutionalization, to intervene to prevent that risk, to screen for I/DD, and to arrange options and provide resources to divert individuals from admission to a nursing facility. A successful PASRR program should require and expect notice from these referral entities sufficiently in advance of any referral to a nursing facility, so that the program

can explore options, identify resources that reasonably accommodate the individual's needs, and create meaningful alternatives to institutionalization.

Texas has issued its own PASRR rules, which substantially track and are explicitly intended to implement the federal requirements concerning identifying, screening, and evaluating individuals with I/DD, prior to and after admission to a nursing facility. HHSC/DADS policies, quality assurance program, and its QSR process recognize the importance of identifying individuals at risk of nursing facility admission, and arranging for alternatives prior to admission, whenever possible and consistent with the individual's choice.

The LIDDA Performance Contract requires that when an individual is referred for admission to a nursing facility, the LIDDA must inform the individual, their family, and the legally authorized representative of the community options, services, and supports for which the individual may be eligible. The LIDDA, under the direction of the Diversion Coordinator, must also identify, arrange, and coordinate access to these services in order to avoid admission to a nursing facility wherever possible. These requirements are part of the LIDDA's responsibility for conducting a PASRR Evaluation (PE), which should be performed prior to admission unless the person is admitted from a hospital on an expedited basis or exempted basis. The PE also should appropriately assess whether the needs of an individual can be met in the community. In practice, the prevalence of expedited and exempted admissions makes the LIDDA's connections to referring entities essential to the early identification of individuals at risk of nursing facility admission.

Under HHSC/DADS policy and contract, the Diversion Coordinator must also provide information and assistance to service coordinators and other LIDDA staff who are facilitating diversion for individuals at risk of admission to a nursing facility, and coordinate educational activities about community services and strategies to avoid nursing facility placement.

The LIDDA Performance Contract further requires that within 45-75 calendar days of admission, the Diversion Coordinator must review individuals admitted into a nursing facility to determine whether community living options, services, and supports that could provide an alternative to ongoing nursing facility placement have been explored. If not, the Diversion Coordinator must refer the individual to the Service Coordinator, who must explore those options. This requirement reflects the importance of beginning the transition planning process soon after admission to a nursing facility, when an individual's existing ties to the community have not eroded and when additional potential barriers posed by long-term stays may still be avoided. States should endeavor to facilitate a prompt discharge to the community, whenever possible.

Texas's QSR process incorporates these requirements, as well as many other PASRR and ADA obligations. Texas has adopted and implemented seven key Outcomes, six of which include numerous Outcome Measures, for evaluating services to three groups of individuals with I/DD: (1) persons who were diverted from nursing facility admission; (2)

persons who are currently residing in nursing facilities; and (3) persons who were recently transitioned from nursing facilities. The methodology, protocols, scoring, and reporting of the status of these Outcomes and Outcome Measures are part of the QSR process that was agreed to by the State and has been in place since 2015. The QSR Outcomes and Outcome Measures describe many actions necessary to comply with certain of the State's federal obligations and complement federal and state regulatory or contract requirements. As such, they constitute important benchmarks for assessing Texas' PASRR and community programs for individuals with I/DD.

QSR Outcome 1 and related Outcome Measures reflect several diversion requirements. They require that each LIDDA has a Diversion Coordinator who is experienced in coordinating and/or providing community services to people with I/DD, including people with complex medical needs. The Diversion Coordinator must identify community living options, supports, and services that will assist individuals with I/DD to successfully live in the community, and coordinate education for Service Coordinators and other LIDDA staff about available community services and strategies to avoid nursing facility placement.

b. Evaluation for and Provision of Specialized Services and a Consistent Program of Active Treatment

Federal law requires a comprehensive functional assessment of all need areas identified through the initial interdisciplinary team meeting which must occur within thirty (30) days of admission (42 C.F.R. Section 483.440(c)(3)). Under federal regulations, such an assessment must be provided to every individual with I/DD in order to determine what habilitative needs the individual has, what services are required to address these needs, and how these services should be delivered. A comprehensive functional assessment is a professional standard for the care and habilitation of individuals with I/DD and is an essential foundational requirement for providing habilitation that constitutes Active Treatment.

The PASRR regulations require that the State (not the nursing facility or any other entity) must provide or arrange for the provision of specialized services to all nursing facility residents with I/DD who need these services. Specialized services are defined by 483.120(a)(2) for I/DD individuals as "… the services specified by the state which, combined with services provided by the NF or other service providers, results in treatment which meets the requirements of 483.440(a)(1) [Active Treatment]."

Specialized services should be based on highly individualized goals, objectives and strategies to address all of an individual's needs, as described in the comprehensive functional assessment, and must be implemented through a program of Active Treatment as defined in federal regulations, Sections 483.440(a)-(f)). Each individual must have an individual, person-centered plan developed by an interdisciplinary team that identifies the individual's needs using a comprehensive functional assessment, and designs programs and a planned sequence to meet those needs and objectives. The plan must identify all habilitative need areas, list goals and timelines for addressing

these need areas, describe the specialized services (including the amount, duration, and scope of such services) that will be provided to meet all identified need areas, and identify the providers responsible for offering and delivering these services. Federal requirements for Active Treatment include an integrated process of planning, documentation, staff qualifications, team participation, goals, objectives and timelines as well as continuous monitoring and revision, as needed, of all needed habilitative services.

Texas's PASRR rules require referring entities to conduct the Level I screen, LIDDAs to conduct the PE, and LIDDA's service coordination program to organize and lead service planning teams that develop an Individual Service Plan (ISP). The ISP must identify the person's strengths; preferences; psychiatric, behavioral, nutritional management, and support needs; and desired outcomes; describe the specialized services to be provided (including the amount, intensity, and frequency of each service); and identify the services and supports to meet the individual's needs, achieve the desired outcomes, and maximize the person's ability to live successfully in the most integrated setting possible.

The LIDDA service coordinators are responsible for monitoring the plan and ensuring that all needed specialized services are provided in a timely and consistent manner. The LIDDA Performance Contract, Texas Administrative Code, and related HHSC/DADS policies and procedures establish the state standards for this program.

Texas has limited the specialized services that it will provide to certain therapies and medical equipment provided by nursing facilities in the facility and certain community services provided by or through the LIDDAs, typically outside of the facility. Nursing facilities routinely offer physical therapy, occupational therapy, and speech therapy designed to *rehabilitate* a condition (like a fall) for a time-limited period, as part of their basic nursing program and as included in the nursing facility's daily rate. For individuals with I/DD who require these same therapies, or a customized wheelchair, on an ongoing basis for *habilitative* purposes – to maintain existing functioning or learn new skills – the nursing facility is supposed to provide them as specialized services and is paid an additional rate, after approval by the State. The LIDDA must provide one specialized service – service coordination/transition assistance – unless the individual refuses, and must make available, as needed, day habilitation, independent living skills training, employment assistance, supported employment, and/or behavior support through its network of community provider agencies, subject to approval by the State. The LIDDA Performance Contract, Texas Administrative Code, and HHSC/DADS specialized services policies and procedures establish the state standards for specialized services. Significantly, these state standards on specialized services never mention and apparently do not require a program of Active Treatment.

C. Informed and Meaningful Choice

In order for individuals with I/DD to determine whether they want to enter and remain in a nursing facility, or move to a community setting, they must be given detailed and

concrete information, meaningful options that address their individual needs, opportunities to explore community living, and concrete experiences of community activities that allow them to understand the differences between institutional and community settings. This information and experience allows the individual to make an informed and meaningful choice between institutional care and life in the community. This process must include a discussion of feasible alternative services, and ideally occurs prior to admission. Individuals must be given a detailed description of how the alternative would address each of their need areas and preferences, as set forth in a comprehensive functional assessment or an ISP that addresses relevant medical, vocational, social, functional, transportation, specialized equipment, and behavioral assessed needs.

This process is particularly important for individuals with I/DD, whose abilities to understand complex or abstract information is limited, and whose decision making capacity may be impacted by their disability. Individuals with I/DD need information presented in a more concrete, rather than abstract, fashion, and tailored to their individual capacities and experiences. Because they have difficulty visioning and relating to unknown situations or new environments, they often need to see an alternative placement, engage in an actual living experience, or speak with an individual who has moved to such a placement, in order to understand the differences between living in a nursing facility or a community setting. Similarly, because individuals with I/DD often fear the unknown, resist change, and prefer familiar routines, it is essential that they be engaged in a trusting and dependable relationship with a service coordinator or other transition specialist who gradually but consistently introduces them to the possibilities of community living.

Informed choice is a process that is most effectively implemented through a series of actions built into an integrated and comprehensive decision making process which is mandated and defined by the State authority for individuals with an I/DD. In Texas that authority would rest with HHSC and be implemented by the LIDDA service coordinator. The process of informed and meaningful choice begins even before the initial screening phase of the PASRR, and requires familiarity with the individuals served by the LIDDA (individuals who are living with family, on their own, or with a residential agency), in order to intervene early with information, options, and resources to divert individuals from admission to a nursing facility. The process extends not only to individuals screened through a Level I PASRR, but also to individuals who may be at risk of admission to a hospital or a nursing facility, and of course to all residents – and particularly long term residents, of a nursing facility.

In order for individuals living in a nursing facility or the community to make an informed and meaningful choice, there should be an array of methods, strategies, techniques, and presentations of information concerning options to nursing facility placement. First, and most importantly, there should be an assessment and planning process for every individual, such as that set forth in Section 9 Phase II of the ISP, that is used by service coordinators to identify and describe what a life in the community would be like for that individual and what residential arrangements and supports must be provided to meet

his/her needs in a community setting. This analysis should lead to a set of practical, individualized options presented through brochures, pamphlets, visits to various community programs, direct experiences of community activities, and participation in transition programs, like LIDDA specialized services, that expose individuals to the community. Other methods that foster informed choice include meeting with people who have made those sorts of decisions and moved from a nursing facility to a community setting, speaking to staff/agencies that operate those kinds of services and, of course, speaking to families whose family members have made a similar choice.

Special efforts must be undertaken to address the predictable effects of institutionalization, such as a loss of autonomy and increased dependency on facility staff to make decisions. In addition, there must be targeted efforts to address individualized barriers to transition, particularly for individuals who have been in nursing facilities for many years or who have had negative prior experiences with certain community providers or living arrangements. In addition to the strategies and actions described above, professional standards, literature, and experience suggest that these efforts should include at least the following: (1) patient but persistent efforts to expose long term nursing facility residents to the community, including individualized experiences with preferred activities; (2) gradual and ongoing exploration of strategies to address fears, concerns, or lack of experience with life in the community; (3) intensified and individualized efforts to address barriers to transition; (4) accurate identification of the factors that contributed to prior problems or challenges in the community; and (5) actions that ensure that such problems or challenges will not re-occur.

Finally, and most obviously, informed choice must include meaningful, individualized community living arrangements and supports that fully address the individuals' needs, concerns, and preferences. Absent meaningful and available options, located in the desired community, there can be no informed choice. Individuals with I/DD in nursing facilities must be given a detailed description of how the alternative to a nursing facility would address each of their need areas and preferences, as set forth in a comprehensive functional assessment or ISP that addresses relevant medical, vocational, social, functional, transportation, specialized equipment, and behavioral assessed needs. The information and description cannot be limited to a simple offer of two different types of service settings -- a nursing facility setting or a community residential setting.

HHSC/DADS policies and its quality assurance monitoring, including the QSR, recognize the importance of many of these essential practices. The LIDDA Performance Contract requires not only that the service coordinator regularly provide information about the range of community living service and support options and alternatives available, but also that the service coordinator facilitate visits to community programs, address concerns about community living, and arrange for or provide regular educational informational activities which can include as family-to-family and peer-to-peer programs and opportunities to meet with other individuals who are living, working, and receiving services in integrated settings with their families and with community

providers. In addition, the forms used to document community living options discussions require the service coordinator to list any issues, concerns, and questions identified by the individual and LAR, describe how these issues, concerns, or questions were addressed, and describe how barriers to community living can be eliminated. The Individual Service Plan requires similar efforts to address barriers. When an individual has not made a decision to move to a community placement, the SPT must state the barriers to living in the community and identify possible resolutions to those barriers.

Texas's QSR includes some of these same standards, recognizing many of the practices necessary to ensure informed and meaningful choice. Outcome 3, which requires that transition planning occur for all individuals who do not oppose exploring community options, includes several related Outcome Measures. These measures require detailed assessments in all relevant habilitative areas; services and supports that include integrated day activities and other opportunities to participate in community activities, in order to expose the individual to experiences in a community setting; information about community living and support programs; visits to community programs; documentation of the reasons for any SPT recommendation for continued nursing facility placement and a descriptions of the steps that will be taken to address the identified barriers to transition in such cases; and targeted efforts to address those barriers to transition. Outcome Measure 4.9 requires the State to identify and address any gaps in medical and nursing provider capacity, particularly for individuals with complex needs.

D. Service and Transition Planning

Service planning is accepted by I/DD professionals as an essential component for serving individuals with I/DD. In Texas, service planning is defined by relevant state regulation, and operationalized by Texas HHSC/DADS through Form 1041, Individual Service Plan/Transition Plan. The essential elements of a well-constructed service plan begin with an individually-driven vision that is descriptive of the individual's aspirations and forms a framework for understanding and responding to the person in the Individual Service Planning (ISP) process. This approach, often called Person Centered Planning, is now the accepted foundation and approach to all service planning for individuals with I/DD. It is uniquely important for transition planning, since that process includes a move from one location to another, with potential dislocations but also enormous opportunities for creating a new environment that is far more sensitive and responsive to the individual's preferences and aspirations, and more likely to result in full integration and participation in real community.

The ISP begins with relevant demographic information collected from the individual, LAR, and other people familiar with the individual who should be included in the planning process if selected by the individual/LAR. The specifics of the Plan should build upon clinically-assessed needs, including health and safety risk factors as well as personally-expressed preferences which are incorporated into an individualized, document that identifies relevant short term and long term goals, measurable objectives, services, and service delivery strategies which complement the individual's

vision and address the individual's assessed needs and preferences. The Plan must describe the frequency, intensity, duration, location, and provider of each service, and how it will achieve the Plan's goals and objectives. All of these elements of the ISP should be incorporated and reflected in the nursing facility Plan of Care (POC), in order to ensure consistency, continuity, and carry-over, as required by Active Treatment.

The service planning process must be coordinated and led by one individual. State policy or regulation should designate an individual to lead the process and delineate timelines related to each step of the planning process, as well as the essential participants of the Service Planning Team (SPT). Monitoring of the service plan is the responsibility of the designated staff person identified in the regulations. In Texas this role is filled by the service coordinator and is set forth in the LIDDA Performance Contract: Attachment G, which details the responsibilities of the service coordinator. In addition to their role as SPT team leader, service coordinators are also required to monitor the effectiveness of the ISP to affirm that progress is being made by the individual pursuant to the established goals and objectives. Where goals either have been met or are not being successfully implemented, the service coordinator is required to modify the ISP, in order to create a more relevant and/or effective plan. If service planning and delivery is supported in part with federal funds, pursuant to a waiver authority, the State planning and coordination requirements are incorporated in the approved waiver, along with assurances provided to CMS that the State is complying with these conditions.

Pursuant to federal and state PASRR requirements, the service coordinator is directly responsible for identifying, coordinating, monitoring, and ensuring that all needed specialized services are provided. Service coordinators must bring together into one integrated ISP the specialized services provided by the nursing facility and the specialized services provided by the LIDDA, and then ensure that these services are delivered in a consistent, continuous, and professionally appropriate manner that constitutes Active Treatment. Further, the ISP must incorporate any other needed services and supports, including those necessary to support transition planning.

Transition planning should be part of the ISP process. For individuals in nursing facilities, this should include a detailed discussion of how, when, and where the individual should transition from a nursing facility to the community. Professional standards and practice require transition planning for all individuals in an institutional setting that describes in some detail the location, living arrangement, services and supports, and preferred activities that allow the individual to live safely and productively in the community. This detailed description of what life in the community would look like is essential to allow the individual to make an informed and meaningful choice about community living.

In Texas, Section 9 of the ISP (Form 1041) calls for this information in Phase I and Phase II. Phase I, "Education/Exploration of Community Settings/Community Living Options," requires the service coordinator to check one box if the individual/LAR explicitly has stated that s/he wants to "pursue community living." If there is not such an

explicit indication of intent or a clear statement, then the service coordinator is expected to check the other box: "remain in nursing facility". In that event, the service coordinator must identify the barriers preventing the individual from living in the community and possible resolutions to those barriers. Phase II includes a description of the supports an individual might need to live in the community. However, Phase II is not completed unless an individual has already chosen to leave the nursing facility, effectively denying many individuals the development and presentation of tangible, individualized options that should inform their choice.

As noted above, QSR Outcome 3 and related Outcome Measures incorporate essential requirements for service and transition planning, including a requirement that a Community Living Discharge Plan identifies all steps and details of a planned transition.

Outcome 5 and related Outcome Measures include specific standards and requirements for service coordination, including, among others, ensuring the provision of all necessary specialized services; ensuring consistency and coordination between the nursing facility's plan of care and the LIDDA's ISP; offering information and opportunities to visit community programs; facilitating informed and meaningful choice concerning services; leading the service and transition planning process by relevant interdisciplinary teams; and promoting and monitoring transition to the community. Outcome 6 and related Outcome Measures address service and transition planning, and reflect similar requirements.

E. Transition to Community Living

The actual transition to the community must include a detailed plan that is developed by a transition team comprised of both institutional staff and community providers which describes, in detail, the actions, timetable, and persons responsible for each step in the individual's move from the institution to a new home in the community. The plan is best accomplished under the direction of one individual who has a clear and complete understanding of the individual, which is usually the service coordinator who developed the individual's ISP. The detailed implementation plan should include relevant components of the ISP that need to be carried over into the community setting, as well as obvious concerns related to medical equipment (i.e. wheelchairs), medication, specific service providers, transportation, and public benefits (i.e. SSI, Medicaid insurance coverage), as well as more general concerns related to the individual's preferences for food, room colors, furniture, friends, and religious exercise.

Once a provider is chosen and a residential location identified, there are very detailed elements of the transition to the community which must be delineated in a discharge plan, such as who will accompany the individual to choose the furniture for their room, who will bring the person to the residence to meet their new house mates and allow the staff to get to know the individual, what are the best ways to provide supervision and support to the individual, etc. Additional considerations that are important to a successful transition are staff training related to the needs and preferences of the person, participation in team meetings by new community providers, when the person

will move from the nursing facility, who will facilitate the move, when the best move day would be and who would greet the individual at the new residence that is familiar to her/him. In Texas, this detailed description is called a Community Living Options Individual Plan (CLOIP) and is set forth in Form 1041, Section 9, Phase III.

V. FINDINGS

The findings detailed in this section are based on a review of HHSC/DADS PASRR policies and procedures, the PASRR sections of DADS'/HHSC's Nursing Facility handbook, LIDDA reports, HHSC reports, the QSR, other documents listed in Attachment B, and information provided by the LIDDAs detailed in Section III (B) when interviewed from 1/30/2017 through 2/2/2017 and 7/21/2017 through 7/28/2017. These findings incorporate those from my prior review, which primarily focused on PASRR standards, and also include additional findings related to the ADA.

I. Texas Does Not Timely Screen and Divert from Admission to Nursing Facilities Adults with I/DD Who Could Be Served in an Alternative Setting.

A. Outreach and coordination with referral entities and service providers rarely occurs.

1. Most LIDDAs that were interviewed have little awareness of the extent of the present or future support needs of the individuals with I/DD in their service area, and, significantly, who are or might be at risk of admission to a nursing facility.

2. With a few exceptions, there is little effort to educate and coordinate with local hospitals, health care facilities, medical professionals, or other likely referral entities for nursing facility admission. As a result, most admissions to nursing facilities occur without any notice to, involvement of, or screening by LIDDA's PASRR coordinators. In fact, most admissions of individuals with I/DD to nursing facilities are exempt or expedited admissions.[1] In those cases, the PE occurs only after the individual has already been admitted to the nursing facility.

3. With a few exceptions, no LIDDA had a process in place to identify individuals currently served in HCS residential programs who have, or might have, a serious medical condition that put them at risk of hospitalization or nursing facility admission. As a result, in some LIDDAs a large number of all nursing facility admissions are from individuals who were living in HCS residential

[1] An exempt admission occurs when a physician certifies that a person being discharged from a hospital is likely to require less than 30 days of nursing services. An expedited admission occurs when a person needs nursing services for one of seven conditions, including convalescent care, terminal illness, severe physical illness, delirium, emergency protective services, respite, or coma. Under Texas' rules, a PE is conducted for these admissions at a designated time after the admission.

settings, were hospitalized, and then were discharged to nursing facilities, all without the active involvement of the provider or the knowledge of the LIDDA.

4. Although most LIDDAs do not know who in their service area are at risk of admission to a hospital or nursing facility, most LIDDA staff acknowledged that making outreach efforts with generic community agencies and referral entities, particularly those that currently provide I/DD services to eligible individuals within the respective LIDDA, would be an important element of an effective outreach/diversion program. There are few LIDDAs that had initiated such outreach efforts. At most, there were occasional mention of connections to other state funded services.

5. Outreach to families associated with the LIDDAs is sporadic. Where general family meetings do occur, they are sparsely attended. In those few LIDDAs that had regular, well-attended family meetings and other outreach, and particularly family to family programs, this approach was reported to be very successful in encouraging both diversion and transition.

B. Admissions to nursing facilities are increasing.

1. Most LIDDAs reported that the number of admissions to nursing facilities in their area is increasing, that they are rarely notified about an admission before it occurs, and that they have no meaningful opportunity to conduct a Level II PASRR evaluation or to divert the individual before the admission is completed.

2. A review of FY17 LIDDA Quarterly PASRR Reports for the LIDDAs I visited consistently showed an increase in admissions to nursing facilities in which the number of admissions to nursing facilities consistently exceeds the number of diversions and transitions in every LIDDA reviewed. This pattern indicates that unless these trends change, there will continue to be growth in the number of individuals with an I/DD in nursing facilities, with little impact from transitioning people out of nursing facilities or improving diversion efforts.

3. During the interviews, it was discovered that the data was incomplete because it does not include people with I/DD residing in nursing facilities who had refused to participate in the “PASRR Program”. One LIDDA had identified 28 individuals in the “Target Population”, but through the interview process, it was revealed that there were another ten (10) people excluded from the Target Population because they had refused the “PASRR Program”. An additional problem with the reporting data is that, although the number of admissions significantly outpace the number of diversions and transitions, the average number of “Target Population” stays fairly consistent. One would expect there to be a correlation between the number of admissions and transitions/diversions to explain the relative consistency of the “Target

Population", but the correlation is not evident. It seems that there are a number of other reasons to account for maintaining relative "Target Population" stability, which include people moving to other nursing facilities, to other LIDDAs, back home, to another setting not covered by a Texas waiver program, refusing the "PASRR Program" or dying, but there is no data that reflects this activity. This raises concerns about whether the State is meeting its federal obligations relative to the provision of services to all eligible individuals residing in a nursing facility, in particular those moving to other nursing facilities.

4. In the FY17 LIDDA Quarterly Reports mentioned above, there is an expectation that LIDDAs identify education efforts for individuals and LARs relative to diversion, transition and PASRR requirements. The list of topics and participants gives an indication of the efforts the LIDDAs are making to educate referral entities, families, individuals and LARs relative to PASRR requirements, specialized services, active treatment, and opportunities for placement through diversion and transition efforts. The reports consistently show a very insignificant, inconsistent, and unimaginative effort of providing these important educational opportunities. In a few instances, there may be three or four events in a quarter, but in many, there were no efforts recorded in a quarterly report.

C. The PASRR pre-admission screening and evaluation process rarely occurs as intended.

1. Pre-admission screening and evaluation is essential to allowing an individual to make an informed choice between a community setting or nursing facility. Properly done, the screening and evaluation process should address the types of services that can be provided in a community setting, in order to enable the individual to recognize that needed services may be available in the community and, if not, the types of nursing facility services that must be provided, in order for them to promptly return to the community. There is little evidence that the PASRR screening and evaluation process is directed toward, or results in, this outcome, except for the small number of pre-admission screenings and evaluations that occur for individuals living in the community.

2. In situations where LIDDAs did conduct a pre-admission screening, they are often able to design services that meet the individual's needs in the community and prevent a nursing facility placement. However, these situations occur infrequently.

3. More often, screening and evaluation of individuals referred to a nursing facility occurs only after the person has already been admitted to the facility. This obviates any possibility of a determination of the feasibility of an alternative placement, as required by PASRR.

4. Since most people were already admitted to a nursing facility before the PASRR evaluation took place, the screening and evaluation process cannot be an effective method for determining the array of community services needed and the intensity and duration of these services, in order to prevent the individual from being placed or retained in a nursing facility. In addition, there is a significant, lost opportunity to prevent the admission in the first place, by identifying additional supports that would allow the individual to remain in his/her current living arrangement, including an existing waiver program.

D. The LIDDAs' diversion programs are not effective.

1. LIDDAs described inadequately-designed diversion processes that lack systemic approaches to an effective diversion program.

2. There are very few diversions compared to the number of admissions to nursing facilities. This is largely because, for the majority of individuals with I/DD entering nursing facilities, placement into the nursing facility occurred well before any meaningful diversion efforts could be initiated. Once placed into a nursing facility, the individual cannot, by Texas' definition and resource allocation, be considered for diversion or provided diversion alternatives. Consistent with the revised PASRR policies, the LIDDAs only can use HCS diversion slots prior to admission to a nursing facility.

3. Successful diversions were relatively few and, according to LIDDA staff, often more the result of advocacy from an individual's family than from an aggressive diversion program. This finding helps explain why there is a low number of diversions reported by most LIDDAs in their quarterly reports to DADS/HHSC. It also may explain why, despite the assertion by some LIDDAs that many people who come from the community are offered a diversion slot, the diversion numbers are low.

4. A review of diversion data over the past several years for each LIDDA indicates that almost half of all diversions occur in a few LIDDAs, and that several LIDDAs have reported almost no diversions at all, for years. This wide discrepancy in performance is difficult to explain and strongly suggests that with monitoring and accountability, the number of diversions could increase substantially.

5. Consistent with PASRR regulations, the LIDDAs do not conduct PASRR Level I screenings for exempt or expedited admissions. The nursing facility must enter a Level 1 screening into the TMHP database portal managed by HHSC for exempted admissions, which will prompt an alert to the LIDDA on the 31st day. For expedited admissions, the LIDDA has a deadline to conduct an initial face to face meeting and Level II evaluation (called the PASRR evaluation or PE) within 7 to 14 days, depending on the category. At this

time, the LIDDA's PASRR reviewer discusses community living options. It does not appear that LIDDAs track the method or category of admission.

6. Although most admissions to nursing facilities are supposed to be short term, under either the expedited or exempt admission categories, many individuals remain in the nursing facility far longer than a month, and then receive the PE when it is too late to divert the admission or facilitate a prompt discharge.

7. Since there are few PASRR Level II PEs done in the community – which is the only time the PE occur before an individual is admitted to a nursing facility – there are few opportunities available for diverting individuals from a nursing facility. Most LIDDAs have not accomplished many diversions because they do not know about the potential admission in advance, and do not complete the PE before admission. As a result, the opportunity to learn about the individual and discuss community options prior to nursing facility placement is squandered.

8. Most LIDDAs do not appear to know many of the people with I/DD who are residing in their service area, and specifically those who have a medical or nursing condition that might prompt a transfer to a hospital or nursing facility. Therefore, they cannot be proactive with families who are struggling to support their family member at home, or with providers serving individuals with acute or chronic conditions. Additionally, the families may not know what kind of support they can expect from their respective LIDDA.

9. Individuals are often diverted if they independently contact the LIDDA and then are identified as being at risk of nursing facility admission through the LIDDA intake and eligibility process.

10. There are few occasions where a LIDDA identifies and coordinates with likely points of referrals to a nursing facility, such as a hospital, physician, or Area Resource Center (ARC). The few LIDDAs that have conducted aggressive outreach to hospitals, community programs, and families learn about potential admissions, often conduct PEs in the community, and are able to successfully divert a number of individuals.

11. Many individuals who are admitted to a nursing facility had been living in HCS provider settings. However, due to the difficulty and delays in obtaining HHSC approval of funding increases in Level of Need, inflexibility or inadequacy of the rate structure, or the inability to address changing needs, providers often transfer the individual to a medical facility and do not maintain meaningful contact with the individual to assist her/him in returning to their community home. When discharged from the hospital, the LIDDA does not usually take action to prevent admissions to a nursing facility or work directly with the HSC provider and/or with HHSC.

12. Prior to 9/1/17, waiver slots for diversion usually were available when requested. Slot availability for this current biennium has been severely curtailed, which will likely result in far fewer diversions if the LIDDA cannot obtain needed community resources to avoid the admission to a nursing facility.

13. Due to a lack of guidance and/or oversight by HHSC, diversion data in the LIDDA quarterly reports often appears to be inaccurate and/or incomplete.

14. There is a significant discrepancy between HHCS diversion policies and LIDDA diversion practices, which indicates a lack of HHSC leadership and oversight of the LIDDAs' diversion program.

II. Texas Does Not Comprehensively and Accurately Assess the Needs of Individuals Entering Nursing Facilities, Appropriately Identify Needed Specialized Services, and Determine if an Alternative Placement Is Possible.

A. Level II evaluations do not comprehensively assess all habilitative need areas.

1. The interviews with all of the LIDDAs consistently mentioned a reliance on the Texas PASRR PE as the means for identifying needed specialized services. However, the PASRR PE is an inadequate method for assessing all habilitative needs.

2. PASRR reviewers do not evaluate all habilitative areas required by the PASRR rules. Rarely do they address vocational, educational, social, independent living, and affective needs.

3. Neither the PE nor subsequent nursing facility processes constitute a Comprehensive Functional Assessment (CFA) of all habilitative need areas.

4. There is no separate instrument(s) or process for conducting a Comprehensive Functional Assessment (CFA) that addresses all habilitative need areas. Unless there is a comprehensive assessment of all habilitative needs, there cannot be an appropriate delivery of specialized services, because a specialized service is highly individualized, rooted in an assessment of habilitative needs, and incorporated in an integrated person-centered plan with specific goals and objectives mediated within the program model which is best suited to deliver the supports necessary to enable the individual to address their assessed needs. This is especially true for the program models of Day Habilitation or Independent Living Skills Training (ILST) which require both an individualized program directed to specific habilitative need areas, with carryover and consistency in other settings and services, like nursing facilities.

5. There was no CFA conducted by any LIDDA that was interviewed. Additionally, there was little understanding of the importance of conducting a CFA, or of evaluating all habilitative needs, which then limits any understanding of needed specialized services and the ability to determine the frequency, intensity, and duration of such services.

6. Some LIDDA staff indicated that HHSC was considering using a modified version of the Individual Comprehensive Assessment Process (ICAP), that currently is used to evaluate Level of Need (LON) in community programs, as a CFA in nursing facilities. This is a surprising development given the fact that the LIDDAs I reviewed in January did not note any inadequacies with the existing assessment tools for nursing facility residents and did not mention another instrument that might be used to serve as an CFA. Moreover, it does not appear that this idea has been implemented.

7. The QSR findings on whether individuals with I/DD in nursing facilities received a Level II PE that appropriately identified needs and specialized services confirms these findings. In 2017, only 9% of nursing facility residents with I/DD had a professionally-appropriate PE.

8. The QSR findings on whether individuals with I/DD in nursing facilities receive all needed assessments also reflected these deficiencies. Specifically, in 2015, the QSR determined that only 30% of nursing facility residents with I/DD had received needed assessments; in 2016, the QSR found only 40% had, and recent data for 2017 indicated that this number actually fell to 38%.

B. Specialized services are not accurately identified, recommended infrequently, and not provided with the requisite frequency, intensity, and duration.

1. Due to the absence of a CFA, there is no complete and contemporaneous assessment that guides individual service planning and identifies all needed specialized services. The result of the absence of a CFA is very evident in the amount of nursing facility and LIDDA specialized services recommended. The analysis of the overall percentage of specialized services recommended in June 2017 based on a "QAI Data Mart: TMHP PASRR3 PL1 and PE" FY 17 Quarterly Report, revealed that only about 13% of individuals participating in the PASRR program were recommended for any type of specialized services, with 12% of the specialized services recommended as nursing facility specialized services and 14% as LIDDA specialized services, including service coordination Significantly, and importantly for purposes of facilitating informed choice concerning transition, the LIDDA percentage of recommended LIDDA specialized services drops to just over 3% if service coordination is not included in the calculation. Since there is a HHSC policy and LIDDA contract requirement that all individuals with I/DD in nursing facilities must have a service coordinator assigned, it is predictable – in fact required – that there is an extremely high participation rate (over 80%) in this

specialized service. That only 3% of all nursing facility residents are recommended for other LIDDA specialized services is extremely problematic.

2. Moreover, and perhaps more significantly, the actual number of residents who *receive* LIDDA specialized services would certainly be even lower than the number recommended. Thus, this problematic level of recommended services masks an even more problematic level of utilization of LIDDA specialized services, other than service coordination. Unfortunately, HHSC does not regularly analyze or determine the number of individuals who receive LIDDDA specialized services, the type of LIDDA specialized services provided, and the amount, duration, and frequency of LIDDA specialized services actually provided.

3. If this data is representative of the amount of specialized services recommended in other quarterly reports, it is apparent that LIDDA specialized services are very rarely recommended. This finding explains a number of troubling patterns identified during my LIDDA interviews. First, there was no reliable means to assess the need for specialized services, and for particular specialized services like Day Habilitation (no CFA). Second, there was a very low percentage of specialized services noted in the February LIDDA reviews, in contrast with certain LIDDAs claiming in our July meetings that they provide a higher percentage of LIDDA specialized services. For instance, one LIDDA reported that 50% of their I/DD nursing residents were receiving LIDDA specialized services other than service coordination. But the FY17 quarterly report did not support that claim. Instead, of the 58 individuals served by that LIDDA, only one LIDDA specialized service other than Service Coordination was recommended for 34% of the individuals. Only four people (less than 4%) were recommended for any of the other six specialized services provided by the LIDDA. There were four LIDDA specialized services for which no one was recommended, including supported employment and employment assistance. In fact, and quite disturbingly, 23% of all PASRR eligible individuals had no information at all as to recommended specialized services, and only 3.5% of the individuals were recommended for any LIDDA specialized service.

4. Third, the lack of recommended LIDDA specialized services indicates that the individuals with I/DD in nursing facilities usually are not able to leave the facility, participate in community activities, and experience community living, as should happen if the individuals regularly were recommended and participated in a range of LIDDA specialized services. Instead, they are relegated to a life segregated from the community, experience, a diminution of skills and abilities needed to successfully be a part of the community, and have few experiences to relate to when discussions of moving into the community are presented through the CLO process. Fourth, the lack of a variety of recommended specialized services shows a lack of leadership at the LIDDA and HHSC levels in analyzing and addressing significant problems

associated with the provision of specialized services., Fifth, because of the low number of recommended LIDDA specialized services, there is a certain lack confidence, or perhaps resistance, on the part of the State to aggressively support a program that has a very low utilization. Finally, the lack of any information on the number, amount, duration, or frequency of LIDDA specialized services actually provided means there is no way of determining what really is happening for individuals with I/DD in nursing facilities.

5. Over the past year, HHSC has conducted numerous PASRR trainings for nursing facilities, which has increased their awareness of, and efforts in, providing nursing facility specialized services. Nevertheless, there still is resistance in many nursing facilities to requesting and providing nursing facility specialized services.

6. Unlike specialized services provided by LIDDAs, the practice for accessing specialized services provided by the nursing facility must begin with an identification and assessment from the nursing facility therapist. Regardless of what the Service Planning Team (SPT) discussed about the need for a particular nursing facility specialized service, the nursing facility therapist and/or nursing facility staff ultimately determine whether the specialized service will be provided. If it is requested, it must then be authorized by DADS/HHSC before the service can be provided, which has resulted in delays and even rejections by the state agency. Decisions of this nature should be made by the interdisciplinary team (the SPT) charged with creating a comprehensive individualized service plan, rather than the judgment of nursing facility specialized services clinician(s) – who may not be part of the team – and could be distant from the discussions and decisions of the SPT.

7. I heard of several occasions where the nursing facilities were reluctant, or possibly resistant, to seek authorization from DADS/HHSC. If the SPT identifies a particular need, it should be unnecessary to delay service provision until authorization is received. Such a delay is at the expense of the individual requiring the specialized service. Additionally, the process is cumbersome, since the nursing facility has to pay for the service up front, without assurance that timely payment will be received. Moreover, the nursing facility therapist often do not even participate in the PASRR and SPT process.

8. When a need for nursing facility specialized services is identified, either through the PE or some other assessment, the identified services may not be provided, and rarely in the intensity, frequency and duration needed. The routine unavailability of these therapies appear to be continual problems for nursing facilities. As noted above, a review of recommended nursing facility specialized services in June 2017 indicated that only 12% of the individuals in nursing facilities throughout the State were being *recommended* for nursing

facility specialized services. The percentage who actually receive these specialized services is certainly lower. Based upon my experience, this is a very low recommendation rate, indicative of the lack of a comprehensive functional assessment as well as factors related to nursing facility reluctance to participate in the "PASRR Program", the uncertainty of payment, and the concern of duplication of services on the part of nursing facility clinical staff who are acutely aware of this apparent vulnerability.

9. LIDDAs report that nursing facilities are reluctant to provide PASRR Occupational Therapy (OT) and Physical Therapy (PT) services to individuals assessed as needing them, because of concern that Texas considers these therapies as duplicating services already covered in the nursing facility rate paid by the State. Alternatively, nursing facilities prefer to provide these therapies, if at all, through Medicare, in order to avoid the complicated, prior approval process managed by HHSC.

10. There remain problems obtaining durable medical equipment (DME), like communication boards and adaptive equipment, because of the means and rate of payment.

11. Based upon my experience and the requirements of Active Treatment, LIDDA specialized services generally are infrequently identified as needed, and when identified, are often not provided with adequate intensity and frequency. I encountered almost no LIDDAs that provided or recommended any use of employment specialized services. Further, almost none of the LIDDAs I reviewed provided or recommended any behavioral specialized services. These findings were supported by the FY17 Specialized Services Quarterly Report noted above.

12. There were many instances where LIDDA specialized services are not being provided. As reflected in both my meetings with LIDDAs and the data reports, there was a fraction of one percent of employment, pre-vocational or behavioral specialized services recommended. Essentially these specialized services were not being recommended throughout the State. The percentage of individuals with I/DD who receive LIDDA Day Habilitation is less than 10% across LIDDAs interviewed, and Independent Living Skills Training (ILST) well less than 15%. The June QAI MART Report mentioned above indicated that the percentage of Day Habilitation specialized services *recommended* was 4.8% and ILST recommended services 12.3%. This level of participation is extraordinarily low considering the large number of individuals residing in nursing facilities across the State, and is even lower than the numbers reflected in the LIDDA reviews. In most instances, there are no LIDDA specialized services recommended at all, other than service coordination. Even in those few instances where LIDDA specialized services were recommended, there was only one or two types of LIDDA specialized service provided, indicating a lack of development of a robust and viable array of

specialized services that would address all habilitative needs, as described in 42 CFR 483.136 (b)(1) through (15). It also reflects a lack of understanding on the local and State level of the need to provide all needed specialized services, as identified in a comprehensive functional assessment for the individual. In fact, the absence of a comprehensive array of LIDDA specialized services in most LIDDA service areas illustrates the lack of an understanding of the need for the array of services required to provide Active Treatment.

13. Not all individuals leave the nursing facility to receive the ILST. This LIDDA service should serve three purposes: habilitative skill development, engaging the individual in community activities, and providing meaningful opportunities to explore the community as an option.

14. The lack of accessible and available Day Habilitation and ILST providers, as well as a lack of transportation to/from community settings, are significant barriers to the provision of LIDDA specialized services.

15. HCS community providers stated that they rarely are asked to provide ILST or other LIDDA specialized services to nursing facility residents with I/DD, even though they offer these same services to hundreds, if not thousands, of individuals in the community.

16. The QSR findings on whether individuals with I/DD in nursing facilities receive all needed specialized services reflect these deficiencies. Specifically, in 2015, the QSR determined that only19% of nursing facility residents received needed all needed specialized services; in 2016, the QSR found the number had dropped to 14%. Recent data for 2017 showed virtually no improvement, with only 16% of individuals with I/DD in nursing facilities receiving all needed specialized services.

17. The QSR findings on whether individuals with I/DD in nursing facilities receive needed specialized services in a coordinated and consistent manner is even more troubling. Specifically, in 2015, the QSR found that only 26% of nursing facility residents received services with appropriate consistency and coordination. In 2016, this number dropped to 25%. And in 2017, it fell even further to only 19% of individuals with I/DD in nursing facllities receiving consistent and coordinated specialized services.

III. Texas Does Not Provide Active Treatment to Residents of Nursing Facilities.

1. Virtually no LIDDA understands or claims they provide active treatment to persons with I/DD in nursing facilities. During the second phase of my review, some LIDDAs stated that they were familiar with the term “active treatment”. This was surprising given the lack of awareness of active treatment by most LIDDA staff during the initial review in February. But when asked to define its

meaning, there was no LIDDA staff who had any real understanding of the term as it applies people with I/DD in nursing facilities.

2. Since very few individuals receive all needed specialized services, even fewer would receive Active Treatment. There was no claim that Active Treatment, as defined in federal law, actually occurred in nursing facilities.

3. Given the inadequacy of the IDT process in identifying and providing all needed nursing facility specialized services; the inadequacy of the SPT process in identifying and providing all needed LIDDA and nursing facility specialized services in the appropriate amount, frequency, intensity and duration, as defined in the individual's service plan; the acknowledged lack of coordination and integration of the nursing facility plan of care in the ISP; the lack of understanding and oversight by the service coordinator of nursing facility and LIDDA services; and the absence of a comprehensive array of specialized services available in each of the LIDDAs visited, it would be very difficult, if not almost impossible, to provide a program of Active Treatment.

IV. The LIDDAs Do Not Provide Timely and Adequate Service Coordination.

1. The role of the service coordinator in the identification and provision of LIDDA and nursing facility specialized services is essential to development off a comprehensive functional assessment, the receipt of Active Treatment and appropriate transition planning by the individual. However, the service coordinator has a limited role in the Individual Disciplinary Team (IDT), which directs all services in the nursing facility, and has no authority to ensure that the nursing facility provides all needed specialized services, coordinates with the SPT, or plays a meaningful role in delivering Active Treatment.

2. The service coordinator does lead the SPT, which develops the Individual Service Plan (ISP). But because of the lack of coordination and integration between the ISP and the nursing facility plan of care, the results of the IDT and SPT meetings do not appear to result in an integrated, coherent, comprehensive, relevant, and coordinated ISP that is the basis for the provision of all needed specialized services and a program of Active Treatment .

3. Service coordinators are assigned to individuals with an I/DD in nursing facilities as a LIDDA specialized service.

4. Service coordinators visit the nursing facility at least monthly, and lead the initial, semi-annual, and annual SPT meeting.

5. Service coordinators conduct the Community Living Options (CLO) process which provides information about the community every six months as required.

6. Service coordinators are expected to arrange the delivery of specialized services and monitor their effectiveness, but absent the accurate identification and provision of all needed specialized services and a program of Active Treatment, they mostly monitor basic health and well-being of the individuals on their caseload. They have a minor role in, and usually do not monitor, the effectiveness of nursing facility specialized services, and often do not arrange or coordinate many LIDDA specialized services because:

    - there are very few LIDDA specialized services provided;
    - they were typically reactive regarding nursing facility specialized services, and had limited awareness of the habilitative needs of the individual because there was no CFA and, therefore, no planning document that included all specialized services with the requisite frequency, intensity, and duration to monitor against.

7. The QSR findings on whether individuals with I/DD in nursing facilities receive appropriate service coordination reflected these deficiencies. Specifically, in 2015, the QSR determined that only 36% had an appropriate ISP; in 2016, the QSR found the number remained the same -- 36% -- and significantly lower than other target populations. And in 2017, this figure remained the same -- 36% -- which means the two-thirds of all nursing facility residents with I/DD lacked adequate service coordination to ensure that they receive needed services.

8. The QSR findings on whether individuals with I/DD in nursing facilities have an appropriate service planning team also reflected these deficiencies. Specifically, in 2015, the QSR determined that only 35% had an appropriate SPT; in 2016, the QSR found the number had dropped to 33%. In 2017, this number slightly increased, but only to 37%.

9. Finally, the QSR findings on whether individuals with I/DD in nursing facilities have an adequate Individual Service Plan that includes all needed services reflected several service planning deficiencies. Specifically, in 2015, the QSR determined that only 19% had an appropriate ISP; in 2016, the QSR found the number had dropped to 14%. In 2017, this figure was still only 16%. Put another way, 84% of all nursing facility residents with I/DD did not have a service plan that identified all needed services and that resulted in the provision of specialized services with the appropriate frequency, intensity, and duration.

V. The LIDDAs Do Not Provide Timely and Adequate Transition Planning.

1. Section 9 of the ISP addresses transition. Phase I of that Section asks a simple yes or no question: Does the individual want to move to the community or stay in the nursing facility? Phase II of the Section describes possible living, working, and social experiences that the person might enjoy in the

community, and provides an individualized description of the person's community preferences, interests, and needs, consistent with principles of person-centered planning (PCP). According to HHSC/DADS policy, if the pursue community living box in Phase 1 is not checked, the service coordinator does not complete, and the SPT does not discuss, any of the community issues in Phase II. Transition planning, as incorporated into the Form 1041 (ISP) in Section 9 Phase II, is completed only if the individual affirmatively choses to leave the nursing facility and move to the community. According to LIDDA staff, this section is not completed even for persons who are considering leaving the nursing facility and want to learn more about community options, unless they already made the expressed decision to leave. The one LIDDA that regularly completed Phase II for such individuals stated that it made an important difference in promoting informed choice and proceeding with an actual transition.

2. The transition planning component of Phase III, which is only completed when a community provider has been selected, identified some key components to a successful transition such as person-centered planning and medications, but lacked detailed elements that would enhance the success of the transition such as staff training, schedules of the moves, and opportunities for the individual to meet the individuals they would live with.

    - There was very little detail in the Section 9 Phase III about the role of providers and family as part of the transition planning process.

3. Attachment G: I. D.6.b.of the LIDDA Performance contract requires the service coordinator to complete Phase I of Section 9 (Transition Plan to the Community) DADS' Form 1041 by indicating an interest in transition, when the individual's PASRR evaluation indicated that the person's needs can be met in an appropriate community setting. However, no LIDDA mentioned this requirement, and there was little indication that a finding in the PE that community placement was appropriate resulted in a transition plan, and no suggestion that a second PASRR PE is ever completed even when the individual had made enough gains to be considered for a community placement and not appropriate for a continued stay in the nursing facility.

VI. There Is Little Assurance that Individuals with I/DD Make an Informed and Meaningful Choice to Remain in a Nursing Facility.

1. Service or diversion coordinators are responsible for providing individuals with I/DD in nursing facilities, or at risk of being admitted to a nursing facility, with sufficient information, realistic and timely options, and adequate supports to make an informed and meaningful choice about whether to enter or remain in a nursing facility.

2. For individuals with I/DD already in nursing facility, the service coordinator provides the Community Living Options process every six months, but may discuss community options more frequently.

3. All LIDDAs claimed that they complete the CLO process shortly after admission, and at least at six month intervals as required. Almost all stated that they provide a standardized, HHSC/DADS-created written brochure and some verbal information about community options to individuals. Some discuss the option to visit community programs or take tours of provider homes, but few actually conduct tours or provide opportunities to visit community settings. Tours are more common after someone has decided s/he definitely wants to transition. Individuals who have not made a decision to transition rarely have the benefit of touring such settings, which could greatly inform their choice.

4. The LIDDAs underscored the importance of giving individuals in nursing facilities the choice of community living or remaining in a nursing facility. However, it appears that the choice is not constructed with a full, well balanced, and relevant amount of information and experiences for the individual and/or LAR to make an informed decision.

5. Many of the service coordinators reported that they asked individuals about transition, beginning with questions like, “Are you happy here?” “Can we get you anything to make your life in the nursing facility more comfortable?” that are superficial, routine, suggestive, or not likely to engage the individual in a meaningful dialogue. They rarely employed a variety of the proven decision-making aids – many of which are listed in Texas’s own policies – that are practical, real, or provide actual experiences to help an individual with I/DD understand their options, such as family-to-family and peer-to-peer discussions, inviting providers into nursing facilities to explain community living options, taking tours of residential services and community programs, or showing videos of community living arrangements.

6. Almost no LIDDAs have family-to-family or peer-to-peer programs that regularly connect families and individuals who are in nursing facilities with other families or individuals who have direct experience in transitioning from nursing facilities to the community, in order to promote transition.

7. Because few individuals receive LIDDA specialized services in the community, they have little or no practical opportunity to learn about and experience community services and activities, as contrasted to life in a nursing facility.

8. The transition portion of the ISP (Sec. 9), and particularly Phase II, is not used to describe what a feasible alternative would look like for the individual. One LIDDA that did complete Phase II for that purpose acknowledged the value of

describing, in concrete terms, how services in the community would address the individual's needs, and discussed how that approach assisted the person in making an informed decision.

9. Almost all individuals with I/DD in nursing facilities lived in the community before their admission. Many lived in a HCS residential program or community living arrangement, and some had unfortunate experiences with community providers. Although the service coordinator is responsible for addressing barriers to transition, it did not appear that service coordinators specifically made efforts or undertook actions to address these barriers.

10. HHSC does not obtain data about barriers to community living for most individuals with I/DD in nursing facilities. The quarterly LIDDA report, which requires information on efforts to address barriers, only is completed for persons who have already decided to leave the nursing facility and are already in the transition process.

11. Developmental disability and other professionals are familiar with the effects of long term institutionalization, including increased dependency and a loss of autonomy, choice, and functioning. It did not appear that service coordinators specifically made efforts or undertook actions to address the negative consequences of institutionalization, or used techniques to ensure that persons living in nursing facilities for many years made an informed choice to remain.

12. Although HCS providers are required to provide all covered services, including residential supports in accessible locations, it does not appear that LIDDAs specifically make efforts or undertake actions to ensure that appropriate residential supports are available in the community that allows the individual to live near families and friends.

13. The QSR findings on whether individuals with I/DD in nursing facilities receive information necessary to make an informed choice about whether to move to the community reflected these deficiencies. Specifically, in 2015, the QSR determined that only 15% had received information about community options and addressed barriers to community living; in 2016, the QSR found the number was 20%. In 2017, this number dropped to 16%. Thus, according to the most recent QSR, 84% of nursing facility residents did not receive adequate information and education about living options in the community.

VI. Few Individuals with I/DD Who Have Been in Nursing Facilities for Many Years Transition to the Community.

1. Most LIDDAs reported there are very few transitions of those individuals who had been in the nursing facility for many years.

2. LIDDAs reported modest success in identifying people wishing to transition from the nursing facility. Most often these individuals are recent admissions to the nursing facility. Most LIDDAs have had little success in transitioning people who were living in a nursing facility prior to the implementation of the PASRR program in 2013 or who had lived there for many years. This reflects an ineffective and inadequate effort in creating an informed decision process as implemented through the CLO process.

3. HHSC has had a practice of making available waiver slots to any individual who may be referred to a nursing facility or may be in a nursing facility and wants to transition a community setting. For individuals who had a PE that indicated they were interested in moving to in the community, a transition waiver slot was automatically released. This "auto-release" policy, begun in 2015, allowed all persons with IDD in nursing facilities prompt access to a transition waiver slot, without having to repeat their interest in leaving the facility in the CLO process. Despite its relative success in promptly identifying individuals for transition, and avoiding a complicated CLO process, HHSC decide to terminate this practice in June 2017.

4. For the current biennium, the Legislature drastically reduced the number of new waiver slots for both diversions and transitions to 150 for diversion and 150 for transition. Because HHSC determined that any individuals currently in the transition process as of August 31, 2017 could only use the new waiver slots for the FY18-19 biennium, this further reduced the number of new transitions slots to approximately 50 for the entire biennium, and the number of new diversion slots to approximately 75. When this action of the Texas Legislature was shared in the LIDDA interviews, there was concern expressed, in some instances, considerable concern, because there was anticipation that the numbers of both diversions and transitions would easily exceed the caps set for the biennium. The Quarterly Reports for FY17 and other transition data suggests that this concern is justified, since the number of diversions and transitions has gradually increased and is on an upward trend.

5. LIDDA staff indicated that a significant portion of their nursing facility census is comprised of long term individuals, who have lived in the nursing facility for more than a year and usually more than three years. There are few transitions from this core group, mostly because individuals are institutionalized, have little if any meaningful contact with the community, are not provided specialized services in the community that would provide some engagement in community living, are unwilling to consider transition, or have families/LARs/guardians that oppose transition.

6. LIDDAs report that most transitions involve recently-admitted individuals or individuals with shorter lengths of stay.

7. A few LIDDAs have had significant success in transitioning a number of individuals in this core group of long term clients, mostly because of aggressive efforts to expose individuals to community services and programs, to participate in community activities, and to receive LIDDA specialized services.

8. Many LIDDAs believe their outreach efforts and relationships with nursing facilities are improving, and that the number of transitions are increasing. This trend is likely to be reversed given the dramatically lower number of transition slots available in this biennieum.

9. HCS waiver slots have historically been available in a timely manner and are the primary resource for accomplishing transitions. Most LIDDAs believe that if the number of HCS waiver slots are substantially decreased (by over 75%), their ability and increasing success in transitioning individuals will be seriously impacted.

VII. Provider Capacity and Resources, Particularly for Individuals with Complex Needs, Is a Significant Barrier to Transition.

1. Providers interviewed have the interest and capacity to participate in providing LIDDA specialized services and HCS living options, if invited to participate by the LIDDAs.

2. Nearly all the providers interviewed had not been encouraged by the LIDDA in their service area to provide LIDDA specialized services, nor were the providers even aware of what the LIDDA specialized services included.

3. Nearly all of the providers interviewed are generally aware of the PASRR program, but do not know many details and have not been involved in serving individuals with I/DD while they are in a nursing facility.

4. In response to a survey from the provider organization, more than half indicated there were significant obstacles accessing day and support services, including Day Habilitation, transportation, nursing, behavior therapy, mental health services, occupational therapy (OT), physical therapy (PT), and speech therapy (ST).

5. Only a small fraction (15%) of providers had the capacity and track record to serve individuals with complex medical or behavioral needs.

6. Almost none of the providers had applied for Level of Need (LON) increases in order to serve individuals with more complex medical needs, apparently because the LON process is time-consuming, cumbersome, lengthy, and not responsive to medical needs.

7. Many providers experienced frustrating barriers to serving individuals with I/DD who were being diverted or transitioning from nursing facilities.

8. Providers expressed considerable concern related to rates for residential services, medical and nursing services as well as clinical services such as occupational therapy (OT), physical therapy (PT), and speech therapy (ST). They also expressed concern around rates for LIDDA specialized services such as Day Habilitation, particularly given the recent Day Habilitation rate reduction that will further restrict providers' ability to serve individuals with more significant needs, and especially people who have significant medical, behavioral and/or ADL needs; individuals living in rural parts of the State needing transportation to their preferred provider service setting; and those individuals needing wheelchair vans for transportation.

9. Providers described a very complex process to obtain authorization to increase the services necessary to meet the changing needs of people in their residential programs, and by extension, people who would be placed from a nursing facility to their residential programs, should their needs change. This, in part, has contributed to the placement of people from residential programs into nursing facilities.

10. Nearly all residential providers have had individuals they served placed into a nursing facility, usually after first being admitted to a hospital for a medical event. Most of these providers were convinced they could and would have continued to serve these individuals in the community, thereby preventing at least the nursing facility admission and often the hospitalization, if they could have obtained a timely increase in nursing or related support services. However, the process for securing approval for this increase, which is managed by HHSC, is cumbersome, labor intensive, conducted by individuals not familiar with the individuals experiencing the changing need, protracted (usually several months), and does not directly consider changed medical needs. As a result, most providers are discouraged from seeking authorization for service increases, leaving them no option but to refer the individual to a medical or nursing facility and discharge them from their residential service system.

11. Providers are very interested in transitioning and placing people out of nursing facilities into their residential programs if properly supported by the State fiscally and administratively.

12. Providers feel that if the ICAP (the assessment tool used to establish the level of support needs and relatedly the rates to be paid to the provider) is done properly, they would be able to serve medically challenging people but, generally, the individuals conducting the ICAPs are very unfamiliar with the individual and the ICAP does not adequately assess medical needs in its current construction.

VI. CONCLUSION

PASRR is a screening, evaluation, and diversion process intended to ensure that individuals diagnosed with I/DD are not unnecessarily admitted into a nursing facility. A successful diversion effort requires timely access to a variety of waiver services that allow the person to have their needs met in the community rather than in a nursing facility. If admitted into a nursing facility because they meet the standards of nursing facility care, there should be the expectation that their medical needs will be promptly addressed, so that the individual can be transitioned out of the facility into a community placement as quickly as possible. As long as the individual remains in the nursing facility, the person should be provided nursing and specialized services, with the requisite frequency, intensity, and duration to meet the federal standard of Active Treatment. Consequently, at every stage of the individual's experience in a nursing facility, there must be a continuous effort to ensure that the individual maintains and/or acquires skills and abilities that would allow the person to live successfully in the community.

The role of the service coordinator as the person knitting all these elements into a coherent, relevant experience for the individual from identification to placement is critical, if the State of Texas is to succeed in meeting its specialized services, Active Treatment, and *Olmstead* requirements. The service coordinator must engage service delivery structures like nursing facility and community service providers who are the mediators of service delivery. They have to know the individuals on their caseload, in order to respond to assessed needs and preferences, and to arrange appropriate services to meet those needs. Additionally, when discussing preferences, they have to provide accurate, relevant information through an informed choice process that includes sufficient education, an engaged dialogue, direct community experiences, and appropriate community options that allow the person to make an informed and meaningful choice about whether to remain in a nursing facility or move to the community.

Finally, all these efforts cannot be successful without the creation of an integrated, coherent, relevant, and comprehensive system of policies, procedures, services and funding supports that align with the federal requirements in every LIDDA throughout the State.

Based upon my reviews of LIDDAs, community providers, HHSC policies and practices, relevant data and reports, and the QSR, I do not believe that Texas is providing an effective or even minimally adequate PASRR program nor ensuring that qualified individuals with I/DD in nursing facilities have a meaningful opportunity to live in the community. Moreover, based on these practices, there is a strong likelihood that there are people with IDD in Texas nursing facilities who could handle or benefit living in community settings and have not made an informed choice to stay in the nursing facility.

Attachment A

Attachment A

Randall Webster
42 Parkview St.
South Weymouth, MA 02190

781-803-6210

EXPERIENCE

COMMONWEALTH OF MASSACHUSETTS 1977 - PRESENT

Consultant to Department of Developmental Services Special Projects 2014 - Present
Maintaining certain responsibilities I had prior to retiring in order to transition the new person into my former role. Additionally, have been working on key projects as assigned by the DDS Commissioner including contract management reform within DDS, maintaining a leadership role in Hutchinson v. Patrick Settlement Agreement working in conjunction with sister State agencies within Massachusetts including Mass Health, maintaining PASRR oversight role to ensure DDS' accomplishments in settling Rolland v. Patrick are maintained, consulting on CMS waiver re-writes and associated revenue implications and participating in rate setting initiatives on a consultative basis as the rates relate to DDS and/or Mass Health.

Assistant Commissioner for Operations 2011-2014
Responsible for overall operational policies and practices for the Department of Developmental Services (DDS) throughout the Commonwealth working under the direction of the Deputy Commissioner for DDS. Particular emphasis has been on waiver implementation and compliance, data management and integrity, resolution of the Rolland v. Patrick Settlement Agreement, participating in fiscal management initiatives including monitoring of expenditures and Chapter 257 compliance and day-to-day operational concerns of the Department with an annual budget of approximately 1.6 billion dollars.

Area Director Department of Developmental Services (and associated roles)— 1989 - 2011
Responsible for a variety of complex management functions related to procurement and service delivery of developmental services to over 850 eligible individuals of the DDS in the Fall River Area with a local budget of approximately $26,000,000. In this role I had routine interactions with families, Area Board members, legislators, service recipients, executive directors, direct care staff, administrators in leadership roles within DDS and occasionally EOHHS. I exercised my responsibilities within legislative statute and Executive Office direction.

In addition to my routine responsibilities as Area Director I was the lead Area Director in litigation related to BRI in the early 1990's, was in a senior role at Otis AFB during the Commonwealth's response to Hurricane Katrina known as "Operation Helping Hands" in 2005. I was the Acting Contracting Manager for the State DDS for over one year responsible for policy and direction of over $650,000,000 MM dollars. In that role I worked on contracting issues identified by the State Auditor and the Operational Services Division.

Cape Cod Assistant Area Director/Area Director - 1986-1988

Responsible for DMH and DMR (now DDS) clinical, administrative and personnel functions for the Cape Cod Area. Primary responsibility was with the DMH. Roles related to personnel management, service oversight and procurement and inpatient unit certification. Interacted with families, agency administrators, Area Boards and legislators.

Associate then Interim District Manager Region V DMH — 1981 - 1986
Responsible for supervision and oversight for mental health and developmental disability services for the Region V District of DMH. Significant budgetary and supervisory responsibility for service delivery all occurring at an Area level.

Region V Quality Assurance Director/Region V DMR Licensor — 1977 - 1981
Participated in the development of the initial licensing function for the DMH then moved into a broader role of quality Assurance Director of DMH Region V. Responsibilities included investigating significant events, assisting in certification of psychiatric units at Taunton State Hospital and overseeing of licensing function of DMH.

EDUCATION

M.S. Syracuse University - Rehabilitation Counseling 1983

M.A. Syracuse University - Education 1970

B.A. LeMoyne College - History 1969

COMMUNITY INVOLVEMENT

Plymouth-Carver Regional School Committee Member (1987 - 1993)

As elected Carver member to the Plymouth Caver Regional School District (Grades 7 - 12) managed the complex relationships associated with being the smaller Town in the relationship. In this role I was the key Carver member related to budget issues because the senior Carver member would not support Plymouth sponsored budget proposals and all budget items required an affirmative Carver vote for enactment. During that period worked with the senior Regional School Committee member toward the dissolution of the Region which did occur in 1993.

Carver K-6 School Committee Member (1992 - 1993)

Was elected to the Carver K-6 Committee in order to provide academic continuity since the Regional structure was going to dissolve. I wanted to make sure there was alignment between the local schools and the Regional system related to academics, collective bargaining, fiscal and administrative management.

Carver School Committee (K-12) (1993 -2008)

Member and, for many years, Chairperson, of the Carver School Committee. Generally, School Committees must have a collaborative, complementary relationship within Town government and the community. Often over 50% of the Town's budget (in Carver it was close to 75% of the Town's budget) goes to the schools which creates challenges and pressures that have to considered, respected and worked through for the betterment of the entire Town. In that context, then, I had direct ongoing relationships with the Selectmen, Town Manager, Capital Outlay Committee, Finance Committee and Building Committee (an on going appointment while on the School Committee). Within the Schools I was the direct contact between the Superintendent and School Committee and at times, the Superintendent and other Town Departments. Participated in collective bargaining with the teachers and other bargaining groups within the schools. Also, Chaired two Superintendent searches during my tenure as Chairperson.

Member Capital Outlay Committee and Carver School Building Committee As School Committee Designee to each Committee (1993 - 2008)

Coach Girls Soccer

Coached for over 15 years as my daughters (3) were growing (both Town Travel Teams and later Club Teams)

Awards

Lifetime Achievement Award Massachusetts Association of School Committees (2007).

Manuel Carballo Governor's Award for Excellence in Public Service (2013)

Certificate of Appreciation from Governor Romney for my role in "Operation Helping Hands" (Commonwealth's response to victims of Hurricane Katrina at Otis AF Base) (2005)

Attachment B

Steward v. Smith
Case No. 5:10-CV-1025-OG
In the United States District Court for the Western District of Texas
San Antonio Division

LOCAL INTELLECTUAL AND DEVELOPMENTAL DISABILITY AUTHORITY
REPORT OF RANDALL WEBSTER
Attachment B

	Document	**Bates Number**
1.	LIDDA Reports re In-Reach-Educational Opportunities, Barriers to Transition, & Specialized Services Q4 FY15	DefE-00000003
2.	NF Population Report 12/31/15 and cover email	DefE-00000030 DefE-00000032
3.	LIDDA Reports re In-Reach-Educational Opportunities, Barriers to Transition, & Specialized Services Q1 FY16	DefE-00000034
4.	LIDDA Compliance Measure (LIDDA v. State (% of compliance))	DefE-00000049 DefE-00000470
5.	LIDDA Reports re In-Reach-Educational Opportunities, Barriers to Transition, & Specialized Services Q1 FY 16	DefE-00000556
6.	LIDDA Reports re In-Reach-Educational Opportunities, Barriers to Transition, & Specialized Service Q2 FY16	DefE-00000557 DefE-00000559
7.	LIDDA PASRR Quality Report FY 16 Q1 with cover email	DefE-00000725 - DefE-00000728
8.	PL2015-33 Top Non-Compliance Trends with the Preadmission Screening and Resident Review (PASRR) Requirements	PL00000137 – PL00000139
9.	PL2015-16 Preadmission Screening and Resident Review (PASRR) Facility Requirements	PL00000140 – PL00000142
10.	IL2015-61 Preadmission Screening and Resident Review Habilitative Specialized Services	PL00000143 – PL00000144
11.	May 2016 Monthly report to stakeholder re slot utilization	PL00000145 – PL00000184
12.	June 2016 Monthly report to stakeholders re slot utilization	PL00000185 – PL00000188
13.	September 2016 Monthly report to stakeholders re slot utilization	PL00000189 – PL00000192
14.	PASRR Provider Resources-LA FAQs- DADS website	PL00000193 – PL00000195

15.	PASRR Specialized Service (PSS) Form	PL00000196 - PL00000199
16.	LIDDA PASRR Reporting Manual	PL00000200 – PL00000213
17.	LIDDA Performance Contract FY16-17	PL00000214 – PL00000250
18.	Kathryn Dupree 2015 Annual Report of Compliance	DefE-00000601-DefE-00000672
19.	Kathryn Dupree Q1 2016 QSR	DefE-00000677 - 716
20.	QSR Matrix	PL00000060-136
21.	QSR Interview Protocol – Nursing Facility Members – Texas	PL00000882-900
22.	*Rolland v. Patrick* Active Treatment Protocol	PL00000001-14
23.	Reviewer's and Quality Review Manual from Rolland case	PL00000015-41
24.	Slot Type 90 FY 16-17	DefE-00000037
25.	Habilitative and Rehabilitative Services	DefE-00000769
26.	Analysis of PASSR Survey	DefE-00000791-793
27.	TMHP Portal Enhancements	DefE-00000855-859
28.	LIDDA Performance Contract FY16-17 and Attachments	DefE-00001706-1911
29.	Nursing Facility Diversion Protocol	DefE-00001936-1937
30.	HCS SW ILR #59 FY'12-'13 Enrollments as of 5/31/13	DefE-00029326
31.	Slot Type 63 FY 14-15 9/30/2013	DefE-00029681
32.	Specialized Services Request Process 4/15/16	DefE-00052224
33.	Minutes of LA Webinar 2/19/15	DefE-00054425-54428
34.	Minutes of LA Webinar 3/19/15	DefE-00054430-54433
35.	Minutes of LA Webinar 4/23/15	DefE-00054438-54442
36.	Minutes of LA Webinar 6/25/15	DefE-00054497-54503
37.	Minutes of LA Webinar 7/16/15	DefE-00054522-54528

38.	Minutes of LA Webinar 8/20/15	DefE-00054530-54535
39.	Minutes of LA Webinar 9/17/15	DefE-00054537-54544
40.	Minutes of LA Webinar 11/19/15	DefE-00054549-54553
41.	Minutes of LA Webinar 12/17/15	DefE-00055464-55468
42.	Minutes of LA Webinar 2/4/16	DefE-00055470-55484
43.	PASRR Quality Reporting Q1 FY16	DefE-00055545
44.	Quarterly PASRR Reporting - Harris County Q2 FY16	DefE-00056059-56064
45.	Quarterly PASRR Reporting - Harris County Q3 FY16	DefE-00056065-56071
46.	Quarterly PASRR Reporting - Harris County Q4 FY16	DefE-00056072-56077
47.	Quarterly PASRR Reporting - Texana Q2 FY16	DefE-00056224-56230
48.	Quarterly PASRR Reporting - Texana Q4 FY16	DefE-00056231-56237
49.	Quarterly PASRR Reporting - Texana Q3 FY16	DefE-00056238-56243
50.	Quarterly PASRR Reporting - Harris County Q1 FY16	DefE-00056476-56481
51.	Quarterly PASRR Reporting - Texana Q1 FY16	DefE-00056558-56563
52.	Quarterly PASRR Reporting - Community Healthcore Q2 FY16	DefE-00055839-55844
53.	Quarterly PASRR Reporting - Community Healthcore Q3 FY16	DefE-00055845-55849
54.	Quarterly PASRR Reporting - Community Healthcore Q4 FY16	DefE-00055850-55855
55.	Quarterly PASRR Reporting - Heart of Texas Q4 FY16	DefE-00055927-55932
56.	Quarterly PASRR Reporting - Heart of Texas Q3 FY16	DefE-00055933-55938
57.	Quarterly PASRR Reporting - Heart of Texas Q2 FY16	DefE-00055939-55944
58.	Quarterly PASRR Reporting - Metrocare Q2 FY16	DefE-00056007-56012

59.	Quarterly PASRR Reporting - Metrocare Q3 FY16	DefE-00056013-56018
60.	Quarterly PASRR Reporting - Metrocare Q4 FY16	DefE-00056019-56024
61.	Quarterly PASRR Reporting - Tarrant County Q2 FY16	DefE-00056078-56086
62.	Tarrant County Training Rosters Dec. 2015-Feb., 2016	DefE-00056087-56100
63.	Quarterly PASRR Reporting - Tarrant County Q3 FY16	DefE-00056101-56108
64.	Tarrant County Training Rosters Mar. 2016-May 2016	DefE-00056139-56148
65.	Quarterly PASRR Reporting - PCVBDH Q2 FY16	DefE-00056149-56154
66.	Quarterly PASRR Reporting - PCVBDH Q3 FY16	DefE-00056155-56159
67.	Quarterly PASRR Reporting - PCVBDH Q4 FY16	DefE-00056160-56165
68.	Quarterly PASRR Reporting - Community Healthcore Q1 FY16	DefE-00056405-56409
69.	Quarterly PASRR Reporting - Heart of Texas Q1 FY16	DefE-00056441-56445
70.	Quarterly PASRR Reporting - Heart of Texas Q1 FY16 Addendum	DefE-00056446
71.	Quarterly PASRR Reporting - Metrocare Q1 FY16	DefE-00056471-56475
72.	Quarterly PASRR Reporting - Tarrant County Q1 FY16	DefE-00056482-56492
73.	Tarrant County Training Rosters Sept. 2015-Nov. 2015	DefE-00056493-56509
74.	Quarterly PASRR Reporting - PCVBDH Q1 FY16	DefE-00056534-56539
75.	Tarrant County Training Rosters Sept. 2015-Nov. 2015 (2)	DefE-56510-56533
76.	IDT Meeting Documentation - July 7, 2015 PP Presentation	DefE-00000754
77.	TEXAS HEALTH AND HUMAN SERVICES, Nursing Facility Requirements for Licensure and Medicaid Certification Handbook, Subchapter BB, §§ 19.2701-19.2709, *available at* https://hhs.texas.gov/laws-regulations/handbooks/nursing-facility-requirements-licensure-medicaid-certification-handbook/nfrlmc-	PL006375-PL006384

	subchapter-bb-nursing-facility-responsibilites-related-preadmission-screening-resident-review	
78.	HEALTH AND HUMAN SERVICES COMMISSION EXECUTIVE COUNCIL, Nursing Facility Specialized Services Agenda Item (February 24, 2017), *available at* https://hhs.texas.gov/sites/hhs/files//documents/about-hhs/communications-events/meetings-events/council/02-24-17/3j-executive-council.pdf	
79.	40 T.A.C., Part 1, Ch. 19., Subch. BB: NF responsibilities related to PASRR	PL00000251-263
80.	40 T.A.C., Part 1, Ch. 17, Subch. A: PASRR General Provisions	PL00000264-285
81.	42 C.F.R. § 483 - PASRR Regulations	PL0095678-PL0095642
82.	Health and Human Services Commission *Waiver Slot Enrollment Progress Report, March 2017*, TEXAS HEALTH AND HUMAN SERVICES, https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/reports-presentations/2017/waiver-slot-enrollment-report.pdf.	US00254930-254941; PL0095964-PL0095975
83.	Health and Human Service Commission, *Report on Cost of Preadmission Screening and Resident Review, February 2017*, TEXAS HEALTH AND HUMAN SERVICES, https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/reports-presentations/2017/cost-of-pasrr-fy2016-feb2017.pdf.	PL0095943-PL0095963
84.	PASRR Evaluation Form	PL00000672-703
85.	STATE OF TEXAS, https://texas.gov.	
86.	TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES, https://www.dads.state.tx.us.	
87.	TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES, *Preadmission Screening and Resident Review (PASRR)*, Computer Based Training (posted July 17, 2015), https://www.dads.state.tx.us/business/CBT/PASRR/index.html.	
88.	Provider Letter No. 16-33 from Mary T. Henderson, Asst. Comm'r, Regulatory Services, to Nursing Facilities (Aug. 31, 2016),	US00253503-253505

	https://hhs.texas.gov/sites/hhs/files//documents/doing-business-with-hhs/provider-portal/letters/2016/letters/pl2016-33.pdf.	
89.	TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES, *PASRR Rules: TAC, Title 40, Part 1, Chapter 19, Subchapter BB*, Computer Based Training (posted Feb. 16, 2016) https://www.dads.state.tx.us/business/cbt/PASRRrules/index.html.	
90.	TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES, *PASRR Specialized Services Training*, Computer Based Training (posted Oct. 12, 2015), https://www.dads.state.tx.us/business/CBT/pasarrspecialized/SpecializedServices101215_print.html.	
91.	TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES, *PASRR PE: What Nursing Facilities Need to Know*, Computer Based Training (posted Dec. 29, 2015), https://www.dads.state.tx.us/business/CBT/PASRRPE/PE_print.html	
92.	Information Letter No. 12-72 from Geri Willems, Manager, PASRR/MERP to Nursing Facility staff (Aug. 2, 2012), https://www.dads.state.tx.us/providers/communications/2012/letters/IL2012-72.pdf	
93.	TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES, *PASRR PL1: Back to Basics*, Computer Based Training (posted Dec. 29, 2015), *available at* https://www.dads.state.tx.us/business/CBT/PASRRPL1/PL114.html	
94.	THE HARRIS CENTER FOR MENTAL HEALTH AND IDD, http://www.mhmraharris.org/.	
95.	TEXANA, http://www.texanacenter.com/	
96.	METROCARE SERVICES, http://www.metrocareservices.org/.	
97.	MHMR TARRANT COUNTY, http://www.mhmrtc.org/.	
98.	PECAN VALLEY CENTERS FOR BEHAVIORAL AND DEVELOPMENTAL HEALTHCARE, http://www.pecanvalley.org.	
99.	HEART OF TEXAS REGION MENTAL HEALTH MENTAL RETARDATION CENTER, http://www.hotrmhmr.org/.	

100.	COMMUNITY HEALTHCORE, http://www.communityhealthcore.com/.	
101.	Behavioral Health Center of Nueces County LIDDA PASSR Quarterly Reporting FY16 Q1-Q4	DefE-00055645, DefE-00055651, DefE-00055657, DefE-00056358
102.	Border Region LIDDA PASRR Quarterly Reporting FY16 Q1-Q4	DefE-00055713, DefE-00055719, DefE-00055725, DefE-00056370
103.	Coastal Plains LIDDA PASRR Quarterly Reporting FY16 Q1, Q3 Q4	DefE-00055829, DefE-00055834, DefE-00056400,
104.	Gulf Bend LIDDA PASRR Quarterly Reporting FY16 Q1-Q4	DefE-00055890, DefE-00055897, DefE-00055902, DefE-00056436
105.	Tropical Texas Behavioral Health LIDDA PASRR Quarterly Reporting FY16 Q1-Q4	DefE-00056301, DefE-00056313, DefE-00056307, DefE-00056576
106.	Texas Health and Human Services Commission, Form 1039, Community Living Options and Instructions	US00253559-253568
107.	Texas Health and Human Services Commission, Form 1041, Local Authorities (LA) Individual Service Plan/Transition Plan – NF and Instructions	US00253775-253800
108.	Centers for Medicare and Medicaid Services, Instructions: Version 3.5 HCBS Waiver Application, Appendix B: Participant Access and Eligibility	US00257518-257519
109.	TEX. HEALTH AND HUMAN SERVS. COMM'N, (formerly, Texas Department of Aging and Disability Services), *Explanation of IDD Services and Supports*	US00253411-253423
110.	TEX. HEALTH AND HUMAN SERVS. COMMI'N (formerly, Texas Department of Aging and Disability Services), *Making Informed Choices: Community Living Options Information Process for Nursing Facility Residents*, February 2016	US00253424-253429
111.	NF Diversion FY14-15	DefE-00001704
112.	NF Diversion FY16-17	DefE-00001941
113.	All LIDDA Quarterly Reporting, Q4 FY16	DefE-00055545
114.	FY16 Q1 NF Member Expressing an Interest in the Community Through MDS Section Q Process, May 2016	DefE-00161335
115.	FY16 Q2 NF Member Expressing an Interest in the Community Through MDS Section Q Process, May 2016	DefE-00161337

116.	All LIDDA Quality Reporting FY 16 Q1	DefE-00000034
117.	All LIDDA Quality Reporting FY 16 Q2	DefE-00000559
118.	All LIDDA Quality Reporting FY16 Q3	DefE-00000726
119.	All LIDDA Quality Reporting FY17 Q1	DefE-00702109
120.	All LIDDA Quality Reporting FY17 Q2	DefE-02005170
121.	All LIDDA Quality Reporting FY17 Q3	DefE-02005171
122.	2016 PASRR QSR Compliance Status Interim Report, Draft, Kathryn DuPree	DefE-00096540
123.	TEXAS HEALTH AND HUM. SVCS. COMM'N, PASRR Webinar: Specialized Services for Nursing Facility Residents with IDD, Presenter: Sally W. Schultz, OT, Ph.D., LPC-S, April 26, 2017.	DefE-00700653
124.	TEXAS HEALTH AND HUMAN SERVICES COMMISSION, PASRR 101, Computer Based Training Module, available at https://learningportal.dfps.state.tx.us/enrol/index.php?id=22	DefE-02220543
125.	FY17 Specialized Services Report	DefE-02034167
126.	Texas Health and Human Services Commission, Draft HCS Enrollment Plan for 2018-2019 Biennium, Exhibit 348, Deposition of Anthony Jalomo, November 3, 2017, Austin, Texas.	DefE-01964251-1964260
127.	Coastal Plains LIDDA PASRR Quarterly Reporting FY17 Q1	DefE-00260263
128.	Gulf Bend LIDDA PASRR Quarterly Reporting FY17 Q1	DefE-00260118
129.	Behavioral Health Center of Nueces County LIDDA PASSR Quarterly Reporting FY17 Q1	DefE-00261173
130.	Tropical Texas Behavioral Health LIDDA PASRR Quarterly Reporting FY17 Q1, Q3	DefE-00260276, DefE-00665820
131.	Coastal Plains LIDDA PASRR Quarterly Reporting FY16 Q2	DefE-00239803
132.	Transcript of the call with Metrocare Services, July 21, 2017	DEFP-00337897
133.	Transcript of the call with MHMR of Tarrant County, July 21, 2107	DEFP-00338022
134.	Transcript of the call with Pecan Valley MHMR, July 21, 2017	DEFP-00337981
135.	Transcript of the call with Heart of Texas MHMR, July 21, 2017	DEFP-00337936
136.	Transcript of the meeting with Coastal Plains, Corpus Christi, Texas, July 24, 2017	DEFP-00338164
137.	Transcript of the meeting with MHMR of Nueces County, Corpus Christi, Texas, July 24, 2017	DEFP-00338058

138.	Transcript of the meeting with Tropical Texas Behavioral Health, Harlingen, Texas, July 25, 2017	DEFP-00338288
139.	Transcript of the meeting with Border Region MHMR, Laredo, Texas, July 26, 2017	DEFP-00338494
140.	Transcript of the meeting with Gulf Bend Centers, Victoria, Texas, July 27, 2017	DEFP-00338709
141.	Transcript of the call with The Harris Center, August 2, 2017	DEFP-00339048
142.	QAI Data Mart Request 1343, Individuals in the PASRR Total Population Residing in a Nursing Facility	DefE-02034155
143.	Transcript of the deposition of Haley Turner, February 23, 2018, Austin, Texas	
144.	Exhibits submitted at the deposition of Haley Turner (PX 1039-PX 1063), Austin, Texas	
145.	Community Provider Survey	US00257595-257638; US00261213-261256
146.	HCS Diversion Slot Data – reorganized	US00257529
147.	HCS Transition Slot Data – reorganized	US00257530
148.	NF Diversion Slot List FY14-FY15	DefE-02195943
149.	NF Diversion Slot List FY16-FY17	DefE-01958694
150.	NF Transition Slot List FY14-FY15	DefE-01695363
151.	NF Transition Slot List FY16-FY17	DefE-01958693
152.	2017 QSR Review Results	US00257639
153.	TROPICAL TEXAS BEAIORAL HEALTH, http://www.ttbh.org/en/tropical-texas-behavioral-health-locations	
154.	COASTAL PLAINS COMMUNITY CENTER, http://www.coastalplainsctr.org/idd_coastal_plains_ctr.html	
155.	BEHAVIORAL HEALTH CENTER OF NUECES COUNTY, http://bhcnc.net/disabilities-services/	
156.	BORDER REGION BEHAVIORAL HEALTH, http://www.borderregion.org/admision.htm	
157.	GULF BEND CENTER, https://www.gulfbend.org/poc/view_doc.php?type=doc&id=57802&cn=0	

158.	MEDICAID.GOV, Preadmission Screening and Resident Review, https://www.medicaid.gov/medicaid/ltss/institutional/pasrr/index.html	
159.	GOVREGS.COM, https://www.govregs.com/regulations/expand/title42_chapterIV_part483_subpartI_section483.440#title42_chapterIV_part483_subpartI_section483.440	
160.	THE UNIVERSITY OF IOWA, COLLEGE OF PUBLIC HEALTH, 42 CFR 483 Subpart C https://www.public-health.uiowa.edu/icmha/meetings/1018-2109/documents/DTimmel-PASRR_regulations.pdf	
161.	Program review questions and considerations	US00259001-259003