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

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

DECLARATION AND EXPERT DISCLOSURE OF NANCY WESTON

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 to be expressed as well as an explanation of the basis and reasons for those opinions.

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

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

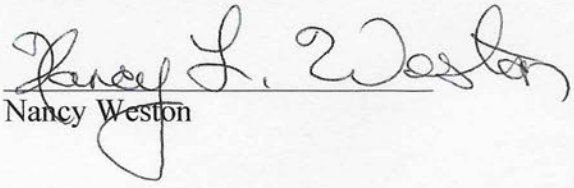
4. There are no exhibits prepared at this time to be used as a summary of or support for my opinions.

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

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

7. 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 $ 125.00 per hour for my reviews, 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: March 29, 2018



Nancy Weston

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 Nancy Weston. was delivered via electronic mail and Federal Express to the attorneys for defendants at the addresses below:

Elizabeth Brown Fore
Elizabeth.BrownFore@oag.texas.gov
Thomas A. Albright
Thomas.Albright@oag.texas.gov
Drew Harris
Drew.Harris@oag.texas.gov
Andrew B. Stephens
Andrew.Stephens@oag.texas.gov
Christopher D. Hilton
Christopher.Hilton@oag.gov
Natalee B. Marion
Natalee.Marion@oag.texas.gov
Rola Daaboul
Rola.Daaboul@oag.texas.gov
Jeffrey Farrell
Jeffrey.Farrell@oag.texas.gov
Attorneys General
General Litigation Division
P.O. Box 12548, Capitol Station
Austin, Texas 78711-2548

Counsel for Defendants

/s/ Garth A. Corbett
GARTH A. CORBETT

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, et. al.
Defendants

The United States of America
Plaintiff-Intervenor

v.

The State of Texas
Defendant

LOCAL INTELLECTUAL AND DEVELOPMENTAL DISABILITY AUTHORITIES AND SYSTEMIC OVERVIEW REPORT OF NANCY WESTON

I. PURPOSE AND SCOPE OF REPORT

I was asked by the Plaintiffs and the United States to conduct two levels of review of Texas's Pre-Admission Screening, Assessment, and Resident Review (PASRR) program. First, I assessed the State's planning, development, administration, regulation, implementation, and oversight of the PASRR program that is operated by the Health and Human Services Commission (HHSC), and formerly through its Department of Aging and Developmental Services (DADS). Second, I reviewed the actual delivery of the PASRR program by the Local Intellectual and Developmental Disability Authorities (LIDDAs) that HHSC/DADS funds to provide PASRR screening, assessment, service and transition planning, specialized services, transition services, and service coordination to individuals with intellectual and developmental disabilities (IDD) in nursing facilities throughout Texas. At both levels, I focused on how the State's redesigned PASRR program that was first implemented in 2013 complies with federal, state, and professional standards.

II. BACKGROUND AND EXPERIENCE

I have thirty-seven years of experience in the field of human services, including twenty years with the Department of Mental Health in a clinical capacity and as the Assistant Director

for a Partial Hospitalization Program overseeing service delivery, crisis intervention, and interagency partnership.

For the last seventeen years, I have been with the Department of Developmental Services (DDS) in Massachusetts. I was hired in 2001 as the statewide Director of PASRR to develop and manage a statewide PASRR program, including the design of a federally compliant PASRR tool and process. At that time, DDS was assuming the responsibility of PASRR, which had previously been managed by a vendor agency. The PASRR process includes the initial identification screening, evaluation, assessment, identification of specialized services, the provision of Active Treatment in nursing facilities, and transition of individuals with IDD to the community as well as diversion from nursing facilities. As the statewide Director of PASRR, I am responsible for the daily oversight and implementation of the PASRR process and its consistent administration by regional and central office PASRR evaluators.

I have developed and provided annual statewide PASRR trainings for target audiences of nursing facility administration and staff, hospital discharge planners, elder service providers, and state staff in partnership with MassHealth (the state Medicaid agency) and the Department of Mental Health in order to provide education and maximize nursing facility PASRR compliance.

In association with the Community First policy in Massachusetts, DDS policy and other initiatives, I helped restructure the DDS PASRR process by converting the PASRR determination for nursing facility level of service from one that allowed open-ended and indefinite approval to remain in a nursing facility to one that limited the PASRR determination for nursing facility level of service to 90 day increments. This restructuring effectively reduced nursing facility lengths of stay and ensures that people with IDD do not inappropriately remain in nursing facility settings. Through this effort, the statewide nursing facility census of individuals with IDD markedly decreased from more than 1600 in 2001 to fewer than 200 mostly short-term nursing facility residents as of this writing.

Following a successful aggressive PASRR community placement effort, I assumed the additional role of Director of Nursing Facility Operations, which includes oversight of a highly skilled Active Treatment team dedicated to ensuring the appropriate delivery of specialized services and the provision of Active Treatment in nursing facilities, consistent with 42 C.F.R. 440(a)-(f). Compliance with this Active Treatment standard is reviewed by annual nursing facility surveys by the Department of Public Health and includes members of the DDS Quality Enhancement teams. As a result of these efforts, and independent findings that all recommended residents of nursing facilities were receiving Active Treatment, consistent with these regulations, the United States District Court found that the Commonwealth of Massachusetts and DDS were in substantial compliance with its orders in *Rolland v. Patrick*, 2013 WL 2322761 (D. Mass. May 23, 2013), and dismissed the case.

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. Texas PASRR System Review

I conducted a high level System Review of Texas's PASRR program to assess how, and to what extent, that program is reasonably designed to adhere to federal and professional requirements, including regulations and policies issued by the Centers for Medicare and Medicaid Services (CMS). I examined HHSC rules, policies, procedures, and bulletins; deposition testimony; and data – with particular reference to the identification and evaluation of individuals with IDD in or at risk of entering nursing facilities; the assessment of habilitative and nursing needs as well as the appropriateness of admission to nursing facilities; the identification of the need for and provision of specialized services; the coordination of nursing facility and specialized services; the provision of Active Treatment; and the oversight and quality monitoring of the PASRR program by HHSC.

The focus of the Texas PASRR System Review was to determine if:

(1) HHSC has designed and is administering a PASRR screening process that ensures that people are identified for diversion, and, are actually diverted from admission to nursing facilities, whenever possible.

(2) HHSC's PASRR system is designed and administered to ensure that the needs of individuals with IDD admitted to nursing facilities are properly identified and assessed, and to provide the full range of specialized services to meet all habilitative needs;

(3) HHSC's PASRR system is designed and administered to ensure that individuals with IDD receive specialized services that are provided in an amount, duration and frequency sufficient to constitute Active Treatment, including whether:

(a) The State has created and communicated a clear expectation that specialized services sufficient to constitute Active Treatment must be provided to individuals with IDD residing in nursing facilities who need such services;

(b) The State has developed and implemented an adequate infrastructure that provides specialized services to individuals with IDD in nursing facilities sufficient to constitute a program of Active Treatment; and

(c) The State regularly monitors and oversees its PASRR program, and the activities of the LIDDAs and nursing facilities, to ensure that they provide specialized services sufficient to constitute a program of Active Treatment to individuals with IDD in nursing facilities.

Documents were provided to me that related to Texas's PASRR design and compliance efforts. I also reviewed additional documents available online. A complete list of documents that I reviewed is set forth in Attachment B to this report.

B. LIDDA Program Review

I, along with another developmental disability expert, Randall Webster, reviewed the LIDDAs' implementation of Texas's PASRR program. LIDDAs are thirty-nine statutorily-created, quasi-public entities that are responsible for determining eligibility for services for people with IDD, then coordinating and monitoring the provision of those services. Texas has designated HHSC (and formerly DADS) as the state agency responsible for meeting its PASRR requirements. HHSC in turn contracts with and funds thirty-nine LIDDAs as part of the state's effort to meet its PASRR requirements, including screening and evaluating for, and provision and monitoring of, specialized services for people with IDD. Federal regulations make clear that the state cannot delegate its statutory obligations and its ultimate responsibility to comply with the NHRA to the LIDDAs. 42 C.F.R. Sec. 483.106(e). The state must ensure that appropriate and timely screening and assessment, specialized services, and coordination and monitoring of nursing facilities and community providers results in a continuous Active Treatment program to adults with IDD in nursing facilities. Similarly, the state largely relies on LIDDAs, through the Level II PASRR process, to assess whether individuals referred to nursing facilities require a nursing facility level of service and, whether their needs can be met in an alternative placement in the community. LIDDAs also must provide information about community living options, and plan for and facilitate diversions and transitions. But Texas is ultimately responsible for ensuring that individuals have the opportunity to make an informed and meaningful choice about where they receive services, and for providing appropriate diversion and transition planning for individuals who do not oppose living in the community.

The scope of the LIDDA review was to determine if:

(1) the LIDDAs were properly identifying and screening persons with IDD consistent with PASRR, and diverting from admission to a nursing facility individuals who could be served in an alternate setting;

(2) the LIDDAs were appropriately assessing the need for specialized services that were based on a comprehensive functional assessment of all relevant habilitative need areas;

(3) the LIDDAs provided or ensured that the nursing facilities provided all recommended specialized services;

(4) the LIDDAs ensured that each person received all needed specialized services with the frequency, intensity, duration, and continuity to constitute a program of Active Treatment; and,

(5) the LIDDAs provided professionally-adequate planning, coordination, and monitoring of services in nursing facilities, and transition from nursing facilities.

Beginning January 30, 2017, I met with LIDDA staff in eight LIDDAs. I had follow up calls with six of these eight agencies in July, 2017 when I also visited an additional eight LIDDAs. I was unable to schedule a follow up call with Texana, one of the LIDDAs I visited in

January, and Mr. Webster had the follow up call with Harris Center, a LIDDA we had visited together in January.

I was asked to focus on these LIDDAs in order to assess, at a program level, the capacity and activities of these LIDDAs, which were responsible for providing PASRR screening, diversion, assessment, service planning, specialized services, Active Treatment and transition services to persons in nursing facilities served by these LIDDAs.

Over the sixth month period, I visited the following LIDDAs:

1. The Harris Center for Mental Health and IDD in Houston, Texas
2. Texana Center in Rosenberg, Texas
3. Camino Real in Lytle, Texas
4. Alamo Local Authority in San Antonio, Texas
5. Austin Travis County Integral Care in Austin, Texas
6. Hill Country MHDD in San Marcos, Texas
7. Central Counties Services in Temple, Texas
8. Bluebonnet Trails Community Services in Round Rock, Texas
9. Emergence in El Paso, Texas
10. Permian Basin Community Center in Midland , Texas
11. West Texas Center in Big Springs, Texas
12. Concho Valley MHMR in San Angelo, Texas
13. Betty Hardwick in Abilene, Texas
14. Star Care in Lubbock, Texas
15. Central Plains in Plainview, Texas
16. Texas Panhandle in Amarillo, Texas

All LIDDA staff interviewed were generous with their time and with sharing their knowledge and experience of Texas's PASRR process. Each LIDDA made available their staff most familiar with PASRR and diversion practices such as diversion coordinators, PASRR service coordinators, and enhanced placement coordinators and occasionally senior LIDDA staff were present. At each LIDDA that I visited, I explored the practices, processes, and experience they each had. My conversations with the staff at the LIDDAs were guided by a series of questions that Randall Webster and I had developed together, prior to our visits to the LIDDAs, to make our separate visits compatible (we made the first two LIDDA visits together). This way, we were able to conduct our visits in a way that was consistent, even if there may be differences in our respective findings.

In the July visits, HHSC attorneys, and the Attorney General's office were also present by phone in most of the LIDDA program reviews. The LIDDA staff adopted a guarded tone in the reviews in which state leadership and attorneys were present. This guarded tone was not evident during the first set of reviews or in the one review from the second set of reviews in which state leadership and attorneys were not present. LIDDA staff reported that they did not request for the interview to be recorded and that the recordings were being done at the request of

the state. Nevertheless, many of my findings, detailed below, were consistently present in each of the LIDDAs reviewed.[1]

In addition to LIDDA program reviews, I interviewed five provider agencies. Mr. Webster and I conducted interviews with providers of varying sizes in a mix of rural and urban areas in order to assess capacity and clinical expertise in supporting a population with complex medical or behavioral needs that may be diverted from or transitioning out of a nursing facility and their role in delivering specialized services to individuals in nursing facilities.

I conducted interviews with the following five providers:

1.People Care in El Paso, Texas
2.Daybreak Community in San Angelo, Texas
3.Rock Houses in Lubbock, Texas
4.Advo in Amarillo, Texas
5.Community Options in Amarillo, Texas

In addition, documents were provided to me that are relevant to these issues. I also reviewed additional documents available online. The documents I reviewed included: HHSC's performance contract with the LIDDAs, Texas regulations and HHSC manuals, instructions, forms, and other guidance; LIDDA quarterly reports; and QSR reports. A complete list of documents that I reviewed is set forth in Attachment B to this report.

IV. STANDARDS

For purposes of the System and Program review, I considered a range of standards including federal statutory and regulatory requirements in the Medicaid Act (PASRR) and Title II of the ADA (the Integration Mandate); Texas's regulations, policies, procedures, and quality assurance measures developed to comply with federal requirements; and professional standards. I also applied my experience, expertise, and knowledge of the field of developmental disabilities and of the practices that are essential to adequate service delivery and opportunities for community integration.

A. Screening and Diversion

1. PASRR Level I Screening and Level II Evaluation

Section 1919(e)(7) of the Social Security Act, as amended by the Omnibus Reconciliation Act of 1987 (OBRA-87) requires the pre-admission screening and assessment of all prospective residents of a Medicaid certified nursing facility, and the provision of a program of Active Treatment to those who need specialized services and who are admitted to nursing facilities. CMS issued final PASRR regulations in 1992 and subsequent guidance concerning the

[1] Based on my review of the transcripts of these visits that were made available to me and also based on my participation in these visits, these transcripts do not always reliably reflect the discussion. At times there are mis-attributions or other inaccuracies.

criteria that describe the requirements for identifying and screening people with IDD and for diverting people with IDD from nursing facility admission. Each state must comply with these PASRR requirements. 42 C.F.R. Sec. 483.100 et seq.

The overarching goals of PASRR are to prevent inappropriate nursing facility placement of individuals with IDD, and to ensure they receive all necessary specialized services if they are admitted. To accomplish these goals, a PASRR program requires a two level PASRR process including a Level I identification function and a Level II evaluation function. Through a two level PASRR process, states are required to determine if placement in an alternative setting, including a community setting, like a Home and Community-Based Waiver program are more appropriate. 42 C.F.R. 483.132(a)(1)-(4). If so, states are expected to offer needed services in that setting.

The Level I component of the PASRR evaluation process is simply for the purpose of identifying the suspicion of ID or DD. States must perform an initial screen of people seeking admission to a nursing facility that are suspected of having an IDD. Referral sources must complete a Level I form for any person suspected of having IDD to identify the need for a Level II PASRR evaluation. This is termed the PASRR Level I or, as termed in Texas, the "PL1." Confirmation or disproof of IDD occurs at a later point in the PASRR process.

The Level II component (PE) of the PASRR process is an evaluation for the purpose of determining whether nursing facility level of services and specialized services are needed, determining the appropriate placement, and informing an individual's plan of care. These determinations must be made based on an analysis of data concerning the individual's strengths and needs, as described in Sections 483.130, 483.132, and 483.136.

Section 483.136 details the 15 data points related to habilitative need areas that must be assessed to determine if specialized services are needed, and include information concerning medical, nursing, cognitive, communication, physical, behavioral, vocational, educational, and decision-making issues, and the level of impact any identified needs have on the individual's independent functioning.

Section 483.132 details the process for evaluating the need for nursing facility level of services. It requires a determination for each applicant to a nursing facility of whether the person's total needs are such that they can be met in an appropriate community setting. At a minimum, determinations must derive from data obtained from evaluations of physical status, mental status, and functional assessment of activities of daily living. Based on this data, the state IDD authority must determine if nursing facility level of service is needed. If a PE determines that a person does not require nursing facility level of service, the person cannot be admitted. Alternatives to institutionalization must be arranged for those individuals. Even for individuals needing nursing or inpatient care, states are required to explore other alternatives that could more appropriately meet the individual's needs, including community-based waiver services. Medicaid guidance requires that individuals with IDD must be offered the most appropriate setting in which to receive services and should receive needed services in that setting.

.

PASRR regulations require that both the Level I screening and PE be performed prior to a nursing facility admission. The only exception – called an exempt admission – is when a person is admitted directly from an acute care hospital for convalescent care not to exceed 30 days, and requires NF services for the condition treated in the hospital. In these circumstances, a PE is not required unless the individual is later found to require more than 30 days of NF services. 42 C.F.R. 483.106(b)(2). In addition, in certain instances, states may elect to make PE advance group categorical determinations regarding the need nursing facility level of service and specialized services. 42 C.F.R. 483.130(c). This categorical PE determination – called expedited admissions – will result in an approval for nursing facility level of service for anyone within the category and specialized services recommendations may be made based on category. Examples of categorical PE determination may include convalescent care from an acute physical illness not otherwise meeting the criteria for exempt hospital discharge, terminal illness, severe physical illness, and other circumstances identified by the state such as emergency situations. As discussed below, Texas has elected to implement seven categorical determinations that result in expedited admission.

States are responsible for both levels of the PASRR process. If the PASRR function is subcontracted, the state retains ultimate control and responsibility of their performance of the PASRR obligation, ensuring that the determination for the need for nursing facility level of service, the appropriateness of alternative placement, and the determination of specialized services are based on a consistent analysis of the data. 42 C.F.R. 483.106(e)(1)(ii) and (iii).

2. Diverting Admission from a Nursing Facility

An effective PASRR screening program will ensure that individuals presenting to a nursing facility have the opportunity to be diverted from this institutional setting if they could otherwise be served in the community.

States have long been on notice about the import of the Olmstead decision and the importance of diversion for individuals who qualify for nursing facility admission but can be served successfully in a community setting. In 2000, the Secretary of the U.S. Department of Health and Human Services, Donna Shalala, issued a letter to state governors affirming that no one should have to live in an institution if they can live in the community, and that states must ensure that people with disabilities receive services in the most integrated setting. Also in 2000, the Health Care Financing Administration (later Centers for Medicare and Medicaid Services or CMS) issued guidance urging states to increase access to community-based services and identifying key principles and practices important to this effort. The guidance urges states to: (1) evaluate whether existing assessment procedures are adequate to identify individuals at risk of placement in an unnecessarily restrictive setting; (2) ensure that individuals with disabilities benefit from assessments to determine how community living might be possible; and (3) provide the opportunity for informed choice during the process. It also notes that states should have a reliable understanding, based upon data, of the individuals with disabilities who are eligible for services in community-based setting in order to plan adequately to meet those needs.

The federal government views the PASRR requirements as an important tool for rebalancing service delivery away from nursing facilities and allowing people with disabilities to

be supported in their homes, in compliance with the Supreme Court's Olmstead decision and the Americans with Disabilities Act (ADA). PASRR requirements support the ongoing commitment to diversion of individuals from a nursing facility.

Central to the purpose of preventing inappropriate admissions to nursing facilities is the identification of an individual's needs prior to a nursing facility admission. This information is essential in order to arrange for the community-based services needed to support such an individual in the most integrated setting possible. A comprehensive assessment of need allows for arrangement of in-home supports and other community services enabling the individual to remain in the community and avoid institutionalization in a nursing facility. A robust PASRR process is key to an effective diversion program.

Successful diversion depends on an early awareness of the needs of individuals living in the community, the identification of people who are at risk of nursing facility admission, and the proactive initiation of supports and services for those individuals. State agencies should have an understanding of the common characteristics that place individuals at risk of admission, in order to plan for needed services and then ensure that these services are available to meet those needs in the community and avoid unnecessary institutionalization. In addition, they should have an understanding of the number of individuals who are eligible for, and do not oppose, services in the community in order to plan for the number of diversions and transitions that are feasible.

Continuous engagement and education with hospital social workers and discharge planners, nursing facility social workers, community physicians, elder service providers, residential and day providers, and community IDD service coordinators are critical to diversion efforts. Widespread education and messaging will ensure families and referral sources are well informed about the PASRR process and the availability of meaningful community supports and services, as an alternative to nursing facility admissions. It will allow them to envision the use of nursing facilities for brief admissions, primarily for rehabilitation purposes, in order to recover from an illness or other medical event, with the goal of returning home or to another, more integrated and less restrictive setting. This outreach and education effort also will aid in the early identification of individuals who are at risk of nursing facility admission.

Texas's own rules, policies, and quality assurance processes acknowledge the importance of identifying individuals at risk of nursing facility admission and arranging for alternatives before the individual ever enters a nursing facility, whenever possible. Texas Administrative Code requires that the PE process include gathering information and making the necessary evaluations to determine whether the resident is best served in a facility or community setting prior to admission.

When conducting a PE, the LIDDA must inform the individual referred for admission to a nursing facility, their family, and the legally authorized representative (LAR) of the community options, services, and supports for which the individual may be eligible. The LIDDA, under the direction of the Diversion Coordinator, must identify, arrange, and coordinate access to these services in order to avoid admission to a nursing facility, wherever possible and consistent with an individual's informed choice.

The HHSC Performance Contract with the LIDDAs specifies that each LIDDA is required to designate a staff as the "Diversion Coordinator" to assist individuals at risk of nursing facility admission to live successfully in the community and to avoid nursing facility admission. Diversion coordinators must be experienced with providing services to individuals with IDD in the community, and are required to provide assistance to service coordinators for individuals at risk for nursing facility admission. The Diversion Coordinator's duties include the identification of community living options, services, and supports needed to avoid admission; and education to service coordinators and other LIDDA staff about community services. Diversion Coordinators must also review admissions to ensure that community living options, services, and supports that could provide an alternative to the nursing facility placement have been explored.

HHSC further acknowledges the importance of educating, engaging, and coordinating with referral sources to avoid nursing facility admissions. The referring entity (RE) is the first entity that proposes nursing facility admission for an individual. An RE can include a hospital discharge planner, a nurse, a physician, a family member, law enforcement, or a provider. Texas Administrative Code instructs that when an individual is seeking admission to a nursing facility, the RE must complete a PL1 and share it with both the nursing facility and the LIDDA. This notifies the LIDDA that an individual suspected of having IDD is seeking admission to a nursing facility. As HHSC acknowledges, communication and collaboration between the RE, LIDDA, and nursing facility is "essential" in order for individuals to receive the most appropriate services.

Additionally, HHSC's Quality Service Reviews (QSRs) are intended to ensure that individuals with IDD are receiving the federally-required PASRR screening and evaluation; are receiving services in the most integrated residential settings consistent with their choice; and, if residing in a nursing facility, are provided the services, including specialized services, needed to maintain their level of functioning and increase their independence. The QSR reviews include an evaluation of a sample of people from three key groups: individuals diverted from nursing facility admission, current nursing facility residents, and persons who have transitioned to the community. They evaluate the state's performance on seven key outcomes.

QSR outcome measures adopted by HHSC acknowledge the importance of certain diversion practices, including proper evaluation and confirmation of whether an individual has IDD; an appropriate assessment of whether the needs of the individual can be met in the community; an accurate identification of the specialized services the person needs if he or she is admitted to a nursing facility; and the identification and provision of all supports and services needed to avoid nursing facility placement. These measures reflect the requirement that the individual and LAR must be informed about community options that will meet the individual's needs, and that individuals who need specialized services should only be admitted to a nursing facility where the individual's needs can be met.

B. Assessment for and Provision of Specialized Services and Active Treatment

PASRR regulations identify minimum data needs that are required on the Level II PASRR evaluation for a determination of the need for specialized services. Fifteen data points

related to areas of need are required elements within a Level II PASRR evaluation tool, which, along with subsequent in depth comprehensive functional assessments, will direct the delivery of specific services required to meet the fully assessed areas of need. The Level II PASRR evaluation, while less in-depth than a Comprehensive Functional Assessment, is to include a review of the individual's clinical and service history (including prior IDD services and programs); a consideration of all medical, nursing, and service records; interviews with the individual, LAR if any, relevant professionals, and family members; and a careful consideration of the individual's habilitation needs. For each identified need, the Level II PASRR evaluator, who must be a qualified IDD professional, should indicate on the evaluation form if specialized services would be beneficial, or if a further, in-depth assessment would be helpful. 42 C.F.R. Sec. 483.136.

Nursing facilities services that are available to all residents typically include physical therapy, occupational therapy, and speech therapy designed to *rehabilitate* conditions and restore an individual's functioning to a level prior to an injury, for example from a fall. These rehabilitative services are included in the nursing facility's daily rate. People with IDD often require physical therapy, speech therapy, and occupational therapy, for another, *habilitative* purpose: to maintain existing functioning or to learn new skills. The latter is a basic element of PASRR, which requires such specialized services that are not part of the nursing facility's regular service array for all residents and not part of the facility's daily rate but instead are reimbursed separately by the state.

Specialized services are not intended to be a collection of services or simply a determination on a Level II PASRR evaluation, but rather a program of Active Treatment and a process that is directed toward the acquisition of skills and behaviors necessary for the person to function with as much self determination and independence as possible. Specialized services are defined by 42 C.F.R. Sec. 483.120(a)(2) as services specified by the state which, combined with services provided by the nursing facility and other services from other service providers, result in a continuous and aggressive plan of care that meets the requirement for Active Treatment.

Active Treatment is defined in Section 483.440 as "a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services . . . that is directed toward (i) The acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status."

But Active Treatment is not only a definition. It is also a process and, more importantly, a federal standard of care for individuals with IDD. That process and standard is described in Section 483.440(b)-(f). All of these requirements must be met in order for the individual to receive a program of Active Treatment. Federal requirements for Active Treatment include an integrated process of planning, documentation, team participation, goals, objectives and timelines, as well as continuous monitoring and revision as indicated through the delivery of services.

As noted, the requirements for a program of Active Treatment are specific and detailed through federal regulation. Fundamental to a program of Active Treatment is comprehensive functional assessment of all need areas, which must be performed within 30 days of admission as a supplement to the Level II PASRR evaluation. A compressive functional assessment will clarify specific skill need areas around which service planning must be developed in order to retain or prevent loss of skill. These assessments must be done by qualified professionals and then used by an interdisciplinary team to determine the exact type, frequency, intensity, and duration of services to focus on areas of skills needed.

Also within 30 days of admission, the service planning team is required to develop an individualized plan based on the comprehensive functional assessment. The plan must include overall goals focused on the person's identified needs and must be directed towards self-determination and independence. Goals must then have specific objectives which are incremental steps towards meeting the needs identified on the comprehensive functional assessment and which are written clearly. Each objective should have a single outcome and be written in measurable terms. The team must develop a detailed service plan that includes goals, timetables, providers, and the amount, intensity, and durations of specialized services.

In implementing these objectives, PASRR regulations require that the State must provide or arrange for the provision of a program of specialized services to all nursing facility residents with IDD whose needs are such that continuous supervision, treatment, and training by a qualified intellectual disability professional is necessary. Services are determined, arranged, and provided for the purpose of meeting objectives, rather than providing a service to fulfill a requirement. Active Treatment standards require that an identified program of services must be provided and that there is ongoing documentation, coordination and monitoring of the service delivery. 42 C.F.R. Sec. 483.120(b).

All team members are responsible for the implementation of the individualized service plan or ISP. Implementation strategies or approaches should be developed in order for all staff in the nursing facility or other specialized service provider, such as a day habilitation agency, to work together to ensure that the objectives are being addressed and reinforced in both settings, and then "carried over" at naturally occurring points throughout the person's day. All staff must be trained in methods of implementation and consistency of approach. Data should be collected regarding the individual's response to meeting the objectives, in order to measure progress and revise strategies when progress is not attained.

A qualified IDD professional must coordinate and monitor the delivery of services and implementation of the ISP. The IDD professional is responsible for ensuring that required services are provided, as well as for the overall coordination of the service plan, reviews, modifications and updates as needed. Active Treatment standards require that identified services must be provided and that there is ongoing coordination and monitoring of nursing facility and other providers to ensure that, together, they deliver a consistent and continuous program of Active Treatment.

CMS provides guidelines for states regarding the survey method for determining the quality of service delivery and individualized treatment planning of an intensity and frequency to constitute a program of Active Treatment. CMS requires a comprehensive and professionally

accepted survey process consisting of interviews of the person, legally authorized representative, nursing facility team members, provider team members, observation, and documentation review to assess the process.

The survey process is based upon a detailed list of indicators, referred to as " tags," which relate to many aspects of service delivery and individualized treatment planning, each with specific questions, or probes, for the surveyors to collect the relevant information needed to determine if a particular tag is met. Although many tags are related to service delivery and treatment planning, specific tags such as W-195 and W-196, which directly relate to the Active Treatment regulation, must be met in order to conclude that Active Treatment is being provided. Guidance regarding whether Active Treatment is "Met" is clearly specified within these tags. Active Treatment is considered met when individuals have developed increased skills in independence and functional life areas or have maintained functioning to the maximum extent possible, and have received continuous and competent training, supervision and support to promote skills and independence and to function on a daily basis.

In Massachusetts, based upon recommendations from a federal court monitor, as well as the parties, a federal court issued a Revised Active Treatment Standard to ensure that Active Treatment was provided to class members residing in nursing facilities. Utilizing federal CMS Active Treatment guidelines and in partnership with the Department of Public Health, annual nursing facility licensure process, a comprehensive Active Treatment survey protocol and review process was established to determine whether Active Treatment is being provided to residents of nursing facilities. This survey protocol includes a number of important indicators, but also requires that the tag W-196 is met, in order to conclude that Active Treatment is being provided. The Active Treatment survey process is conducted by the Department of Public Health and Department of Developmental Services Quality Enhancement team members during an unannounced onsite nursing facility visit. Failure to comply with Active Treatment standards results in citations requiring a plan of correction and re-review. Fines and sanctions for nursing facilities may apply and Day Habilitation settings may risk further reimbursement if the conditions of Active Treatment are not met. In my role as the Massachusetts Director of PASRR, I review Active Treatment survey results and plans of correction to ensure that the Active Treatment standard is met.

The State of Texas identifies in the Texas Administrative Code the responsibilities of the LIDDAs for monitoring the delivery of specialized services through their service coordination program. Service Coordinators are required to organize and lead service planning teams and to develop ISPs that include all professionally-appropriate assessments, identify all habilitative need areas, list goals and timelines for addressing these need areas, describe specialized services that will be provided to meet all identified need areas, identify the providers responsible for offering these services, and incorporate transition plans for people who would benefit from placement in the community. The LIDDA service coordinators are required to monitor the plan and ensure that all needed specialized services are provided in a timely and consistent manner. 40 T.A.C. Sec. 17.101 *et seq.*

Categories of specialized services identified by the State of Texas include certain therapies and medical equipment that are provided onsite in nursing facility settings and certain

community services provided by or through the LIDDAs and generally outside of the facility. For specialized services provided by the nursing facilities, the nursing facility bills the state and is paid an additional rate, after approval by the State. Specialized services categories provided by the LIDDA for people with IDD in nursing facilities include service coordination and transition assistance, day habilitation, independent living skills training, employment assistance, supported employment, and behavior support.

The LIDDA Performance Contract and HHSC policies and procedures establish the state standards for specialized services, and require LIDDA coordination, monitoring and oversight of specialized services delivery. Existing rules, policies, and quality assurance processes confirm the importance of many essential practices related to specialized services delivery, including a PE that appropriately assesses an individual's specialized services needs; the development of an ISP based on assessments of a person's needs, and the provision of needed and recommended services and supports. HHSC recognizes that the ISP must be individualized and developed using a person-centered process; identify the individual's needs, preferences, strengths, and desired outcomes; and identify the amount, intensity, and frequency of each specialized service. HHSC further recognizes that the ISP, including specialized services, must be integrated into the nursing facility's plan of care, monitored in a consistent manner, and provided in the frequency, intensity, and duration specified in the ISP.

Texas is required to provide Active Treatment in its ICF-ID system, subject to survey and plans of correction. In 2013, the state issued a provider letter containing Frequently Asked Questions including the provision of Active Treatment to people living in ICF-IDs. In October of 2016 the state provided a web based training on "10 Most Frequently Cited Deficiencies in Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions FY 2015" in which the state outlined the principles, requirements, and expectations of a program of Active Treatment for people in ICF-IDs. The purpose, expectations, and specific elements of Active treatment are well established in Texas. However, despite PASRR regulations, HHSC does not even mention the concept of Active Treatment for individuals with IDD in nursing facilities in any of the state's nursing facility rules, policies, procedures, bulletins, or trainings. Nor does it require the provision of specialized services in the frequency, intensity, and duration to constitute a program of Active Treatment in nursing facilities. There is not even the suggestion in Texas policies, guidance or the LIDDA contracts that HHSC expects an aggressive, consistent implementation of a program of training, treatment, and health services directed towards the acquisition of skills and behaviors promoting independence and self determination, and to prevent a loss or deceleration of skills.

C. Informed and Meaningful Choice

People with IDD and their LAR must be provided a full range of information, opportunities, and experiences regarding appropriate community supports and services as an alternative to nursing facility placement. Individuals seeking nursing facility placement must be advised in detail of alternative community supports to make an informed and meaningful choice about whether to avoid institutionalization in a nursing facility.

Individuals with IDD may require additional time and support to understand how community supports and services would apply to them. Multiple methods of communication, extended time for processing information, repetition, and strategies for addressing fears and anxieties are necessary to ensure individuals with IDD truly understand their options. There must be detailed information and options based upon the individual's preferences, daily routines, familiar schedules, life goals, families and friends, and desired activities in an alternative community setting in order to ensure that all service delivery options are fully understood and made available.

First, detailed and individualized information regarding community services and how health and long term services needs may be met must be incorporated into a frequently reviewed ISP, which should, in most cases, include a transition plan. The ISP and transition plan must take into account language, learning style, cultural sensitivities, and actual opportunities to explore new experiences in the community. Individuals with IDD must be provided with detailed information about their options in order to make a meaningful, informed choice between institutional and community based services. This should include a discussion of feasible alternatives to nursing facility placement that is tailored to the individual, based on an assessment of the person's needs. Typically, the most effective way for an individual with IDD to gain and understand information about community options is to experience that option in some concrete way. Visits and discussions with peers, especially friends, who are living in the community, are also effective.

A comprehensive community assessment process should be used to identify the concrete services that the individual needs and prefers, as well as potential individualized barriers to transition. Alternative services based on assessed need must be presented in a manner that is clear and understandable. Opportunities to observe and experience least restrictive, community integrated alternatives must be provided in order for the individual to appreciate the relative advantages, benefits, and expanded opportunities attendant to community living.

Specialized services are one important strategy for promoting informed choice for individuals in nursing facilities. Ongoing opportunities for community exposure and participation in integrated activities are important for individuals to not only achieve their goals and maximize their potential, but to envision and understand what community opportunities have to offer. Other methods for promoting community participation, engaging in community activities, or simply experiencing time outside of a facility should be encouraged and facilitated.

Texas acknowledges the importance of informed decision-making in its rules, policies, and quality assurance processes. HHSC's Performance Contract with the LIDDAs requires that the service coordinator provide information developed by the state about community living options to residents of nursing facilities and their legally authorized representative at the first interdisciplinary team meeting, and at least every six months thereafter. For individuals refusing service coordination, the service coordinator is required to provide the same information at the initial meeting with the individual and legally authorized representative, and then annually thereafter. Service coordinators are required to arrange for tours of community programs, as appropriate, to address concerns about community living with the service planning team, and

provide semi-annual informational and educational opportunities to nursing facility residents and the legally authorized representatives.

HHSC identifies peer-to-peer and family-to-family programs, tours of community services and supports, and the opportunity to meet with other individuals living and working in the community and their families, as well as with community providers, as potential educational and informational activities, demonstrating an understanding of the value of such programs.

In addition, HHSC forms and instructions reflect the importance of identifying and resolving concerns and barriers to community living. HHSC forms such as the PE, the CLO (Form 1039) and the ISP (Form 1041) require this documentation. The PE form, Section F includes item F0200A, requires the reviewer to ensure that community supports and services which could avoid nursing facility admission have been offered. The CLO form requires documentation of any issues, concerns, and questions raised by either the individual or the LAR, documentation of how these issues, concerns, or questions were addressed, and documentation of how barriers to community living could be eliminated. The ISP requires ongoing documentation in Section 9, Phase I of the date of which community living options were presented and the outcome of the presentation. If remain in NF is checked, barriers to community living and problem solving regarding the barriers and efforts to resolve barriers must be documented.

QSR Outcome Measures reflect many of the same important principles regarding informed decision-making. Measures address whether individuals seeking admission to a nursing facility are informed of community options that meet the individual's needs, and whether those who wish to remain living in the community receive supports consistent with their individual choice. Other Outcome Measures assess whether semi-annual discussions about community options have occurred, as well as whether the Community Living Options process presents a range of community alternatives, facilitates visits to community programs, and addresses concerns about community living to "better enable individuals to make an informed decision." Outcome Measures also assess whether information is provided by people knowledgeable about community supports and services; whether the benefits of community living are explained, and whether concerns about community living have been addressed in order to help individuals make informed choices about whether to move.

D. Transition from Nursing Facility Institutional Setting

Effective transition from nursing facilities requires ongoing evaluation of need for nursing facility level of service, assessment of community support needs, identification of services to meet those needs, a continuous service and transition planning process, repeated exposure to community opportunities that are meaningful to the individual, continuous transitional support, and eventual move to the community. Transition from a nursing facility with appropriate community supports is possible for most people with IDD regardless of age, medical condition, or length of institutionalization.

Federal PASRR regulations require some of the practices necessary for effective transition planning. Assessment of need is fundamental to the determination of appropriate alternative placement and long term supports and services. Resident review processes involve an

ongoing evaluation to ensure that people with IDD continue to need nursing facility placement according to data obtained from an evaluation of physical health, mental health, and functional assessment. A resident review process may determine whether the person's total needs are such that they can be met in an appropriate community setting. Individuals with low or no need may be determined not to need a nursing facility level of service.

In addition, a systemic commitment to transition, with transition service planning beginning at admission, is critical to community integration. Early service planning with a goal of a prompt return to existing community supports and services or the arrangement of new or additional supports and services effectively prevents long-term institutionalization and retains relationships with service providers, family members, and important community connections.

A successful transition process is facilitated by consistent and trusted service coordinators, transition coordinators, or specialized service providers such as independent living skills trainers that are providing continuous, personalized, and meaningful community opportunities in accordance with a person's assessed needs and life vision, as incorporated in a person-centered ISP. Meaningful opportunities are provided at a pace that allows for a period of adjustment to the community. Repeated community experiences reflective of assessed needs and a personal vision which also take into account the importance of personal routines, personal interests, cultural, religious, or spiritual needs, preferred leisure activities, preferred foods, and other core needs mitigate fears and apprehensions for people with lengthy nursing facility institution stays. Proactive arrangement of supports and services as a result of assessed need provides a greater opportunity for long term success in the community.

Again, Texas's rules and policies confirm the importance of many of these principles. In apparent recognition of the value in early transition planning, HHSC's Performance Contract with the LIDDAs requires that Diversion Coordinators review the individual's admission within 45-75 calendar days to ensure that all community supports and services that may otherwise provide an alternative to nursing facility placement have been explored. Diversion Coordinators must refer the individual back to their service coordinator if these supports and services have not been adequately explored.

Texas Administrative Code Section 17.503 addresses transition planning for nursing facility residents determined to have IDD through PASRR. The Texas Administrative Code requires a transition plan that details the services, responsibilities, timeframes, and other actions that are necessary to support a person's choice of provider and move to the community. A transition plan must be developed if Section Q of the Minimum Data Set (MDS) indicates an interest in moving from a nursing facility, if the PE determination is that the individual's needs can be met in an appropriate community setting, or after an expressed interest in transition.

Texas Administrative Code 17.503(2)(g) further details that if the planning team recommends continued placement in a nursing facility, that team must document the reason for the recommendation for continued institutionalization, identify barriers to moving to a more integrated setting, and describe in the ISP the steps that the team will take towards addressing these barriers.

Instructions for HHSC's ISP form, which governs the documentation of the transition process for the service planning team (SPT), require that a transition plan is developed and implemented, and then reviewed at least quarterly with more frequent updates as needed. The transition plan is in Section 9 of the ISP form (Form 1041). Earlier sections of the same document relate to the service and support planning that is integral to transition, reflecting an acknowledgment of the important connection between ongoing assessments, service planning, and service delivery to successful transition.

HHSC's QSR measures also confirm the connection between these foundational practices and transition planning, since QSR Outcome Measures related to transition address the PASRR Level II, and the assessment for and provision of specialized services. Among other things, QSR transition measures include: (1) a PASRR Level II evaluation that appropriately assesses whether the needs of the individual can be met in the community, and identifies specialized services needs; (2) quarterly revisions of the ISP and assessment of the adequacy of the services and supports provided; and (3) a person-centered ISP process that is based on appropriate assessments, identifies the individual's needs, preferences, strengths, and goals, and develops annual objectives to assist in achieving these goals.

HHSC's transition planning is segmented into three Phases in Section 9. Phase I of the transition plan is developed at the initial meeting of the SPT, and is updated quarterly thereafter. It documents that the individual received information of community living options (CLO) and indicated a preference to remain in the nursing facility. If so, barriers that prevent community living, and possible resolutions to barriers must also be documented.

Phase II of the ISP transition plan is titled "Identifying the Individual's Needs for Community Living" and forms a framework for transition planning through the identification of some of the supports and services that will be needed. The ISP instruction requires identification of the supports needed, the waiver program that will be used, and the plan for arranging interviews and/or visits with potential providers. This is the critical opportunity for presenting a concrete description of what the community might look like for that individual, including where he or she might live, with whom she might share a home, what he or she might do during the day, and what community opportunities and activities he or she might enjoy.

Effective transition planning will address this information for all individuals. As HHSC officials such as Deputy Associate Commissioner of IDD Services, Ms. Turner, recognize, completing Phase II of the ISP and developing a real transition plan can help individuals understand what life in the community would be like, thus serving as an important tool for ensuring informed choice. The form and instructions do not provide clear guidance about when Phase II must be completed, but indicate that these phases are not completed all at once. Rather, phases are completed "as the SPT progresses through the phases of the transition plan," and the SPT will proceed to Phase II when "pursue community living" in Phase I is checked.

Phase III of the ISP transition plan contains many elements required for an impending discharge from the nursing facility to the community. Phase III is titled "Transitioning from Nursing Facility" and contains specific detail of services and supports needed, the name and location of providers who will offer these services, and arrangements that must be made prior to

a projected move date. The ISP Instruction requires that all essential supports must be in place prior to the move date. Essential services must be separately detailed along with any comments. Phase III also requires the identification of staff training needs prior to discharge. Detail regarding specific items that are required, adaptive or medical equipment, nutritional supplements, medications and their dosages must all be documented.

V. FINDINGS OF THE SYSTEM REVIEW

A. Texas does not ensure that people are appropriately identified and diverted prior to nursing facility admission

HHSC defines diversion as preventing admission to an institutional setting such as a nursing facility. To be considered a diversion, the individual must be identified, evaluated, and diverted before admission ever occurs.

The PE is essential to diversion, both to identify an individual's service needs, and as a means for ensuring community living options are explained, identified, and made available prior to admission. A diversion plan is not prepared until the PE is completed. In addition, the PE is a prerequisite to qualifying for a diversion waiver slot, which is how many individuals secure the community-based services needed to avoid admission. As the state explains in its PASRR 101 training: "If an individual diagnosed with MI, ID, or DD elects community placement instead of NF placement, a waiver slot will be used." Each waiver slot allows one individual to receive community-based services funded by the program. Nursing facility diversion slots are reserved for individuals at imminent risk of nursing facility admission. Eligibility for a diversion slot also requires confirmation on the PE that the individual is positive for IDD and appropriate for community placement.

Despite the importance of completing a PE before admission in facilitating diversion for the PASRR population, Texas has elected to implement seven categorical determinations, under which nursing facility level of service may be approved.[2] These categories allow for "expedited admission" and postpone the completion of the PE until after admission. Expedited admissions account for approximately 90% of all PASRR admissions in Texas. Thus, as a result of HHSC planning and design of its PASRR program, almost all admissions bypass the diversion process. In addition, exempted hospital discharges – under which a PE is not required unless the nursing facility stay exceeds 30 days – account for another 7% of admissions. As a result, the majority of people with IDD entering Texas nursing facilities never have an opportunity for diversion.

[2] (1) Convalescent care from an acute physical illness which required hospitalization and does not meet the criteria for an exempted hospital discharge; (2) Terminal illness; (3) Severe physical illness resulting in ventilator dependence diagnosis such as chronic obstructive pulmonary disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis, congestive heart failure which result in a level of impairment so severe that the individual could not be expected to benefit from specialized services; (4) Provisional admission pending further assessment in case of delirium where an accurate diagnosis cannot be made until the delirium clears; (5) Provisional admission pending further assessment in emergency situations requiring protective services, with placement in nursing facility not to exceed 7 days; (6) Very brief and finite stays of up to a fixed number of days to provide respite to in home caregivers to whom the individual is expected to return; and (7) Coma or functioning at a brain stem level.

By comparison, in Massachusetts, a PASRR categorical determination for nursing facility level service is not used. In Massachusetts, level II PASRRs are conducted prior to admission for all people seeking admission to a nursing facility unless they have an exempted hospital discharge. PASRR evaluation prior to admission has allowed for ongoing community support and reduction in the overall nursing facility census. As a result, Massachusetts successfully diverts potential admissions, primarily because it has designed and implemented a PASRR evaluation process that can intercede before, rather than after, an individual with IDD is admitted to a nursing facility.

Not surprisingly, HHSC data shows that the number of diversions, while increasing, remains low. Enrollment Status Reports show that in the last four fiscal years combined, September 2013 to August 31, 2017, 522 individuals were successfully diverted from nursing facility admission and enrolled in HCS waiver slots. 382 individuals were diverted in the Fiscal Year 2016-2017 biennium, compared to 140 individuals in the previous biennium. By way of comparison, data reported by the LIDDAs illustrates that these numbers account for a small portion of the individuals seeking admission. LIDDAs reported that in the first three quarters of Fiscal Year 2017, over 300 individuals with IDD entered nursing facilities each quarter, which would result in approximately 1200 admissions per year, compared to less than 200 diversions per year in the last biennium. The total number of individuals with IDD in nursing facilities is over 3,000.

An analysis of the underlying individualized data in HHSC management reports shows that individuals wait on average 114 days, or almost four months, between the date a diversion slot is released and the date of enrollment -- when the waiver services needed to divert admission begin. For a population that, by definition, is at imminent risk of admission, this delay can make diversion from nursing facilities impossible. Moreover, an analysis of this data by LIDDA reveals that almost 40 percent of the 522 diversions over the past four years were accomplished by three of the 39 LIDDAs: Austin-Travis County (79), Harris County (59), and Tarrant County (63). By contrast, 6 LIDDAs completed zero diversions in all of Fiscal Year 2016-2017, and an additional 14 completed fewer than five diversions. Population differences do not sufficiently explain these discrepancies. For example, Alamo Local Authority reported a higher number of admissions and a higher total population than Austin-Travis County, yet far fewer diversions.

As HHSC's Associate Commissioner of Behavioral Health and IDD Services Sonja Gaines acknowledges, a LIDDA's failure to accomplish diversions should prompt an evaluation by HHSC, which retains responsibility for ensuring that people with IDD have the opportunity to divert from admission to nursing facilities. Similarly, such inconsistent performance among the LIDDAs presents an opportunity to evaluate and address barriers to diversion, and to replicate successful strategies statewide. However, I have seen no indication that this analysis is done, that these evaluations occur, that performance improvement initiatives are required, that enforcement actions are taken, or that successful strategies are shared.

HHSC's primary methods for monitoring LIDDA performance are the IDD Services Unit's oversight of the LIDDA contract compliance, and the Quality Service Reviews. Within the IDD Services Unit, the Contract Accountability and Oversight office (CAO) is largely responsible for reviewing and ensuring compliance with the LIDDAs' contract. CAO conducts

annual reviews of LIDDAs by reviewing the cases of about three to five individuals per LIDDA. The tool used for these reviews includes a section related to diversion practice, but if a LIDDA did not divert any individuals during the review period, this portion of the review is deemed inapplicable and there is no assessment of the LIDDA's diversion practices. This is problematic, because HHSC fails to identify poor performance or assess the reasons for poor diversion performance. The CAO unit does not consider the LIDDA quarterly reports, which allow for LIDDA comparison and reflect the small numbers of diversion by LIDDA. These reports are not consistently used by HHSC managers. The reports also identify barriers to diversion, but this information is not aggregated, or even reviewed by the Unit to identify patterns and trends. In this way, HHSC fails to evaluate or remedy clear indications that diversion is not happening as required.

In addition, HHSC has failed to adequately train LIDDA staff. LIDDA training materials related to diversion focus almost exclusively on the process for requesting an HCS diversion slot. State trainers did not know of any training provided to LIDDA staff about how to determine whether an individual can be successfully diverted from a nursing facility, and did not know whether LIDDA staff are consistently trained on how to develop a diversion plan. HHSC has acknowledged that training on diversion planning is needed. In my experience, training is a foundational piece of a PASRR program, and is necessary so that individuals can avoid nursing facility placement when appropriate.

Further, HHSC does not engage community referral sources in the diversion process, which, given its expansive use of categorical expedited admissions to avoid the diversion process altogether, is the only realistic opportunity to prevent unnecessary nursing facility admissions. HHSC does not appear to ensure the ongoing education and competency of community support members – such as hospital social workers and discharge planners, nursing facility social workers, community physicians, elder service providers, residential and day providers, and community IDD service coordinators – regarding available and meaningful community in home supports and services as an alternative to nursing facility institutional admission. While HHSC recognized the need to increase these efforts and launched a training initiative for referring entities, this did not even begin until June of 2017. The training itself explains the PASRR process at a very basic level, barely touches on diversion, and does not adequately explain community alternatives in a way that will educate these entities on the importance of accessing community supports in order to prevent unnecessary institutionalization. There has been no effort on the part of HHSC to evaluate the effectiveness of this limited effort.

HHSC reports also indicate that people with IDD are being admitted to nursing facilities without the required certification by the nursing facilities that the specific needs of the individuals with IDD may be met in the nursing facilities. In Texas, HHSC reassigns this certification to the nursing facility, in effect asking the facility to confirm that it can meet the needs of its own residents. The determination of whether or not the nursing facility can meet the person's specialized needs is a substantive determination required to prevent admissions where needed specialized services will not be available. Notwithstanding this important substantive purpose, nursing facilities routinely fail to determine and certify that they can provide all needed specialized services. A recent report shows that for the period from June 2016 to March 2017,

715 individuals were admitted to nursing facilities without a certification by the nursing facility that it could meet the individual's needs.

Because HHSC managers failed to provide the QSR independent reviewer, Kathryn DuPree, with several necessary state reports, even after requesting two extensions, first until May 2017, then until August 2017, Ms. DuPree has been unable to finalize the 2016 QSR report, as expected. Nevertheless, data collected from reviews of each individual in the QSR sample is available for the last three years, and it reflects these failures in HHSC's diversion process. Outcome Measure 1-3 measures whether the Level II Evaluation confirms IDD, appropriately assesses whether the needs of the individual can be met in the community and accurately identifies, based on the information available, the specialized services the person needs if he or she is admitted to a nursing facility. Performance on this measure declined from 41% in 2015 to 29% in 2016 and 32% in 2017. Outcome Measure 1-9 assesses whether, for individuals with IDD who are living in the community and can be diverted from nursing facility admission, the service coordinator or other LIDDA staff "identify, arrange and coordinate all community options, services, and supports for which the individual may be eligible and that are necessary to enable the individual to remain in the community and avoid admission to a nursing facility. Services and supports will be consistent with an individual's or LAR's informed choice." Performance on this measure declined from 56% in 2015 to 33% in both 2016 and 2017.

Outcome Measure 2-13 seeks to confirm that individuals who need specialized services are only admitted to a nursing facility if the needs for specialized services can be met by the nursing facility, LIDDA, or both. Performance on this measure dramatically declined from 75% in 2015 to 39% in 2016 and to 33% in 2017. Despite the regulatory requirements and apparent regulatory violations, Deputy Associate Commissioner of IDD Services Haley Turner could not recall whether HHSC had taken any action to address this drop. Further, key IDD Services managers such as Mr. Jalomo and Ms. Gaines have little awareness of the State's performance on these measures or any action steps taken in response, revealing a disturbing lack of understanding or interest in key system deficiencies.

The key managers responsible for IDD services and LIDDA oversight are unaware of any HHSC analysis or projections about the number of diversion slots they expect individuals will need in future fiscal years. In addition, they could not recall any analysis of information that might inform such planning and improvement efforts, such as an assessment of the sources and reasons for admission, successful and unsuccessful strategies to avoid admission, the characteristics that place people at risk of admission, or an assessment of the referring entities that generate the most number of admission.

Such analysis would have supported HHSC's appropriation request for additional diversion waiver slots needed to support the needs of this population, a critical component of its Promoting Independence Plan. According to the Plan, the state's approach to supporting individuals to remain in the community and avoid institutional placement is through legislatively approved diversion slots in the Home and Community Based Services ("HCS") program.

HHSC initially represented to the Legislature that 600 diversion slots were needed for the upcoming biennium. In my opinion, this seems reasonable in light of the increased utilization

from FY14-15 to FY16-17, and HHSC's hope that diversions will continue to increase, although it is not clear HHSC considered the upward trend in order to project expected need. This initial request was undercut by subsequent communications by HHSC to the Legislature, appearing to indicate that fewer diversion slots would suffice. The reduced request was not supported by any careful analysis as noted above. Available documentation of the information communicated to the Legislature does not mention any hope or expectation that diversions will increase over time.

Unfortunately, the Legislature responded by appropriating money for only 150 diversion slots for the Fiscal Year 2018-19 biennium, raising significant concerns about the state's ability to support individuals who wish to remain in the community. In fact, because some diversions were in process but had not been completed at the end of FY 2017, there are just 79 diversion waiver slots available for the entire FY 2018-19 biennium.

HHSC has acknowledged the risk that slots will not be available to meet the need for people with IDD who want to be diverted or transitioned from nursing facilities, including the risk that so-called "attrition" slots will not be available in sufficient quantities to accommodate the PASRR population, in light of the reduced appropriation.

B. HHSC's PASRR evaluation process is not designed to ensure that habilitative needs of people with IDD in nursing facilities are identified and assessed.

PASRR regulations include minimum data and process requirements for determining the continuous program of specialized services that is required for individuals with IDD in nursing facilities. There are fifteen data points that must be reviewed and then assessed in order to determine the required continuous program of specialized services.

First, the fifteen habilitative data points or need areas must be identified in the PASRR evaluation process. This identification includes the individual's clinical and service history (including prior IDD services and programs); a consideration of all medical, nursing, and service records; interviews with the individual, LAR if any, relevant professionals, and family members; and a careful consideration of the individual's habilitation needs.

If the individual is admitted to the nursing facility, the individual must receive a comprehensive functional assessment of all habilitative need areas as a basis for planning and delivering specialized services. All habilitative areas must be assessed following admission, in order to determine specific need areas and to determine the range of specialized services required to address identified needs. These assessments must be done by qualified professionals and then used by an interdisciplinary team to determine the exact type, amount, intensity, and durations of specialized services. The team must develop a detailed service plan that includes goals, timetables, providers, and the amount, intensity, and durations of specialized services. A qualified IDD professional must coordinate and monitor these services, modify the plan as needed, review and update it annually, and ensure that all identified services are actually provided. 42 C.F.R. Secs. 483.120 and 483.440.

Comprehensive functional assessments, whether pursuant to one instrument or multiple ones implemented contemporaneously, provide the foundational elements to service planning

and delivery by establishing baseline functioning and the identification of skill need areas. A comprehensive functional assessment must identify the presenting problems and disabilities and their causes, developmental strengths, developmental and behavioral management needs, and the identification of need for services without regard to the availability of services. For individuals with IDD in nursing facilities, appropriate assessments will include the following need areas, if identified: physical development and health, nutritional status, sensorimotor development, affective development, speech and language development, auditory functioning, cognitive development, social development, adaptive behaviors or independent living skills necessary to be able to function in the community, and as applicable, vocational skills. This is necessary to determine the supports and services that will focus on the identified needs and is particularly critical for people with IDD in NFs who are unable for a variety of reasons to assess their own needs.

But in HHSC's PASRR process, the PE, which includes some but not all required habilitative need areas, is the primary tool for determining which specialized services will be recommended. Section B of the PE, which HHSC uses to determine specialized services, identifies only some of the federally required areas for specialized services, and specifically omits key areas like self-monitoring of health status, inappropriate behaviors, and the impact of medical problems on the individual's independent functioning. Further, the PE does not amount to an assessment of any of the need areas. For LIDDA specialized services, when assessments are conducted, HHSC has indicated that they are conducted *after* a specialized service has been identified, rather than as the vehicle for determining *if* a specialized service is appropriate. HHSC's PASRR process is backwards, inconsistent with accepted standards of practice, and not compliant with federal law. Without a comprehensive assessment of habilitative need areas as the foundation for specialized services, there is high likelihood that needed services will be missed, and virtually no likelihood that Active Treatment will be provided.

HHSC acknowledges that when the PE indicates a habilitative need, assessments should be conducted to determine the intensity, frequency and duration of services to address that need. However, standardized assessments for this purpose have not been required in Texas's PASRR program. There is no standardized or assessment to determine if the individual would benefit from key LIDDA specialized services, which partly explains the very low utilization of these services, as discussed below.

HHSC's PE form and process do not meet the federal PASRR requirement that all habilitative need areas are adequately and comprehensively assessed. And even when specialized services are agreed to at the IDT or SPT, limited assessments are conducted, they are not comprehensive and they are not required. In addition, unless the entire IDT agrees on certain specialized services, they may not be recommended, notwithstanding observed or identified need. Contrary to statements from HHSC staff, specialized services recommendations should be based on assessments, not solely the PASRR evaluator's opinion.

HHSC has acknowledged that a comprehensive functional assessment is important to inform the service planning process in its PASRR program, and has retained the University of Massachusetts to evaluate and provide feedback on various assessment tools that HHSC might

implement. HHSC has not adopted any of its consultants' recommendations nor operationalized any other comprehensive assessment process.

There is a MDS assessment tool that is also used for all individuals in nursing facilities. But this not a comprehensive functional assessment tailored to or focused on people with IDD and their unique conditions. Rather, it is a point-in-time reflection of standardized data collected for all people who enter a Medicare or Medicaid-certified nursing facility. The MDS tool generates information for the purposes of generalized quality assurance, the determination of resource utilization groups and level of acuity for the purpose of billing, and to identify medical and functional problems for all individuals in the nursing facility general population. The MDS has specific definitions and coding categories which creates a standard data set across all nursing facilities, but has no particular relevance to individuals with IDD. The MDS does not address many habilitative need areas, is not completed by an IDD professional, and is not based upon a review of IDD history, records, or relevant information.

HHSC has made technology improvements with regard to the entry of the PL1 and the PE into the Medicaid data portal, to meet the requisites for billing. HHSC has automated entry of the PASRR forms and appropriately allocated to the LIDDAs responsibility for completing the PE. However, none of these purported technological improvements to HHSC's PASRR process for data entry have remedied HHSC's failure to comply with PASRR's requirements to identify and assess required areas of need.

HHSC's PASRR program is overseen by HHSC's IDD Services Unit. Staff in this Unit are responsible for training, supporting, overseeing, reviewing and holding accountable the LIDDAs in connection with fulfilling HHSC's PASRR requirements. Yet, staff have demonstrated a lack of understanding of even basic PASRR requirements to identify and assess habilitative needs. Even with its purported improvements to its PASRR program, HHSC has not effectively communicated PASRR requirements to identify and assess habilitative needs, either internally across sections in the IDD Services Unit, or externally to the LIDDAs, who have the contractually delegated responsibility for implementing HHSC's PASRR program. This fundamental lack of understanding of PASRR is directly reflected in poor outcomes for individuals and the pervasive failure in failing to provide all needed specialized services and Active Treatment.

HHSC also fails to ensure that specialized services recommendations are made when appropriate. HHSC trainers do not provide qualitative guidance to LIDDA staff about how to identify and assess habilitative needs HHSC's CAO Unit, responsible for evaluating compliance with the LIDDA contract and holding LIDDAs accountable for their delegated PASRR duties, does not consistently review whether LIDDAs are appropriately assessing and recommending needed services. While CAO reviewers may offer occasional suggestions or note that a service recommendation is missing, they are not clinicians and are not expected to make independent judgments about the need for specialized services.

QSR findings confirm that appropriate assessments are not usually conducted and that needed services are not usually recommended. For the PASRR population in nursing facilities, Outcome Measure 3-3 evaluates whether the "PASRR Level II evaluation appropriately assesses

whether the needs of the individual can be met in the community and identifies the specialized services the individual needs. Population." HHSC's compliance on this measure for 2017 is only 9%. Outcome Measure 2-4, assesses whether the ISP "is based on assessments of the person's needs that appropriately identify these needs and recommend services and supports to address them," and whether "assessments are completed by licensed and qualified staff within the timeframes established by the SPT" and "include assessments of the medical, nursing, nutritional management, psychiatric, behavioral, therapy, independent living, community participation and the integrated day activity needs of the individual." Data from the QSR reviews shows 30% compliance with this measure in 2015, 40% compliance in 2016, and 38% compliance in 2017.

C. HHSC's PASRR program for planning, providing, delivering, and monitoring specialized services is not reasonably calculated to ensure that individuals with IDD in nursing facilities receive all needed specialized services.

Following from its failure to identify and assess all required habilitative need areas, HHSC's PASRR program does not ensure that specialized services are offered, provided or monitored to meet all habilitative needs, as required by PASRR regulations and accepted standards of practice.

HHSC's redesign of its PASRR program includes additional specialized service categories for people with IDD. Specialized services provided by nursing facilities include physical therapy, occupational therapy, speech therapy durable medical equipment and customized manual wheelchairs. Specialized services provided by LIDDAs include service coordination, employment assistance, supported employment, day habilitation, independent living skills training, and behavioral supports. However, as of September 1, 2017, HHSC does not have a centralized data system for monitoring the utilization of these specialized services, and no way to determine if they are actually provided with the requisite frequency, intensity, and duration to meet each individual's needs.

The PASSR group within the IDD Services Unit maintains tracking spreadsheets of nursing facility specialized services approvals and denials, and timely requests for authorization, but these do not show whether specialized services are actually delivered. Similarly, CAO staff track LIDDA specialized services that are requested. However, HHSC does not have a consistent, reliable method for tracking whether the specialized services recommended are actually received.

HHSC workgroup meeting notes acknowledge these issues:

> The consensus was that currently there is no system available to run a report to identify services provided so we can adequately monitor as well as improve our ability to forecast service demands and funds needed. The current process for monitoring involves a significant amount of manual review of reports detailing the services recommended and comparing them to the billing data for services provided (which assumes the billing data is accurate).

The notes also indicate that there is inconsistent data collection amongst LIDDAs and that HHSC lacks "a consistent process for LIDDA specialized services to include identifying service needs, the determination of hours, and the conduct of reviews." Without reliable data, HHSC cannot forecast the need for specialized services, or determine if its PASRR program is having the intended effect of promoting independence and facilitating community integration.

The available data on LIDDA specialized services, based on only on service recommendations and not actual delivery - indicates that very few adults with IDD in nursing facilities receive LIDDA specialized services. Even assuming all recommended services are delivered, a summary of the recommendation data produced by HHSC shows that as of June 2017, fewer than 2 percent of adults with IDD in nursing facilities were receiving any form of behavioral supports and fewer than five percent were getting day habilitation. Independent living skills, another LIDDA specialized service, is being authorized at a rate of only 12.3 percent. Service coordination, authorized at a rate of approximately 76 percent, is the only specialized service being provided to more than thirteen percent of the PASRR population. These low utilization numbers, compared to specialized service utilization in Massachusetts, strongly suggest that a large number of individuals with IDD in nursing facilities are not receiving all needed specialized services. In addition, the low utilization of specialized services that offer opportunities for community integration hinders HHSC's ability to promote the independence of people with IDD in nursing facilities and explains in part HHSC's low rate of transition for people with IDD out of nursing.

HHSC's service planning and delivery structure includes the nursing facility-led interdisciplinary team (IDT) and the LIDDA-led service planning team (SPT). HHSC's service planning and delivery structure – with its two distinct planning teams and two distinct plans – creates a significant risk that the nursing facility and LIDDA specialized services are not properly planned and coordinated, and that the services, methods, and strategies of each are not properly communicated, provided or understood. The separation of IDT and SPT teams and professionals creates a lack of coordination of service delivery and creates a significant risk of different or inadequate service planning, delivery, and outcomes. Independent service planning by two separate teams is confusing to both entities and creates fragmented service planning and delivery.

Nursing facilities are unable to provide nursing facility specialized services unless a nursing facility professional requests and obtains from HHSC/DADS written approval to provide that service. This creates a potentially significant gap between the identification and provision of services. It also creates the possibility of denial of clinically-needed services by a distant official who is not part of the IDT. If an authorization is not obtained prior to purchase or delivery of a nursing facility specialized service, or if a request for reimbursement is denied, the nursing facility is held responsible for the cost of the item or the service. And even if authorization is delayed due to documentation problems, individuals are not provided needed specialized services in the interim. HHSC has undertaken improved training for nursing facility providers in connection with PASRR obligations in nursing facilities. However, HHSC's new authorization system, unveiled in an April webinar, seems to perpetuate the same structural problems – separate teams and centralized and challenging authorization process.

Other HHSC divisions and units, such as the Regulatory Unit, which are responsible for enforcing aspects of PASRR with respect to nursing facilities, appear to have an insufficient understanding of PASRR. Regulatory's lack of PASRR understanding is reflected in its review of complaints regarding nursing facilities' failure to deliver specialized services. Regulatory's response to a complaint filed by HHSC's independent QSR reviewer, identifying a clear failure by a nursing facility to ensure delivery of a customized manual wheel chair, provides a clear example. Instead of responding to the complaint that a recommended specialized service had not been delivered as required by PASRR, regulatory staff determined that there was "not a need" for the specialized service in the first place, in clear contravention to PASRR requirements and process.

QSR findings are consistent with the concerns reflected above. Outcome Measure 2-5 measures whether all needed specialized services are being provided. In 2015, the QSR determined that only 19% of nursing facility residents received all needed specialized services; in 2016, the number had dropped to 14%; in 2017 it was only 16%. Outcome Measure 2-5 determines if the individual has an ISP that includes all of the services and supports, including integrated day activities, s/he needs to achieve his/her goals, maximize his/her potential, and participate in community activities, and whether the individual receives all of the specialized services identified in the frequency, intensity, and duration specified in the ISP. HHSC's own consultant, Kathryn Dupree reported on this measure that "The lack of both NF and LIDDA SS [specialized services] is apparent and there is little to no discussion of day habilitation or employment options."

D. HHSC's PASRR program is not designed and implemented to ensure that individuals with IDD receive specialized services that are provided in the amount, duration, and frequency sufficient to constitute Active Treatment.

In the absence of identification and comprehensive functional assessment of habilitative needs, it is impossible to construct an adequate and professionally-appropriate service plan that reflects the individual's needs for training, habilitation, and skill development, including specific strategies for implementation such as the frequency, intensity, and duration of needed specialized services. A program of Active Treatment can only be developed from a comprehensive functional assessment of all need areas. In a program of Active Treatment, all team members are trained in strategies for the consistent implementation of a plan that addresses specific skill areas. All team members focus on developing the skills and behaviors necessary to meet desired objectives at structured and naturally occurring points in a person's day. This plan and skill development is implemented across settings. In a program of Active Treatment, data is collected regarding a person's progress in achieving desired objectives. Active Treatment requires a consistent and continuous approach with close monitoring, modifications, and revisions to an individualized plan based on need.

HHSC's PASRR program mostly includes the sporadic provision of nursing facility therapies, as long as authorization is obtained, and the occasional provision of LIDDA specialized services. It lacks the essential components of assessment, engagement, monitoring, data collection, and ongoing plan revision, combined with other services, with a frequency, intensity, and duration as to constitute a federally-required program of Active Treatment.

The expanded list of specialized services has not resulted in individuals with IDD in nursing facilities receiving needed specialized services to meet all habilitative needs with the frequency, intensity and duration required. In particular, most people with IDD in nursing facilities do not have the opportunity to receive specialized services in integrated, community settings.

HHSC fails to communicate an expectation that nursing facility or LIDDA specialized services must be of a frequency, intensity, and duration as to create a program of Active Treatment. HHSC staff responsible for supporting and overseeing HHSC's PASRR program are unaware of the correct definition of Active Treatment and its relevance to individuals with IDD in nursing facilities.

The state has not communicated through policies, procedures, webinars, calls, bulletins, or trainings an expectation that individuals with IDD in nursing facilities must be provided a continuous program of specialized services delivered consistently across settings sufficient to meet the federal Active Treatment standard. HHSC does not have rules, regulations, or training materials concerning the federal Active Treatment standard in relation to the provision of specialized services. There are no references, explanations, or definitions of Active Treatment, or of the federal Active Treatment requirement in any descriptions of the Texas's delivery of specialized services. In addition, HHSC has no policies and procedures to ensure that individuals with IDD residing in nursing facilities receive comprehensive functional assessments to identify need areas and determine appropriate specialized services to serve as a foundation for a program of Active Treatment. HHSC provides no training to nursing facility or LIDDA staff on the implementation and strategies of a plan required for staff of all disciplines to provide carryover of objectives across settings as required with Active Treatment. There are no policies and procedures to ensure that the LIDDA service coordinators monitor and ensure that the specialized services provided by the nursing facility and the LIDDA are planned, coordinated, implemented, and monitored to ensure that they meet all federal Active Treatment requirements. HHSC has not provided a definition of Active Treatment or any training regarding the provision of a program of Active Treatment in a nursing facility setting resulting in many state and LIDDA staff lacking familiarity with the meaning of the term or with the provision of a program of Active Treatment in a nursing facility setting.

In all of the materials that I reviewed, the only time that HHSC even mentioned the term Active Treatment was in its budget requests for the 2016-17 biennium. In this one instance, where HHSC was seeking an increased legislative appropriation, it acknowledged not only the Active Treatment PASRR requirement, but also that this obligation requires more funding for specialized services than has been historically provided by HHSC for people with IDD in nursing facilities. In response to HHSC's request, the Legislature appropriated approximately 5.3 million dollars, a significantly increased amount for PASRR specialized services for the 2016 and 2017 biennium. HHSC used only approximately 1.6 million dollars of these appropriated funds because HHSC failed to operationalize the Active Treatment requirement for people with IDD in nursing facilities. HHSC appears to have failed to train key staff and LIDDA staff on this Active Treatment requirement and failed to incorporate the requirement in any way in its

reviews of LIDDA performance. 3.7 million dollars went unused because HHSC failed to implement its federal obligations to people with IDD in nursing facilities.

As set forth below, many of these system findings are further confirmed by my findings from the visits to the LIDDAs and other data and documents I reviewed.

VI. FINDINGS OF THE PROGRAM REVIEW

A. PASRR Level I Screenings, Level II Evaluations, and Diversion

1. As discussed above, the PASRR Level I is the first step of the two-phase PASRR process. PASRR Level I is required by federal regulation for the purpose of identification of individuals suspected of having an intellectual disability or related condition such as a developmental disability. The Level I identification of a suspicion of ID or DD constitutes a referral for the PASRR Level II or PASRR Evaluation (PE). PASRR Level I screenings are most often completed by a nursing facility or other referring entity but may be completed by LIDDA PASRR staff for individuals seeking admission to a nursing facility directly from the community. In these cases, information for the completion of the Level I form may be provided to the LIDDA by physician's offices, family members, or involved others.

2. HHSC defines diversion as a pre-admission alternative to nursing facility placement. Completion of the PE prior to admission for individuals in the community is necessary for the identification of potential diversion supports and waiver services, and for establishing a foundation for nursing facility service planning. When they receive referrals to do a PE for people in the community, LIDDAs reported that they are completing the PE within the required timeframes. LIDDAs also monitor the TMHP portal for alerts entered by a nursing facility for individuals who have already been admitted to a nursing facility and require a PE. Often LIDDAs do not receive an alert until after admission, when there is no longer an opportunity to divert. LIDDAs reported that most PEs are completed after admission, since most nursing facility residents are admitted as a result of an exempted hospital discharge or due to an expedited admission which categorically approves nursing facility admission.

3. LIDDAs reported that diversion waiver slots have been generally available for individuals seeking a nursing facility admission who want to remain in the community. Interviews indicate that waiver diversion slots may be offered to individuals seeking an alternative to nursing facility placement. Diversion waiver slots as of the time of my review had been released by HHSC upon request, when an individual is at imminent risk of nursing facility admission, and the PE confirms a diagnosis of ID or a related condition such as DD and can be supported in the community.

4. The LIDDA quarterly reports and other available data, as well as LIDDA interviews, indicated low numbers of diversions relative to the number of nursing facility admissions. Several LIDDAs reported that intake requests from people with IDD in the community who need additional supports to remain in their homes has resulted in some people from the community obtaining diversion slots. However, community members are not always aware of the opportunities for diversion. The inadequate outreach, training, and public awareness efforts to inform individuals with IDD about alternatives to hospitalization and nursing facility admission means many persons who could remain in the community, often with additional supports, are unnecessarily institutionalized in a nursing facility.

5. This issue is particularly troubling for individuals in residential and other HCS waiver programs who should be well-known to the LIDDAs and their service coordinators. There was little evidence of strategies to identify persons served by the LIDDA's provider network who are at risk of hospitalization, to intervene before a medical crisis arises, and to proactively provide additional supports, as needed, to avoid unnecessary institutionalization.

6. Outreach and education regarding alternatives to nursing facility placement and the availability of waiver diversion slots is inconsistent. While LIDDAs are generally providing some education and information to individuals with IDD and their families, utilizing standardized materials developed by HHSC, there is no evidence of a systematic approach of outreach to the entities that refer most people with IDD to nursing facilities, including hospitals, medical service providers elder service agencies, and general revenue service coordinators. Since these referring entities cannot only refer but, in fact, bypass the entire diversion process, this lack of outreach, training, engagement, and oversight of referring entities by the LIDDAs and HHSC contributes to the large number of admissions and the low number of diversions.

B. Comprehensive Functional Assessment

7. Comprehensive functional assessments of specific habilitative need areas are fundamental to the development of individualized plans for specialized services. LIDDA interviews indicated that comprehensive functional assessments are not performed by qualified IDD professionals at any stage of planning, either during the PE or resulting from the interdisciplinary team meeting at the nursing facility. Most LIDDA staff did not demonstrate an understanding of the purpose of comprehensive functional assessments of all habilitative need areas. Since comprehensive functional assessments are not performed, individualized plans for delivery of specialized services cannot be developed to address the required habilitative need areas or to provide services that would prevent the loss or deceleration of skills in a nursing facility setting.

8. There was little evidence that they conducted separate assessments for most of the LIDDA specialized services, like day habilitation, independent living skills, or vocational services. It appears that there was no meaningful involvement by the LIDDAs in any nursing facility assessments.

C. Specialized Services

(a) Planning and Identifying Needed Specialized Services

9. Comprehensive functional assessments to identify habilitative needs and determine the specialized services that are required to address those needs are supposed to form the basis for all service planning. Without this foundation, the nursing facility-led interdisciplinary team and the LIDDA-led service planning team are without a sound, objective, professionally-appropriate information to address habilitative needs. Without a comprehensive functional assessment, there is no basis for a service plan that includes habilitative goals directed towards the acquisition of skills, identification of individualized specialized services based on habilitative need areas, and specifications of the frequency, intensity, and duration of the services. Thus, since LIDDAs do not conduct comprehensive functional assessments, appropriate specialized services cannot be provided.

10. HHSC Individual Service Plan (ISP) forms include service categories such as day habilitation or independent living skills but do not include specific habilitative goals, strategies for implementation, or clinical interventions. The service categories described by the LIDDAs frequently take the form of an activity or companionship rather than specialized services with goal-directed outcomes towards the acquisition or prevention of loss of skills in an individualized treatment plan.

(b) Nursing Facility Specialized Services

11. Following agreement by an interdisciplinary team of a need for nursing facility specialized service(s), the nursing facility therapist must make a request to DADS/HHSC for authorization for any specialized service. LIDDAs report that some nursing facility therapists identify nursing facility services independent of the interdisciplinary team, apparently deeming these services, such as occupational therapy, physical therapy, speech therapy, etc., to be medical and, therefore, under the purview of the nursing facility staff alone. People with IDD in nursing facilities will not receive needed and recommended nursing facility specialized services unless the nursing facility staff and clinicians submit the appropriate forms for authorization from HHSC. When the nursing facility clinicians disregard the recommendations for PASRR services in completing these forms, the services will not be authorized.

12. LIDDAs reported challenges with the process of nursing facilities requesting and obtaining authorization for nursing facility specialized services from

DADS/HHSC. LIDDAs reported that nursing facilities did not prioritize the process. Some LIDDAs reported nursing facility resistance to making requests and to providing these specialized services due to availability of professional staff or financial burden on the facility. Some LIDDAs reported repeated attempts to assist nursing facilities with submission of nursing facility specialized service requests. While there have been efforts to increase nursing facility education, there continue to be delays in services caused by incorrect or incomplete requests for authorization. This results in individuals not receiving nursing facility specialized services that have been recommended in the PE or agreed to by the interdisciplinary team.

13. Some LIDDAs noted a communication from DADS/HHSC instructing PASRR service coordinators to refrain from contacting DADS/HHSC for the purpose of inquiring into the status of the request for authorization for nursing facility services. This process change renders the service coordinator unable to fulfill their role of monitoring and tracking service delivery with respect to nursing facility specialized services and to ensure the delivery of these recommended services. Nursing facility reluctance or resistance along with LIDDA inability to provide follow-up for the purpose of ensuring service delivery results in many individuals failing to receive nursing facility specialized services.

14. HHSC's prior-authorization requirement for nursing facility – but not LIDDA – specialized services is problematic. When interdisciplinary teams, that have the most knowledge and contact with the individual, recommend critical specialized services, and when professional therapists join in that clinical determination of need, having a distant state official, with no knowledge of the person and no involvement in the team decision approve or disapprove that service is not consistent with PASRR. This is particularly true given the high disapproval rate of nursing facility specialized services, which by recent reports exceeds 20%. Other states, like Massachusetts, do not require central office approval of every specialized service.

(c) LIDDA Specialized Services

15. Some LIDDA staff recognize the potential benefit from utilizing LIDDA specialized services for the purpose of addressing skill development, and facilitating transitions through community exposure. Nevertheless, utilization remains low.

16. LIDDAs report that many individuals in Texas nursing facilities who have IDD and have had a PE have a recommendation for and are receiving LIDDA service coordination from a PASRR service coordinator. This is not surprising since the LIDDA contract requires them to assign a service coordinator to every PASRR eligible individual with IDD in a nursing facility, unless the person refuses. Due to LIDDA staffing patterns, service coordinators may at times fulfill additional roles such as diversion coordinator or enhanced placement coordinator.

17. Almost no one in nursing facilities receives behavioral supports or supported employment specialized services. Some LIDDAs report instances of the development of behavioral plans which were unable to be implemented due to inadequate staffing and training needs of the nursing facility. Otherwise behavioral supports are generally not provided.

18. Day habilitation services are also provided to a small percentage of individuals with IDD (it is recommended for less than 5% of individuals according to statewide data). Day habilitation services are provided in a center-based location outside of the nursing facility, and LIDDAs reported several barriers to delivery.

    a. Day habilitation centers are generally unable to provide transportation to and from their facility due to the lack of an accessible vehicle. Nursing facilities are often unwilling to provide transportation due to associated costs. Several LIDDAs reported that because there were few day habilitation centers spread out in large geographic counties, the amount of time for transportation to and from the day habilitation facility created a disincentive for day habilitation services to be provided, even if recommended.

    b. Day habilitation centers typically do not have on-site nursing available for individuals with specific medical needs such as for monitoring of blood sugars for diabetes and monitoring for seizure activity. LIDDAs report that some day habilitation centers do not have accommodations such as an adult changing area or wheelchair accessibility, preventing individuals from attending who might benefit.

    c. LIDDAs indicated that day habilitation staff did not provide services in nursing facility settings to individuals who may need or be recommended for the services. In order to access day habilitation services, individuals must have the ability to travel to the day habilitation center and typically have few medical needs.

19. Few individuals are receiving the specialized service of independent living skills (it is recommended for less than 15% of individuals according to statewide data), although some LIDDAs reported hiring staff as Independent Skills Trainers to expand this service.

D. Active Treatment

20. LIDDAs were aware of a requirement for a PASRR Level I and a PE, but were mostly unaware of a requirement to provide Active Treatment to individuals with IDD in nursing facilities. The term Active Treatment was unfamiliar to most LIDDA staff. When interviewed and asked about specialized services and Active Treatment, most LIDDA staff asked for clarification as to its meaning, or offered general references to increased engagement and participation in nursing facility

activities. With prompts, some more experienced staff understood the concept in relation to the ICF model, but had no understanding of its application in nursing facilities.

21. In an attempt to address Active Treatment, LIDDA staff often referred to the daily schedule of activities offered in a nursing facility, displaying a fundamental misunderstanding of what Active Treatment is. These staff acknowledged that the activities were not were not part of a comprehensive, consistent, individualized, and continuous habilitative program.

22. Specialized services within nursing facilities are not consistently provided and monitored as a part of a continuous, consistent, coordinated program of Active Treatment. Due to this, there is no observation across settings to assess the implementation, effectiveness, and training needs of a coordinated program in order to make necessary modifications towards achieving assessed needs and goals.

23. No LIDDA staff reported that Active Treatment, as defined by federal law, was occurring in a nursing facility.

E. Service Coordination

24. All individuals are assigned to LIDDA PASRR service coordinators. Individuals refusing service coordination do not receive any ongoing LIDDA monitoring. With that exception, service coordinators must visit the individuals once a month or more frequently, and must be aware of and monitoring their clients. However, they do so without the identification and assessment of needs and provision of specific specialized services that are necessary under PASRR, as found above, to ensure Active Treatment.

25. While some service coordinators demonstrated knowledge of their clients and the nursing facilities, others, often because of high turnover, had limited understanding of the PASRR program and the specific strengths and needs of the individuals they serve. Many service coordinators, while advocating for their clients, did not demonstrate understanding that the individuals they served, and particularly those who had been institutionalized for years, could benefit from community placement.

F. Transition

26. The LIDDA quarterly reports and other available data, as well as LIDDA interviews, indicated low numbers of transitions, relative to the population.

27. Transition service planning does not ensure that many designated residents are provided opportunities for community integration, as required in Texas Administrative Code 17.502 (4). Utilization of LIDDA specialized services that

offer opportunities to participate in and experience community activities is very low, and nursing facility residents are not consistently provided meaningful opportunities for community integration.

28. LIDDAs fail to provide other opportunities to learn about and participate in community activities for most nursing facility residents. Most individuals, and particularly those who have been in nursing facilities for years, rarely leave the institution, except perhaps on planned nursing facility outings.

29. HHSC requires that a transition plan is developed when individuals are found appropriate for community placement in the PE, or express an interest to move, whether documented in section Q of the MDS or through an expressed at another time.

30. Phase II of the transition plan, which is part of the ISP, forms a framework for transition decisions and planning, through the identification of some of the supports and services that will be needed. Absent a clear statement that the individual does not want to remain in a nursing facility, LIDDAs rarely develop a transition plan that presents a concrete picture of what the community might look like for the individual, describes specific and individualized community services and locations, and that addresses fears and apprehensions. Similarly, they rarely offer community opportunities, and take other actions that may provide individuals with IDD necessary time to understand how community options apply to them in a specific and meaningful way.

31. LIDDA staff report that Phase II of the ISP form is not completed, until and unless an individual has decided, or is ready, to move. This is consistent with the ISP form instructions, which state that the SPT will proceed to Phase II when "pursue community living" in Phase I is checked, and with the LIDDA performance contract, which requires that Phase II only be completed by an enhanced community coordinator (ECC). ECCs are not assigned until an individual has already begun the transition process. As a result, transition plans are not consistently used as a planning tool for individuals who may require additional time to consider community options.

32. The state does not have a systemic approach to transition for most individuals in which service coordinators, transition coordinators, specialized service providers, and others provide repeated, individualized, and meaningful community opportunities in accordance with a person's assessed needs and life vision and incorporate them into a transition plan. Such a systemic and individualized approach would include opportunities provided at a pace that allows for a period of adjustment to the community and a period of successful community experiences.

33. HHSC's established transition processes do not include a requirement for assessments necessary to the provision of appropriate and needed community

supports and services until after a person has made the decision to move and has selected a provider. This significantly impedes successful transitions and long term community success, which are predicated on proper assessments of individual needs and preferences that must be included in the early stages of the transition process.

34. Those individuals who do successfully transition have more opportunities to be active and integrated in the community. LIDDA staff told stories of individuals who kept to themselves in the nursing facility, but then flourished upon transition.

G. Informed and Meaningful Choice

35. LIDDAs reported that individuals who are admitted to nursing facilities by expedited admission or exempted hospital discharge are informed of community living options after admission, when the PE is conducted. Some staff explained that before the Community Living Options (CLO) presentation takes place, there may be a shorter discussion about community living during the PE. These individuals and their LARs may remain unaware of community supports and services until after this discussion during the PE, when the nursing facility admission has already occurred and diversion waiver slots are no longer available.

36. LIDDAs are required to provide a CLO presentation to individuals and their LAR at the interdisciplinary team meeting and at six month intervals thereafter, or annually when service coordination is refused. LIDDAs report that they meet these timeframes. According to staff descriptions, these conversations or presentations are often focused on the nursing facility, initiating the discussion with such questions as “Do you like it here ?” and “Is everyone treating you well?” Standard pamphlets provided to individuals and LARs include information regarding the array of available community options, but this does not provide individualized and concrete examples tailored to the individual’s needs or preferences.

37. These conversations do not consistently address the communication and processing needs of some individuals with IDD in order for a full understanding of community options. Individuals with special needs may require frequent repetition, additional time for processing of information, opportunities for visualization, and experiences for personalization of community options. Multiple methods of communication, repetition, and a practical approach must be provided while addressing specific details such as familiar routines, food preferences, sleep schedule, life goals, and other important factors.

38. There is not a robust, systemic approach to education about the provision of supports and services in a community setting, which would include provider involvement, family-to-family and peer-to-peer involvement, and community residential visits. LIDDAs are required to offer such educational opportunities on a semi-annual basis. However, data from recent LIDDA Quarterly Reports shows

that in each of the first three quarters in Fiscal Year 2017, LIDDAs reported that less than 17% of individuals with IDD in nursing facilities participated in these educational activities.

39. Few individuals are actually provided tours of community provider agencies or visit community living arrangements and HCS residential settings. In the absence of seeing what community living really looks like and can be like, few individuals with IDD are in a position to make an informed choice whether to transition to the community or remain in the nursing facility.

40. As a result, the CLO process that is required by HHSC and implemented by the LIDDAs is often ineffective in promoting and supporting transition to the community.

H. Community Capacity

41. A survey of HCS community providers conducted by the provider association found that more than half of all respondents stated that there were considerable obstacles accessing needed support services, such as medical, psychiatric, day habilitation, and transportation services.

42. Few providers are willing and able to serve individuals with complex medical conditions, often because of HHSC's rate structure and the challenges of obtaining additional supports and reimbursement through a Level of Need change.

43. Nevertheless, based upon my meetings with various HCS providers, many are interested in supporting individuals who are in nursing facilities both experience community activities through LIDDA specialized services or facilitate their transition to the community. But they are rarely engaged by LIDDAs and rarely have opportunities to meet with and offer services to individuals with IDD who are in nursing facilities.

VI. CONCLUSION

Viewing Texas's PASRR program from both the state agency level and the LIDDA level was instructive. Because the state fails to require, oversee, monitor, and ensure that PASRR evaluations appropriately identify all habilitative needs, that comprehensive functional assessments are conducted, that all needed specialized services are provided, and that each individual with IDD in nursing facilities receives a program of Active Treatment, as defined by CMS, it is not surprising that LIDDAs do not meet these requirements. These failures to comply with PASRR contribute to the low number of diversions and transitions accomplished by HHSC. To the extent that the state believes that the LIDDAs are in fact complying with PASRR, my visits to LIDDAs and my additional review confirmed they are not.

Attachment A

Nancy L. Weston
A2-12 Lydon Lane
Halifax, Ma. 02338
(781) 243-9639

SUMMARY OF QUALIFICATIONS

Dedicated and respected professional with strength in presentation and in communicating. Excellent supervisory, clinical, and management skills. Special talent for fact finding, assessing needs, and presenting effective solutions to problems. Highly motivated, results oriented professional. Strong ability to provide program direction and leadership. Outstanding ability to foster team cohesion. Licensed social worker.

CAREER HIGHLIGHTS AND ACHIEVEMENTS

- Manage the statewide Active Treatment team. Ensure ongoing provision of active treatment in accordance with Active Treatment regulation and Department of Public Health review for individuals remaining in nursing facilities per PASRR. Provide supervision to Active Treatment clinical team coordinator and staff.

- Provided independent consultation with PASRR systems review and findings to Rucker, Powell, and Associates regarding the proposed plan by the state of Maine regarding the administration and oversight of PASRR in reference to the Van Meter v. Mayhew settlement agreement

- Manage statewide Rolland Settlement Agreement processes related to the overall provision of active treatment, community placement efforts, and ongoing communications with the independent Rolland court monitor. Provide direction to field staff regarding the required corrective action plans regarding the provision of active treatment for individuals residing in nursing facilities.

- Manage statewide PASRR (pre-admission screening and resident review) program for the Department of Developmental Services. Direct, manage, and supervise the statewide process by which individuals with intellectual and/or other developmental disabilities are screened for potential nursing facility admission as pursuant to Federal Law. Provide supervision to Statewide Nursing Facility Specialists regarding the implementation of the PASRR process and to ensure consistency and quality. Collaborate with and advise senior staff from DDS, DPH, and the Executive Office of Elder Affairs to strategize an effective interagency approach to meeting Federal regulations. Develop and implement formal training conferences and provide ongoing technical assistance to DDS staff, community elder service agencies, hospitals, nursing facilities, rehabilitation facilities, as well as to individuals with disabilities and their families. Collect and analyze data to identify trends that impact the Commonwealth's policy directions in relation to the provision of quality services to medically fragile persons with disabilities.

- Directed and managed operational activities of the Partial Hospital program at Quincy Mental Health Center, a Department of Mental Health (DMH) agency. Develop and maintain a therapeutic and effective program for acutely mentally ill clients

- Provided oversight and implementation of clinical intake screenings to determine appropriateness of referrals from hospitals, crisis teams, and other state and private agencies. Serve as a liaison to state and local agencies, hospitals, and referral centers.

- Directed, supervised, monitored, and evaluated therapeutic group treatment program. Assist staff in developing creative and flexible approaches to individuals presenting with complex problems requiring a high levels of clinical expertise.

- Served as a crisis liaison between Quincy Mental Health Center and the South Shore Mental Health Center crisis team. Represented Partial Hospital program in meetings with various agencies, hospital providers, and referral centers to encourage informational exchange of program activities at Quincy Mental Health Center. Develop and increase community network and promote marketing strategies to enhance the visibility of program to community and referring agencies.

- Promote and participated in quality assurance and other activities designed to improve client and staff safety, health promotions, and maintenance. Conducted quality assurance studies to ensure adherence to established quality assurance guidelines, and to monitor the delivery of services to clients served.

- Provided individual assessment and treatment to acute psychiatric clients with multiple emotional, developmental, physical, and psychosocial problems. Facilitate family and therapy groups, providing interventions to improve coping strategies, strengthen family and social relationships, and to assist clients in building supports. Presented problematic clinical cases to consulting psychiatrists and senior staff.

PROFESSIONAL HISTORY

DEPARTMENT OF DEVELOPMENTAL SERVICES
Director of PASRR and Nursing Facility Operations — January 2014 – Present
Independent consultant — May –June 2013
Massachusetts PASRR Director — February 2002- 2013
Central Office Nursing Facility Specialist — November 2001 –February, 2002

QUINCY MENTAL HEALTH CENTER, — 1984-2001
Partial Hospital Assistant Director, — 1995 - 2001
Program Coordinator, — 1991-1995
Crisis Liaison, — 1988-1991
Staff Social Worker, — 1984 – 1988

WESTWOOD LODGE / PEMBROKE HOSPITAL — 1983-1984
ERICH LINDEMANN MENTAL HEALTH CENTER — 1981-1983

EDUCATION: CURRY COLLEGE, Milton, MA.
B.A. Psychology and English

LICENSES AND CERTIFICATIONS
Social Work License, LSW

AWARDS AND RECOGNITIONS
Manuel Carballo Award for Excellence in Public Service

Attachment B

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

LOCAL INTELLECTUAL AND DEVELOPMENTAL DISABILITY AUTHORITIES AND SYSTEMIC OVERVIEW REPORT OF NANCY WESTON
Attachment B

	DOCUMENT	**BATES NUMBER**
1.	PL2015-16 Preadmission Screening and Resident Review (PASRR) Facility Requirements	PL00000140 – PL00000142
2.	LIDDA Reports re In-Reach-Educational Opportunities, Barriers to Transition, & Specialized Services Q4 FY15	DefE-00000003
3.	NF Population Report 12/31/15 and cover email	DefE-00000030-DefE-00000032
4.	LIDDA Reports re In-Reach-Educational Opportunities, Barriers to Transition, & Specialized Services Q1 FY16	DefE-00000034
5.	Service Coordination Roles and Responsibilities 09 24 15	DefE-00000038-DefE-00000046
6.	LIDDA Compliance Measure (LIDDA v. State (% of compliance))	DefE-00000049-DefE-00000470
7.	LIDDA Reports re In-Reach-Educational Opportunities, Barriers to Transition, & Specialized Services Q1 FY 16	DefE-00000556
8.	LIDDA Reports re In-Reach-Educational Opportunities, Barriers to Transition, & Specialized Service Q2 FY16	DefE-00000557-DefE-00000559
9.	LIDDA PASRR Quality Report FY 16 Q1 with cover email	DefE-00000725-DefE-00000728
10.	PASRR Education for LIDDA Staff	DefE-00000730
11.	PL2015-33 Top Non-Compliance Trends with the Preadmission Screening and Resident Review (PASRR) Requirements	PL00000137-PL00000139
12.	IL2015-61 Preadmission Screening and Resident Review Habilitative Specialized Services	PL00000143-PL00000144
13.	May 2016 Monthly report to stakeholder re slot utilization	PL00000145-PL00000184
14.	June 2016 Monthly report to stakeholders re slot utilization	PL00000185-PL00000188
15.	September 2016 Monthly report to stakeholders re slot utilization	PL00000189-PL00000192
16.	PASRR Provider Resources-LA FAQs- DADS website	PL00000193-PL00000195

17.	PASRR Specialized Service (PSS) Form	PL00000196-PL00000199
18.	LIDDA PASRR Reporting Manual	PL00000200-PL00000213
19.	LIDDA Performance Contract FY16-17	PL00000214-Pl000000250
20.	Slot Type 90 FY 16-17	DefE-00000037
21.	Habilitative and Rehabilitative Services	DefE-00000769
22.	Analysis of PASRR Survey	DefE-00000791-DefE-00000793
23.	TMHP Portal Enhancements	DefE-00000855-DefE-00000859
24.	LIDDA Performance Contract FY16-17 and Attachments	DefE-00001706-DefE-00001911
25.	LIDDA Performance Contract and Attachments, FY 16-17	DefE-00001706-DefE-00001911
26.	Nursing Facility Diversion Protocol	DefE-00001936-DefE-00001937
27.	HCS SW ILR #59 FY ‘12-‘13 Enrollments as of 5/31/13	DefE-00029326
28.	Slot Type 63 FY 14-15 9/30/2013	DefE-00029681
29.	Specialized Services Request Process 4/15/16	DefE-00052224
30.	Minutes of LA Webinar 2/19/15	DefE-00054425-DefE-00054428
31.	Minutes of LA Webinar 3/19/15	DefE-00054430-DefE-00054433
32.	Minutes of LA Webinar 4/23/15	DefE-00054438-DefE-00054442
33.	Minutes of LA Webinar 6/25/15	DefE-00054497-DefE-00054503
34.	Minutes of LA Webinar 7/16/15	DefE-00054522-DefE-00054528
35.	Minutes of LA Webinar 8/20/15	DefE-00054530-DefE-000054535
36.	Minutes of LA Webinar 9/17/15	DefE-00054537-DefE-00054544
37.	Minutes of LA Webinar 11/19/15	DefE-00054549-DefE-00054553

38.	Minutes of LA Webinar 12/17/15	DefE-00055464-DefE-00055468
39.	Minutes of LA Webinar 2/4/16	DefE-00055470-DefE-00055484
40.	PASRR Quality Reporting Q1 FY16	DefE-00055545
41.	Quarterly PASRR Reporting - ALA Q4 FY16	DefE-00055564-DefE-00055569
42.	Quarterly PASRR Reporting - ALA Q2 FY16	DefE-00055570-DefE-00055574
43.	Quarterly PASRR Reporting - ALA Q3 FY16	DefE-00055575-DefE-00055580
44.	Quarterly PASRR Reporting - ATCIC Q2 FY16	DefE-00055616-DefE-00055622
45.	Quarterly PASRR Reporting - ATCIC Q3 FY16	DefE-00055623-DefE-00055630
46.	Quarterly PASRR Reporting - ATCIC Q3 FY16 Addendum	DefE-00055631-DefE-00055633
47.	Quarterly PASRR Reporting - ATCIC Q4 FY16	DefE-00055634-DefE-00055644
48.	Quarterly PASRR Reporting - ATCIC Q4 FY16 Addendum	DefE-00055691
49.	Quarterly PASRR Reporting - BBTCS Q2 FY16	DefE-00055692-DefE-00055698
50.	Quarterly PASRR Reporting - BBTCS Q3 FY16	DefE-00055699-DefE-00055705
51.	Quarterly PASRR Reporting - BBTCS Q4 FY16	DefE-00055706-DefE-00055712
52.	Quarterly PASRR Reporting - Camino Real Q2 FY16	DefE-00055759-DefE-00055764
53.	Quarterly PASRR Reporting - Camino Real Q3 FY16	DefE-00055765-DefE-00055770
54.	Quarterly PASRR Reporting - Camino Real Q4 Fy16	DefE-00055771-DefE-00055776
55.	Quarterly PASRR Reporting - Central Counties Svcs Q2 FY16	DefE-00055796-DefE-00055801
56.	Quarterly PASRR Reporting - Central Counties Svcs Q3 FY16	DefE-00055802-DEfE-00055807
57.	Quarterly PASRR Reporting - Central Counties Svcs Q4 FY16	DefE-00055808-DefE-00055812
58.	Quarterly PASRR Reporting - HCMHDD Q2 FY16	DefE-00055963-DefE-00055968

59.	Quarterly PASRR Reporting - HCMHDD Q3 FY16	DefE-00055969-DefE-00055974
60.	Quarterly PASRR Reporting HCMHDD Q4 FY16	DefE-00055975-DefE-00055981
61.	Quarterly PASRR Reporting - Harris County Q2 FY16	DefE-00056059-DefE-00056064
62.	Quarterly PASRR Reporting - Harris County Q3 FY16	DefE-00056065-DefE-00056071
63.	Quarterly PASRR Reporting - Harris County Q4 FY16	DefE-00056072-DefE-00056077
64.	Quarterly PASRR Reporting - Texana Q2 FY16	DefE-00056224-DefE-00056230
65.	Quarterly PASRR Reporting - Texana Q4 FY16	DefE-00056231-DefE-00056237
66.	Quarterly PASRR Reporting - Texana Q3 FY16	DefE-00056238-DefE-00056243
67.	Quarterly PASRR Reporting - ALA Q1 FY16	DefE-00056337-DefE-00056341
68.	Quarterly PASRR Reporting - ATCIC Q1 FY16	DefE-00056348-DefE-00056354
69.	Quarterly PASRR Reporting - ATCIC Q1 FY16 Addendum	DefE-00056355-DefE-00056357
70.	Quarterly PASRR Reporting - BBTCS Q1 FY16	DefE-00056364-DefE-00056369
71.	Quarterly PASRR Reporting - Camino Real Q1 FY16	DefE-00056383-DefE-00056387
72.	Quarterly PASRR Reporting - Central Counties Svcs Q1 FY16	DefE-00056388-DefE-00056393
73.	Quarterly PASRR Reporting - HCMHDD Q1 FY16	DefE-00056459-DefE-00056464
74.	Quarterly PASRR Reporting - Harris County Q1 FY16	DefE-00056476-DefE-00056481
75.	Quarterly PASRR Reporting - Texana Q1 FY16	DefE-00056558-DefE-00056563
76.	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	
77.	IDT Meeting Documentation, PowerPoint Presentation (July 7, 2015).	DefE-00000754
78.	TEXAS HEALTH AND HUMAN SERVICES, Nursing Facility Requirements for Licensure and Medicaid Certification	PL006375-PL006384

	Handbook, Subchapter BB, §§ 19.2701-19.2709, *available at* https://hhs.texas.gov/laws-regulations/handbooks/nursing-facility-requirements-licensure-medicaid-certification-handbook/nfrlmc-subchapter-bb-nursing-facility-responsibilites-related-preadmission-screening-resident-review	
79.	Habilitative Services definition	DefE-00000769
80.	PASRR: all about NF Specialized Services 2016 PP Presentation	DefE-00000834
81.	PASRR: All About the IDT and Changes to the PASRR Program 2016 PP Presentation	DefE-00000845
82.	DADS Recommendation for Legislative Priorities/LAR - Delivery of Specialized Services for Persons with IDD in Nursing Facilities	DefE-00030697
83.	Specialized Services Verification	DefE-00052220
84.	PASRR Specialized Services (PSS) Form	DefE-00080592
85.	Detailed Item by Item Guide for Completing the PASRR Specialized Services Form	DefE-00080597
86.	PASRR Rehabilitative v. Habilitative Therapy - DADS webpage	PL00000373-PL00000374
87.	Kathryn Dupree 2015 Annual Report of Compliance	DefE-00000601-DefE-00000672
88.	Kathryn Dupree Q1 2016 QSR	DefE-00000677-DefE-00000716
89.	QSR Matrix	PL00000060-PL00000136
90.	40 T.A.C., Part 1, Ch. 19. Subch. BB: NF responsibilities related to PASRR	PL00000251-PL00000263
91.	40 T.A.C., Part 1, Ch. 17, Subch. A: PASRR General Provisions	PL00000264-PL00000285
92.	QSR Interview Protocol - Nursing Facility Members – Texas	PL00000882-PL00000900
93.	42 C.F.R. §§ 483.100, *et seq.*	PL0095678-PL0095642
94.	Transcript of the deposition of Stacy Lindsey, February 8, 2017, Austin, Texas.	PL0095095-PL00
95.	Transcript of the deposition of Mirenda Blevins, February 7, 2017, Austin, Texas.	PL0095095-PL0094789 – PL0095093
96.	HHSC IDD Organizational Chart dated 10/21/16	PL0095094

97.	Transcript of the deposition of Cathy Belliveau, February 2, 2017, Austin, Texas.	PL0095308 – PL0095493
98.	Letter from Bill Brooks, Associate Regional Administrator, Centers for Medicare & Medicaid Services to Billy Millwee, Deputy Exec. Commn'r for Health Services, Tex. Health & Human Svcs. Comm'n, re: State Plan Amendment TX-11-54 (July 18, 2012), *available at* https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/medicaid-state-plan-amendments.html (enter filters by state to "Texas," by Topic to "Program Administration," and search: "11-54").	PL0095923 – PL0095935
99.	HHSC 11-54 Responses to CMS 5/2/2012	PL0095936 – PL0095941
100.	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.	PL0095964-PL0095963
101.	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.	PL0096649
102.	PASRR Evaluation Form	PL00000672-PL00000703
103.	LIDDA – Local Procedure Development Support Unit Staff Assignments	DefE-00054437
104.	Order Approving Revised Active Treatment Standards (*Rolland* Order), Civil Action No. 98-30208-KPN, Docket No. 456 (August 2, 2007), including the Revised Active Treatment Standard attached as Docket No. 456-2.	
105.	Nursing Facility Rehabilitative and Specialized Therapy Services Payment Rates, Effective March 1, 2008, TEX. HEALTH & HUMAN SVCS. COMM'N COMM'N, *available at* https://hhs.texas.gov/sites/hhs/files/documents/doing-business-with-hhs/providers/health/2008-nf-rehab-ss-rates.pdf	
106.	CTRS. FOR MEDICARE & MEDICAID SERVS., Minimum Data Sets 3.0 Public Reports, MDS 3.0 Frequency Report, *available at*	

	https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Minimum-Data-Set-3-0-Public-Reports/Minimum-Data-Set-3-0-Frequency-Report.html (select FY and Quarter).	
107.	TEXAS HEALTH AND HUMAN SERVICES COMMISSION, https://hhs.texas.gov/.	
108.	TEX. HEALTH & HUMAN SVCS. COMM'N COMM'N, Intellectual or Developmental Disabilities (IDD) – Long-term Care, https://hhs.texas.gov/services/disability/intellectual-or-developmental-disabilities-idd-long-term-care.	
109.	TEX. HEALTH & HUMAN SVCS. COMM'N COMM'N, Preadmission Screening and Resident Review (PASRR), https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/preadmission-screening-resident-review-pasrr.	
110.	TEX. DEPT. OF AGING AND DISABILITY SERVS., https://www.dads.state.tx.us.	
111.	TEX. HEALTH & HUMAN SVCS. COMM'N COMM'N, Local Intellectual and Developmental Disability Authorities Directory, https://www.dads.state.tx.us/contact/la.cfm.	
112.	THE HARRIS CENTER FOR MENTAL HEALTH AND IDD, http://www.mhmraharris.org/.	
113.	AUSTIN TRAVIS COUNTY INTEGRAL CARE, http://www.integralcare.org/.	
114.	ALAMO LOCAL AUTHORITY FOR INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (ALA FOR IDD), http://www.aacog.com/66/Alamo-Local-AuthorityIDD-Services.	
115.	BLUEBONNET TRAILS CMTY. SERVS., http://bbtrails.org/.	
116.	CAMINO REAL CMTY. SERVS., http://caminorealcs.org/	
117.	HILL COUNTRY MHDD CTRS., http://www.hillcountry.org/	
118.	TEXANA CTR., About Us, https://www.texanacenter.com/about-us/	
119.	CENTRAL COUNTIES SERVS., http://www.cccmhmr.org/	
120.	TEX. DEPT. OF AGING AND DISABILITY SERVS., *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.	

121.	TEX. HEALTH & HUMAN SVCS. COMM'N, LIDDA Performance Contract, https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/local-intellectual-developmental-disability-authority-lidda/lidda-performance-contract.	
122.	TEX. HEALTH & HUMAN SVCS. COMM'N, LIDDA Performance Contract, Attachment B, https://hhs.texas.gov/sites/hhs/files/documents/doing-business-with-hhs/providers/long-term-care/lidda/attachmentb.pdf.	
123.	TEX. DEPT. OF AGING AND DISABILITY SERVS., *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.	
124.	TEX. DEPT. OF AGING AND DISABILITY SERVS., *Preadmission Screening and Resident Review (PASRR)*, Computer Based Training (posted July 17, 2015), https://www.dads.state.tx.us/business/CBT/PASRR/index.html.	
125.	TEX. DEPT. OF AGING AND DISABILITY SERVS., *PASRR Specialized Services Training*, Computer Based Training (posted Oct. 12, 2015), https://www.dads.state.tx.us/business/CBT/pasarrspecialized/SpecializedServices101215_print.html.	
126.	Provider Letter No. 16-41 from Mary T. Henderson, Asst. Comm'r, Regulatory Services, to Nursing Facilities (Sept. 9, 2016), https://www.dads.state.tx.us/providers/communications/2016/letters/PL2016-41.pdf.	
127.	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.	
128.	Information Letter No. 13-08 from Geri Willems, Manager, PASRR/MERP to Nursing Facility Staff (Feb. 11, 2013), https://www.dads.state.tx.us/providers/communications/2013/letters/IL2013-08.pdf.	
129.	Information Letter No. 13-07 from Geri Willems, Manager, PASRR/MERP to Local Authorities (Feb. 11, 2013), https://www.dads.state.tx.us/providers/communications/2013/letters/IL2013-07.pdf.	

130.	TEX. DEPT. OF AGING AND DISABILITY SERVS., *High Level Summary of DADS Budget for Fiscal Years 2016 - 2017 House Bill 1 - 84th Legislature, Regular Session*, https://www.dads.state.tx.us/news_info/publications/legislative/84thlegislature-hb1.pdf.	
131.	TEX. HEALTH & HUMAN SVCS. COMM'N , Waivers, https://hhs.texas.gov/laws-regulations/policies-rules/waiversttps://hhs.texas.gov/laws-regulations/policies-rules.	
132.	TEX. HEALTH & HUMAN SVCS. COMM'N, Billing FAQs (PASRR), https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/preadmission-screening-resident-review-pasrr/pasrr-faqs/billing-faqs-pasrr.	
133.	TEX. HEALTH & HUMAN SVCS. COMM'N, Local Authority FAQs (PASRR), https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/preadmission-screening-resident-review-pasrr/pasrr-faqs/local-authority-faqs.	
134.	TEX. HEALTH & HUMAN SVCS. COMM'N, Nursing Facility FAQs for PASRR, https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/preadmission-screening-resident-review-pasrr/pasrr-faqs/nursing-facility-faqs-pasrr.	
135.	TEX. HEALTH & HUMAN SVCS. COMM'N, Referring Entity FAQs (PASRR), https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/preadmission-screening-resident-review-pasrr/pasrr-faqs/referring-entity-faqs.	
136.	TEX. HEALTH & HUMAN SVCS. COMM'N, Preadmission Screening and Resident Review (PASRR), https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/preadmission-screening-resident-review-pasrr.	
137.	TEX. MEDICAID & HEALTHCARE PARTNERSHIP, PASRR Level 1 Screening Forms Converted for Medicaid Nursing Facility Residents Without a PL1 (posted June 25, 2014), *available at* http://www.tmhp.com/News_Items/2014/06-June/PASRR%20Level%201%20Screening%20Forms%20Converted%20for%20Medicaid%20Nursing%20Facility%20Residents%20Without%20a%20PL1.pdf.	
138.	TEX. MEDICAID & HEALTHCARE PARTNERSHIP, Important Nursing Facility Updates (posted May 23, 2014), *available at* http://www.tmhp.com/News_Items/2014/05%20May/Important%20Nursing%20Facility%20Updates.pdf.	
139.	TEX. MEDICAID & HEALTHCARE PARTNERSHIP, Important Local Authority (LA)/Local Mental Health Authority	

	(LMHA) Updates (posted May 23, 2014), *available at* http://www.tmhp.com/News_Items/2014/05%20May/Important%20Local%20Authority%20Local%20Mental%20Health%20Authority%20Updates.pdf	
140.	TEX. MEDICAID & HEALTHCARE PARTNERSHIP, Important Nursing Facility Updates (posted April 28, 2014), *available at* http://www.tmhp.com/News_Items/2014/04-Apr/Important%20Updates%20for%20the%20Nursing%20Facility.pdf	
141.	TEX. MEDICAID & HEALTHCARE PARTNERSHIP, Important Local Authority (LA)/Local Mental Health Authority (LMHA) Updates (posted April 28, 2014), *available at* http://www.tmhp.com/News_Items/2014/04-Apr/Important%20Updates%20for%20the%20Local%20Authority.pdf.	
142.	TEX. MEDICAID & HEALTHCARE PARTNERSHIP, Important Changes to Preadmission Screening and Resident Review (PASRR) for the Nursing Facility (posted March 21, 2014), *available at* http://www.tmhp.com/News_Items/2014/03-Mar/Important%20Changes%20to%20Preadmission%20Screening%20and%20Resident%20Review%20%28PASRR%29%20for%20the%20Nursing%20Facility.pdf.	
143.	TEX. MEDICAID & HEALTHCARE PARTNERSHIP, Important Changes to Preadmission Screening and Resident Review (PASRR) for the Local Authority (posted March 21, 2014), *available at* http://www.tmhp.com/News_Items/2014/03-Mar/Important%20Changes%20to%20Preadmission%20Screening%20and%20Resident%20Review%20%28PASRR%29%20for%20the%20Local%20Authority.pdf	
144.	Information Letter No. 16-19 from Elisa Garza, Asst. Comm'r, Access and Intake, Tex. Dept. of Aging and Disability Servs. to LIDDAs and LMHAs (July18, 2016), *available at* https://www.dads.state.tx.us/providers/communications/2016/letters/IL2016-19.pdf.	
145.	Information Letter No. 16-10 from Elisa Garza, Asst. Comm'r, Access and Intake, Tex. Dept. of Aging and Disability Servs. to Nursing Facility Providers (March 22, 2016), *available at* https://www.dads.state.tx.us/providers/communications/2016/letters/IL2016-10.pdf.	
146.	Information Letter No. 16-05 from Elisa Garza, Asst. Comm'r, Access and Intake, Tex. Dept. of Aging and	

	Disability Servs. to Nursing Facilities (Feb. 24, 2016), *available at* https://www.dads.state.tx.us/providers/communications/2016/letters/IL2016-05.pdf.	
147.	Information Letter No. 15-84 from Elisa Garza, Asst. Comm'r, Access and Intake, Tex. Dept. of Aging and Disability Servs. to Nursing Facilities (Dec. 31, 2015), *available at* https://www.dads.state.tx.us/providers/communications/2015/letters/IL2015-84.pdf.	
148.	Provider Letter No. 15-16 from Mary T. Henderson, Assistant Commissioner, Regulatory Services, Tex. Dept. of Aging and Disability Servs. (July 7, 2015), *available at* https://www.dads.state.tx.us/providers/communications/2015/letters/PL2015-16.pdf.	
149.	TEX. MEDICAID & HEALTHCARE PARTNERSHIP, PASRR Level 1 Screening Forms Converted for Medicaid Nursing Facility Residents Without a PL1 (posted June 25, 2014), http://www.tmhp.com/News_Items/2014/06-June/PASRR%20Level%201%20Screening%20Forms%20Converted%20for%20Medicaid%20Nursing%20Facility%20Residents%20Without%20a%20PL1.pdf.	
150.	TEX. MEDICAID & HEALTHCARE PARTNERSHIP, Important Nursing Facility Updates (posted May 23,2014), http://www.tmhp.com/News_Items/2014/05%20May/Important%20Nursing%20Facility%20Updates.pdf.	
151.	TEX. MEDICAID & HEALTHCARE PARTNERSHIP, Important Changes to Preadmission Screening and Resident Review (PASRR) for the Nursing Facility (posted March 21, 2014), http://www.tmhp.com/News_Items/2014/03-Mar/Important%20Changes%20to%20Preadmission%20Screening%20and%20Resident%20Review%20(PASRR)%20for%20the%20Nursing%20Facility.pdf.	
152.	TEX. HEALTH & HUMAN SVCS. COMM'N, Day Activity and Health Services Provider Manual, Section 1000, Day Activity and Health Services Program Overview, (effective Nov. 7, 2014) *available at* https://hhs.texas.gov/laws-regulations/handbooks/day-activity-health-services-provider-manual/dahs-section-1000-day-activity-health-services-program-overview	
153.	TEX. HEALTH & HUMAN SVCS. COMM'N, Day Activity and Health Services Provider Manual, Section 7000, Monitoring (effective June 5. 2015), *available at* https://hhs.texas.gov/laws-regulations/handbooks/day-	

	activity-health-services-provider-manual/dahs-section-7000-monitoring.	
154.	TEX. HEALTH & HUMAN SVCS. COMM'N, Person-Centered Planning (PCP) Training for Providers, https://hhs.texas.gov/services/disability/person-centered-planning/person-centered-planning-waiver-program-providers/person-centered-planning-pcp-training-providers.	
155.	TEX. HEALTH & HUMAN SVCS. COMM'N, LIDDA Transition Support Teams, https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/local-intellectual-developmental-disability-authority-lidda/lidda-transition-support-teams.	
156.	DEPT. OF AGING AND DISABILITY SERVS., ACCESS AND INTAKE, LOCAL AUTHORITIES SECTION, Service Definition Manual (updated May 2014), *available at* https://hhs.texas.gov/sites/hhs/files//documents/doing-business-with-hhs/providers/long-term-care/lidda/servicedefinitionmanual.pdf.	
157.	TEX. HEALTH & HUMAN SVCS. COMM'N, Contact LIDDA Program Staff, https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/local-intellectual-developmental-disability-authority-lidda/contact-lidda-program-staff.	
158.	TEX. HEALTH & HUMAN SVCS. COMM'N, Nursing Facilities (NF), https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/nursing-facilities-nf.	
159.	TEX. HEALTH & HUMAN SVCS. COMM'N, Local Intellectual and Development Disability Authority Handbook, https://hhs.texas.gov/laws-regulations/handbooks/local-intellectual-and-developmental-disability-authority-handbook.	
160.	TEX. DEPT. OF AGING AND DISABILITY SERVICES, Nursing Facility Directory (March 2017), https://hhs.texas.gov/sites/hhs/files/documents/doing-business-with-hhs/providers/long-term-care/nf/nf.pdf.	
161.	TEX. HEALTH & HUMAN SVCS. COMM'N, How to Become a Nursing Facility Provider, https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/nursing-facilities-nf/how-become-a-nursing-facility-provider.	
162.	TEX. DEPT. OF AGING AND DISABILITY SERVICES, Consumer Rights and Services, https://www.dads.state.tx.us/services/crs/incidentforms/.	

163.	TEX. HEALTH & HUMAN SVCS. COMM'N, Nursing Facility Frequently Asked Questions, https://hhs.texas.gov/services/health/medicaid-chip/provider-information/expansion-managed-care/nursing-facility-frequently-asked-questions.	
164.	TEX. HEALTH & HUMAN SVCS. COMM'N, Form 1013, Request to Change a Negative PASRR Level 1 (PL1), *available at* https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1013-request-change-a-negative-pasrr-level-1-pl1.	
165.	TEX. HEALTH & HUMAN SVCS. COMM'N, Form 1018, Specialized Services Customized Manual Wheelchair (CMWC) Authorization Request, *available at* https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1018-specialized-services-customized-manual-wheelchair-cmwc-authorization-request.	
166.	TEX. HEALTH & HUMAN SVCS. COMM'N, Form 1018, Attachment 1, Specialized Services Customized Manual Wheelchair (CMWC) Authorization, *available at* https://hhs.texas.gov/sites/hhs/files//documents/laws-regulations/forms/1018/Attach1.pdf.	
167.	CTRS. FOR MEDICARE AND MEDICAID SVCS., MDS 3.0 Training (last updated Nov. 9, 2016), https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TrainingMaterials.html.	
168.	CTRS. FOR MEDICARE AND MEDICAID SVCS., MDS 3.0 for Nursing Homes and Swing Bed Providers (last updated March 6, 2015), https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30.html.	
169.	CTRS. FOR MEDICARE AND MEDICAID SVCS., MDS 3.0 Technical Information (last updated Dec. 23, 2016), https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html.	
170.	CTRS. FOR MEDICARE AND MEDICAID SVCS., Nursing Home Quality Initiative, Spotlight (last updated July 25, 2016), https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Spotlight.html.	

171.	CTRS. FOR MEDICARE AND MEDICAID SVCS., Skilled Nursing Facility Quality Reporting Program (IMPACT Act 2014) (last updated Dec. 6, 2016), https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-IMPACT-Act-2014.html	
172.	CTRS. FOR MEDICARE AND MEDICAID SVCS., MDS 3.0 RAIL Manual (last updated March 20, 2017), https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html	
173.	Betty Hardwick Center LIDDA PASSR Quarterly Reporting; FY16 Q2-Q4, FY17 Q1	DefE-00055678, DefE-00055684, DefE-00055670, DefE-00055663
174.	Central Plains LIDDA PASRR Quarterly Reporting FY16 Q1-Q4	DefE-00055813, DefE-00055819, DefE-00055824, DefE-00056394
175.	Concho Valley LIDDA PASRR Quarterly Reporting FY16 Q1-Q4	DefE-00056041, DefE-00056047, DefE-00056053, DefE-00056410
176.	Emergence Health Network LIDDA PASRR Quarterly Reporting FY16 Q1-Q4	DefE-00055874, DefE-00005879, DefE-00055884, DefE-00056431, DefE-00056592,
177.	Permian Basic Community Centers LIDDA PASRR Quarterly Reporting FY16 Q1-Q4	DefE-00056166, DefE-00056171, DefE-00056177, DefE-00056182
178.	Star Care LIDDA PASRR Quarterly Reporting FY16 Q1-Q4	DefE-00056206, DefE-00056212, DefE-00056218, DefE-00056552
179.	Texas Panhandle LIDDA PASRR Quarterly Reporting FY16 Q1-Q4	DefE-00056244, DefE-00056254, DefE-00056259, DefE-00056587
180.	West Texas Center LIDDA PASRR Quarterly Reporting FY16 Q1-Q4	DefE-00056319, DefE-00056325,

		DefE-00056331, DefE-00056582
181.	TEX. HEALTH & HUMAN SVCS. COMM'N, Form 1039, Community Living Options and Instructions, *available at* https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1039-community-living-options	US00253559-253568
182.	TEX. HEALTH & HUMAN SVCS. COMM'N, Form 1041, Local Authorities (LA) Individual Service Plan/Transition Plan – NF and Instructions, *available at* https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1041-individual-service-plantransition-plan-nf	US00252775-253800
183.	Centers for Medicare and Medicaid Services, Instructions: Version 3.5 HCBS Waiver Application, Appendix B: Participant Access and Eligibility	US00257518-257519
184.	TEX. HEALTH & HUMAN SVCS. COMM'N, (formerly, Texas Department of Aging and Disability Services), *Explanation of IDD Services and Supports*	US00253411-253423
185.	TEX. HEALTH & HUMAN SVCS. COMM'N (formerly, Texas Department of Aging and Disability Services), *Making Informed Choices: Community Living Options Information Process for Nursing Facility Residents*, February 2016	US00253434-253429
186.	NF Diversion FY14-15	DefE-00001704
187.	NF Diversion FY16-17	DefE-00001941
188.	All LIDDA Quarterly Reporting, Q4 FY16	DefE-00055545
189.	FY16 Q1 NF Member Expressing an Interest in the Community Through MDS Section Q Process, May 2016	DefE-00161335
190.	FY16 Q2 NF Member Expressing an Interest in the Community Through MDS Section Q Process, May 2016	DefE-00161337
191.	All LIDDA Quality Reporting FY16 Q1	DefE-00000034
192.	All LIDDA Quality Reporting FY16 Q2	DefE-00000559
193.	All LIDDA Quality Reporting FY16 Q3	DefE-00000726
194.	All LIDDA Quality Reporting FY17 Q1	DefE-00702109
195.	All LIDDA Quality Reporting FY17 Q2	DefE-02005170

196.	All LIDDA Quality Reporting FY17 Q3	DefE-02005171
197.	2016 PASRR QSR Compliance Status Interim Report, Draft, Kathryn DuPree	DefE-00096540
198.	TEX. HEALTH & 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
199.	TEX. HEALTH & HUMAN SERVICES COMMISSION, PASRR 101, Computer Based Training Module, available at https://learningportal.dfps.state.tx.us/enrol/index.php?id=22	DefE-02220543
200.	FY17 Specialized Services Report	DefE-02034167
201.	TEX. HEALTH & HUMAN SVCS. COMM'N , Draft HCS Enrollment Plan for 2018-2019 Biennium, Exhibit 348, Deposition of Anthony Jalomo, November 3, 2017, Austin, Texas	DefE-01964251-1964260
202.	Concho Valley LIDDA PASRR Quarterly Reporting FY17 Q1	DefE-00261965
203.	Emergence Health Network LIDDA PASRR Quarterly Reporting FY17 Q1	DefE-00261292
204.	Texas Panhandle LIDDA PASRR Quarterly Reporting FY17 Q1	DefE-00260415
205.	West Texas Center LIDDA PASRR Quarterly Reporting FY17 Q1	DefE-00260598
206.	Betty Hardwick Center LIDDA PASSR Quarterly Reporting; FY17 Q1	DefE-00260223
207.	Transcript of the meeting with West Texas Center, Big Spring, Texas, July 25, 2017.	DEFP-00338333
208.	Transcript of the meeting with Concho Valley MHMR, San Angelo, Texas, July 26, 2017.	DEFP-00338577
209.	Transcript of the meeting with Betty Hardwick Abilene, Texas, July 26, 2017.	DEFP-00338419
210.	Transcript of the meeting with Star Care, Lubbock, Texas, July 27, 2017.	DEFP-00338862
211.	Transcript of the meeting with Central Plains, Plainview, Texas, July 27, 2017.	DEFP-00338645
212.	Transcript of the meeting with Texas Panhandle, Amarillo, Texas, July 28, 2017.	DEFP-00338951
213.	Transcript of the deposition of Cathy Belliveau, October 20, 2017, Austin Texas.	
214.	Exhibits submitted at the deposition of Cathy Belliveau (PX 276-PX 303), October 20, 2017, Austin, Texas.	

215.	Transcript of the deposition of Jennifer Cochran, September 14, 2017, Austin, Texas.	
216.	Exhibits submitted at the deposition of Jennifer Cochran (PX 43-PX 54), September 14, 2017, Austin, Texas.	
217.	Transcript of the deposition of David Cook, November 15, 2017, Austin, Texas.	
218.	Exhibits submitted at the deposition of David Cook (PX 436-PX 474), November 15, 2017, Austin, Texas.	
219.	Transcript of the 30(b)(6) deposition of Terry Hernandez, October 5, 2017, Austin, Texas.	
220.	Exhibits submitted at the 30(b)(6) deposition of Terry Hernandez (PX 96-PX 110), October 5, 2017, Austin, Texas.	
221.	Transcript of the deposition of Terry Hernandez, January 9, 2018, Austin, Texas.	
222.	Exhibits submitted at the deposition of Terry Hernandez (PX 684-PX 711), January 9, 2018, Austin, Texas.	
223.	Transcript of the 30(b)(6) deposition of Anthony Jalomo, November 2, 2017, Austin, Texas.	
224.	Exhibits submitted at the 30(b)(6) deposition of Anthony Jalomo (PX 330-PX 343), November 2, 2017, Austin, Texas.	
225.	Transcript of the deposition of Anthony Jalomo, November 3, 2017, Austin, Texas.	
226.	Exhibits submitted at the deposition of Anthony Jalomo (PX 344-PX 355), November 3, 2017, Austin, Texas.	
227.	Transcript of the deposition of Richard Miller, October 13, 2017, Austin, Texas.	
228.	Exhibits submitted at the deposition of Richard Miller (PX 201-PX 217), October 13, 2017, Austin, Texas.	
229.	Transcript of the deposition of Debbie Reece, September 13, 2017, Austin, Texas.	
230.	Exhibits submitted at the deposition of Debbie Reece, (PX 1-PX 42)	
231.	Transcript of the 30(b)(6) deposition of Debbie Reece, October 11, 2017, Austin, Texas.	
232.	Exhibits submitted at the 30(b)(6) deposition of Debbie Reece (PX 161-PX 173), October 11, 2017, Austin, Texas.	
233.	Transcript of the deposition of Sally Schultz, December 18, 2017, Austin, Texas.	
234.	Exhibits submitted at the deposition of Sally Schultz (PX 633-PX 658), December 18, 2017, Austin, Texas.	

235.	Transcript of the deposition of Geri Willems, February 3, 2017, Austin, Texas.	
236.	Transcript of the 30(b)(6) deposition of Geri Willems (Vol. I), October 16, 2017, Austin, Texas.	PL0095494-PL0095641
237.	Exhibits submitted at the 30(b)(6) deposition of Geri Willems (Vol. II) (PX 218-PX 237), October 16, 2017, Austin, Texas.	
238.	Transcript of the 30(b)(6) deposition of Geri Willems (Vol. II), January 18, 2018, Austin, Texas.	
239.	Exhibits submitted at the 30(b)(6) deposition of Geri Willems (Vol. II) (PX 750-PX 762), January 18, 2018, Austin, Texas	
240.	Minimum Data Set (MDS) Version 3.0	DefE-00169817
241.	PASRR Level 1 Focus Areas	DefE-00418191
242.	TEX. HEALTH & HUMAN SVCS. COMM'N, Information Letter No. 12-47 from Jon Weizenbaum, former Deputy Commissioner, and Gary Jessee, former Asst. Commissioner, Access and Intake, to HCS Providers, TxHML Providers, and Local Authorities (June 5, 2012), *available at* https://www.dads.state.tx.us/providers/communications/2012/letters/IL2012-47.pdf	US00257520-257521
243.	FY16-17 Q1-Q3 PASRR Compliance Report, Outcome Measures 2-6, 5-6.	DefE-05187144
244.	Number of IDT Meetings Held and Specialized Services Recommended, November 2016.	DefE-00779445
245.	Number of IDT Meetings Held and Specialized Services Recommended, December 2016.	DefE-03726606
246.	Number of IDT Meetings Held and Specialized Services Recommended, November 2016-January 2017	DefE-02070828
247.	Number of IDT Meetings Held and Specialized Services Recommended, January 2017	DefE-02229932
248.	Number of IDT Meetings Held and Specialized Services Recommended, February 2017	DefE-02016527
249.	Number of IDT Meetings Held and Specialized Services Recommended, May 2017	DefE-02228396
250.	QAI Data Mart Request 1729, Summary of all SPT meetings and LIDDA Specialized Services for PASRR IDD Individuals currently residing in a Nursing Facility, prepared August 16, 2017.	DefE-02034167
251.	Specialized Services Spreadsheet	DefE-02034155

252.	Transcript of the 30(b)(6) deposition of David Cook, February 1, 2018, Austin, Texas.	
253.	Transcript of the deposition of David Cook, February 1, 2018, Austin, Texas.	
254.	Exhibits submitted at the depositions of David Cook (PX 803-PX 840), February 1, 2018, Austin, Texas	
255.	Transcript of the deposition of Linda Lotringer, November 6, 2017, Austin, Texas.	
256.	Exhibits submitted at the deposition of Linda Lothringer (PX 356-PX 388), November 6, 2017, Austin, Texas.	
257.	Transcript of the deposition of Deborah Mills, October 19, 2017, Austin, Texas.	
258.	Exhibits submitted at the deposition of Deborah Mills (PX 265- PX 275), October 19, 2017, Austin, Texas	
259.	Transcript of the deposition of Richard Rees, January 11, 2018, Austin, Texas.	
260.	Exhibits submitted at the deposition of Richard Rees (PX 750-PX 780), January 11, 2018, Austin, Texas.	
261.	Transcript of the deposition of Kathryn duPree, February 6, 2018, Austin, Texas.	
262.	Exhibits submitted at the deposition of Kathryn duPree (PX 841- PX 864), February 6, 2018, Austin, Texas.	
263.	Transcript of the 30(b)(6) deposition of Haley Turner, February 21, 2018, Austin, Texas.	
264.	Exhibits submitted at the 30(b)(6) deposition of Haley Turner (PX 943- PX 1016), February 21, 2018, Austin, Texas.	
265.	Transcript of the deposition of Haley Turner, February 23, 2018, Austin, Texas	
266.	Exhibits submitted at the deposition of Haley Turner (PX 1039-PX 1063), February 23, 2018, Austin, Texas	
267.	Transcript of the deposition of Judy Southall, October 14, 2017, Austin, Texas.	
268.	Exhibits submitted at the deposition of Judy Southall (PX 80-PX 95), October 14, 2017, Austin, Texas.	
269.	Transcript of the deposition of Judy Southall, November 17, 2017, Austin, Texas.	
270.	Exhibits submitted at the deposition of Judy Southall (PX 389- PX 415), November 17, 2017, Austin, Texas.	
271.	Transcript of the deposition of Sonja Gaines, February 27, 2018, Austin, Texas.	
272.	Exhibits submitted at the deposition of Sonja Gaines (PX 1064-PX 1092), February 27, 2018, Austin, Texas.	

273.	Letter from Billy R. Millwee, Texas State Medicaid Director to Bill Brooks, Associate Regional Administrator, Division of Medicaid and Children's Health, Centers for Medicare & :Medicaid Services, re: State Plan Amendment 11-053 (Sept. 30, 2011).	US00257522-00257529
274.	Community Provider Survey	US00257595-257638 US00261213-261256
275.	TEX. HEALTH AND HUMAN SVCS. COMM'N, Report of Funds Recouped from Local Intellectual and Developmental Disability Authorities in Fiscal Year 2016 (March 2017)	DefE-00734601
276.	HCS Diversion Slot Data – reorganized	US00257530
277.	HCS Transition Slot Data – reorganized	US00257531
278.	NF Diversion Slot List FY14-FY15	DefE-02195943
279.	NF Diversion Slot List FY16-FY17	DefE-01958694
280.	NF Transition Slot List FY14-FY15	DefE-01695363
281.	NF Transition Slot List FY16-FY17	DefE-01958693
282.	Letter from Sally K. Richardson, Director, Center for Medicaid State Operation, U.S. Dept. of Health & Hum. Svcs., to State Medicaid Directors (July 29, 1998), Olmstead Update No. 1, *available at* http://www.nasddds.org/resource-library/employment/achieving-a-better-life-experience-act-of-2014/medicaid-hcbs-authorities/hcbs-waiver-state-medicaid-director-letters/olmstead-state-medicaid-director-letters/	US00257562-257535
283.	Letter from Timothy Westmoreland, Director Center for Medicaid and State Operations Health Care Financing Administration, and Thomas Perez, Director of Office for Civil Rights, U.S. Dept. of Health & Hum. Svcs., to State Medicaid Directors (January 14, 2000), Olmstead Update No. 2, *available at* http://www.nasddds.org/resource-library/employment/achieving-a-better-life-experience-act-of-2014/medicaid-hcbs-authorities/hcbs-waiver-state-medicaid-director-letters/olmstead-state-medicaid-director-letters/	US00257536-257546

284.	Letter from Timothy Westmoreland, Director Center for Medicaid and State Operations Health Care Financing Administration, U.S. Dept. of Health & Hum. Svcs., to State Medicaid Directors (July 25, 2000), Olmstead Update No. 3, *available at* http://www.nasddds.org/resource-library/employment/achieving-a-better-life-experience-act-of-2014/medicaid-hcbs-authorities/hcbs-waiver-state-medicaid-director-letters/olmstead-state-medicaid-director-letters/	US00257547-257567
285.	Letter from Timothy Westmoreland, Director Center for Medicaid and State Operations Health Care Financing Administration, U.S. Dept. of Health & Hum. Svcs., to State Medicaid Directors (January 10, 2001), Olmstead Update No. 4, *available at* http://www.nasddds.org/resource-library/employment/achieving-a-better-life-experience-act-of-2014/medicaid-hcbs-authorities/hcbs-waiver-state-medicaid-director-letters/olmstead-state-medicaid-director-letters/	US00257568-257579
286.	Letter from Timothy Westmoreland, Director Center for Medicaid and State Operations Health Care Financing Administration, U.S. Dept. of Health & Hum. Svcs., to State Medicaid Directors (July 25, 2000), *available at* https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd072500a.pdf	US00257580-257590
287.	Letter from Donna E. Shalala, U.S. Dept. of Health & Hum. Svcs., to U.S. Governors (January 14, 2000), *available at* http://www.freedomclearinghouse.com/know/shalala011400.htm	US00257591
288.	MEDICAID.GOV, Preadmission Screening and Resident Review, https://www.medicaid.gov/medicaid/ltss/institutional/pasrr/index.html	
289.	PASRR TECHNICAL ASSISTANCE CENTER, PASRR in Plain English (July 29, 2016), http://www.pasrrassist.org/resources/federal-regulations/pasrr-plain-english	

290.	TEX. HEALTH & HUMAN SVCS. COMM'N, Expedited Admissions, https://hhs.texas.gov/sites/default/files//basic_page/expeditedadmissioncategories.pdf	US00257592
291.	TEX. HEALTH & HUMAN SVCS. COMM'N, Expedited Admissions Process, https://hhs.texas.gov/sites/default/files//basic_page/expeditedadmissionprocess.pdf	US00257593
292.	TEX. HEALTH & HUMAN SVCS. COMM'N, Form 1047 (June 2016), https://hhs.texas.gov/sites/default/files//documents/laws-regulations/forms/1047/1047.pdf.	US00261257
293.	40 T.A.C., Part 1, Ch. 2, Subch. L: Local Authority Responsibilities, Service Coordination for Individuals with an Intellectual Disability, *available at* http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=40&pt=1&ch=2&sch=L&rl=Y	
294.	2017 QSR Review Results	US00257639
295.	Program review questions and considerations	US00259001-259003
296.	TEX. HEALTH & HUMAN SVCS. COMM'N, Provider Letter 13-31 from Mary Henderson, Asst. Comm'r, Regulatory Services, Tex. Health & Human Svcs. Comm'n (formerly Tex. Dept. of Aging & Disability Svcs.), to ICFs/IDDs (Dec. 17, 2013) https://www.dads.state.tx.us/providers/communications/2013/letters/PL2013-31.pdf	
297.	40 T.A.C. ch. 9, subch. E, ICF/IID Programs — Contracting, *available at* https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/long-term-care/icf/chapter9-E.pdf	
298.	TEX. DEPT. OF AGING & DISABILITY SVCS., 10 *Most Frequently Cited Deficiencies: Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions FY 2015*, Computer Based Training (updated Oct. 19, 2016),	

	https://www.dads.state.tx.us/business/CBT/deficiences/icf-2015.html	
299.	Transcript of the 30(b)(6) deposition of Michelle Dionne-Vahalik, October 12, 2017, Austin, Texas.	
300.	Exhibits submitted at the 30(b)(6) deposition of Michelle Dionne-Vahalik, October 12, 2017, Austin, Texas.	
301.	Transcript of the deposition of Michelle Dionne-Vahalik, December 19, 2017, Austin, Texas.	
302.	Exhibits submitted at the deposition of Michelle Dionne-Vahalik, December 19, 2017, Austin, Texas.	
303.	Transcript of the deposition of Gary Jessee, February 8, 2018, Austin, Texas.	
304.	Exhibits submitted at the deposition of Gary Jessee, February 8, 2018, Austin, Texas.	