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

ERIC STEWARD, *et al*., *Plaintiffs,* v. COURTNEY N. PHILLIPS, in her official capacity as the Executive Commissioner of Texas's Health and Human Services Commission, *et al.,* *Defendants.*	§ § § § § § § § § § §	
THE UNITED STATES OF AMERICA, *Plaintiff-Intervenor,* v. THE STATE OF TEXAS *Defendant.*	§ § § § § § § §	Case No. 5:10-CV-1025-OLG

PLAINTIFFS' AND UNITED STATES' POST-TRIAL BRIEF IN SUPPORT OF THEIR JOINT FINDINGS OF FACT AND CONCLUSIONS OF LAW

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I. Introduction

Consistent with the Court's January 10, 2019 text Order granting Unopposed Motion to Vary General Order, ECF No. 648, Plaintiffs submit this Memorandum in support of their claim that Defendants are violating the Nursing Home Reform Amendments (NHRA) and its implementing regulations, 42 U.S.C. § 1396r(e) & 42 C.F.R. § 483.100, *et seq.*, and other provisions of the Medicaid Act, 42 U.S.C. § 1396a(a)(8) (reasonable promptness) & § 1396n(2) (freedom of choice). Plaintiffs and the United States submit this Memorandum in support of their claims under the Americans with Disabilities Act (ADA) and its implementing regulations, 42 U.S.C. § 12101, *et seq.* & 28 C.F.R. § 130(b) & (d), and the Rehabilitation Act, 29 U.S.C. § 504 (Section 504).

Based upon the evidence at trial, as well as the evidence submitted in support of Plaintiffs' Motion for a Preliminary Injunction, the Court should find that Defendants are violating the federal rights of people with intellectual and developmental disabilities (IDD) in, or at serious risk of admission to, nursing facilities. The Court should enter a declaratory judgment and, after affording the parties an opportunity to confer and propose a process for developing a remedial order, and to make submissions on a proposed remedial plan, enter appropriate injunctive relief that sets forth the actions necessary to remedy these violations of the Medicaid Act, the ADA, and Section 504.

II. Summary of Facts

A. The Plaintiffs

As of September 1, 2017, all but five of the 12 Named Plaintiffs had successfully transitioned from a nursing facility and were residing in the community. They were able to do so precisely because of their status as Named Plaintiffs and advocacy they received from Disability

Rights Texas (DRTx). Pls.' and U.S.' Findings of Fact (FOF) ¶ 1247. The same is not true for all the other people with IDD in nursing facilities. Most remain in nursing facilities without the needed specialized services, active treatment, or opportunities to make an informed choice whether to enter or remain in a nursing facility. Others remain at serious risk of admission.

B. Texas' 2013 PASRR Redesign Does Not Achieve the Purposes or Meet the Requirements of the NHRA.

1. Texas' PASRR Level 1 Screening and Level 2 Evaluation

Sections E and D of the PASRR Level 1 screening (PL1), which are critical to meeting PASRR's purpose of avoiding inappropriate nursing facility placement, are rarely completed as required. FOF ¶¶ 241,243-264; FOF § II.C (describing the PASRR process). Because Texas designed its PASRR system to rely almost exclusively on nursing facility admissions categories ("exempt" and "expedited") that bypass the PASRR pre-admission evaluation (called "Level 2" or "PE"), the evaluation does not consider alternate placement in the community for as many as 97% of individuals with IDD admitted to nursing facilities or make a reliable determination of needed specialized services.[1] FOF ¶ 226. For example, the Quality Service Review (QSR) reviewers, *infra*, § III, found that the number of people who received a PE that appropriately identified their needs for specialized services was extremely low, had steadily decreased since 2015, and even when conducted, were not followed. FOF ¶¶ 271-272. Texas also does not require that individuals with IDD in nursing facilities receive comprehensive assessments, making it impossible to accurately determine the individuals' needs. FOF ¶¶ 265, 326-361, 425, 485, 541. Texas' data also shows that the PASRR evaluator does not determine whether the

[1] The PE confirms whether people have IDD, whether they meet the nursing facility level of care criteria, whether their needs can be met in the community, and whether they could benefit from the specialized services designed to maximize their functioning or to prevent regression. 42 C.F.R. §§ 483.128(a), 132.

nursing facility can provide the needed specialized services, as required by PASRR regulations, 42 C.F.R. §§ 132(a)(3), (b). FOF ¶¶ 252-259.

2. People with IDD Do Not Receive All Needed Specialized Services.

Texas' PASRR process fails to ensure that people with IDD in nursing facilities receive all needed specialized services, as set forth in 42 C.F.R. § 483.120(b). FOF ¶¶ 398-439.[2] The rate of recommendation is less than 34% for nursing facility specialized services and less than 25% for Local Intellectual and Developmental Disability Authority (LIDDA) specialized services, and decreases as the process moves from the PE to the nursing facility Interdisciplinary Team (IDT) meeting to the LIDDA Service Planning Team (SPT) meeting. FOF ¶¶ 423-425. This is particularly true for LIDDA specialized services, except service coordination.[3] FOF ¶ 424. Even when specialized services are recommended, most people with IDD in nursing facilities do not receive all needed specialized services. FOF ¶¶ 426-432.

Due to widespread nursing facility resistance to providing specialized services, requests for recommended specialized services are often delayed or submitted incorrectly, resulting in a high rate of denial by the Health and Human Services Commission (HHSC). FOF ¶¶ 434-437. Although HHSC is aware of the low number of recommended specialized services, it does not address the reasons for this pattern. FOF ¶¶ 415, 419-422, 432-433, 438-439.

3. People with IDD Do Not Receive Active Treatment.

Texas does not ensure or require the provision of active treatment to people with IDD in

[2] Specialized services for people with IDD are defined by 42 C.F.R. § 483.120(a)(2) as "… the services specified by the State which, combined with services provided by the [nursing facility] or other service providers, results in treatment which meets the requirements of 483.440(a)(1) [Active Treatment]."

[3] These LIDDA specialized services include behavioral support, independent living skills, employment support, day habilitation services, and service coordination.

nursing facilities, as required by 42 C.F.R. § 483.440(a)-(f).[4] The term "active treatment" is completely absent from HHSC's rules, policies, procedures, and training, since HHSC does not expect or require that nursing facilities or LIDDAs provide active treatment. FOF ¶¶ 487-490.

C. Texas Unnecessarily Institutionalizes People In Nursing Facilities.

1. Texas Rarely Diverts People with IDD from Nursing Facilities.

In order to qualify for a diversion slot and avoid nursing facility admission, individuals must have a PE completed prior to admission that confirms they have IDD and are appropriate for community placement. FOF ¶¶ 304-305, 734. But, as noted above, a PE is not completed prior to admission for almost all people with IDD who enter nursing facilities. FOF ¶¶ 304-309, 734, 823-826, 830; *see also* ¶¶ 876-878, 880. Other barriers to diversion include insufficiently funded diversion resources, and Texas' failure to proactively address serious medical conditions that place individuals in the State's programs at risk of hospitalization and then nursing facility admission, among others. FOF ¶¶ 833-838, 876, 881-904, 929-937.

2. Texas Fails to Transition People with IDD from Nursing Facilities.

Texas does not transition qualified individuals with IDD from nursing facilities to the community. As of September 1, 2017, Texas had dramatically cut funding for transition resources including Home and Community Services (HCS) Medicaid waiver slots, which are the primary means Texas uses for transition. FOF ¶¶ 1170-1174, 1189-1215. Even when Texas appropriated sufficient funding of HCS waiver slots in the prior biennium, these slots were underutilized because, among other things, Texas failed to ensure people could make an informed choice and people with complex needs could promptly transition to the community. FOF ¶¶ 920-928.

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[4] *See* FOF ¶¶ 477-508 for a description of the scope of active treatment.

According to Texas' QSR data, approximately 46% of people with IDD in nursing facilities are interested in transitioning from nursing facilities. Expert data found that over 70% are interested in learning more about transition. FOF ¶ 621, 622. Texas does not: provide sufficient information about community living in a manner that accommodates disabilities; ensure that people with IDD in nursing facilities receive regular opportunities to have experiences in community settings; or address barriers to community transition. FOF ¶¶ 774-75, 777-813, 833-875, 959-960, 985, 991, 1000, 1011, 1016-19, 1100, 1206. As a result, individuals with IDD are not able to make an informed choice whether to remain in a nursing facility. FOF ¶¶ 756, 776, 805. Further, Texas does not analyze data regarding informed choice including: the number of individuals who chose to remain in a nursing facility and the reasons for their choice; barriers to transition; the number or type of visits to community providers and homes; the number and type of meetings between people with IDD and providers, peers, or family groups; or the type of information and experiences provided to allow people with IDD and their guardians to make an informed choice whether to remain in a nursing facility. FOF ¶¶ 905-928, 938-942, 960, 1181-1185, 1187-1188, 1195-1196.

D. HHSC Does Not Appropriately Manage and Administer its IDD System.

HHSC does not appropriately manage or administer its IDD system to ensure the timely placement of qualified individuals with IDD in integrated settings. First, Texas does not ensure there is adequate provider capacity throughout the State, particularly for people with more complex needs; does not administer and fund provider programs to ensure they can serve individuals with complex needs; does not systematically collect and analyze data on barriers to transition; and does not analyze complaints it receives regarding insufficient community capacity. FOF ¶¶ 833, 860-862. Second, Texas' *Olmstead* Plan lacks specific and measurable

goals, benchmarks, and timeframes to prevent the unnecessary institutionalization of individuals with IDD in nursing facilities. FOF ¶¶ 1136-1137. Texas' own data shows that the nursing facility census of individuals with IDD has not decreased over the last six years. FOF ¶¶ 818-822. Texas also does not know the number of individuals who desire to transition from nursing facilities or who are at risk of nursing facility placement who would need diversion slots. FOF ¶ 1215.

E. People with IDD Have Suffered Irreparable Harm.

Because Texas has designed its PASRR program in a manner that does not ensure that needed specialized services are delivered to individuals with the requisite frequency, intensity, and duration, people with IDD suffer, or are at serious risk of suffering, irreparable harm, including aspiration, choking, painful and irreversible contractures, loss of skills, and decreased functioning. FOF §§ II.G-I; ¶¶ 509-527; Pls.' and U.S.' Concl. of Law (COL) ¶¶ 151-152, 154-155, 157. In addition, because Texas has designed its IDD system in a manner that does not prevent unnecessary admissions to segregated nursing facilities and that does not provide transition services to all qualified individuals with IDD in nursing facilities, people with IDD suffer, or are at serious risk of suffering, unnecessary segregation. FOF §§ II.D, III.D, IV.C.9.c-d; COL ¶¶ 153-156.

III. The QSR Measures Compliance with Federal Law and Its Findings Are Reliable Evidence of HHSC's Ongoing Violations of Federal Law.

A. The State Designed, Implemented, and Adopted the QSR to Measure Compliance with Federal Law.

The parties negotiated and executed an Interim Settlement Agreement (IA) that was approved by the Court on August 13, 2013, ECF No. 180. That IA was designed to set forth the actions that the State would take to comply with the NHRA and other provisions of the Medicaid

Act, the ADA, and Section 504. IA § I.C. A key component of the IA was the development and implementation of a Quality Service Review (QSR), which was designed to measure the State's compliance with these agreements and with areas of federal law. IA § VII.C.4. As the Court noted: "[A]lthough the outcome measures developed by the parties and applied by the [Expert Reviewer] may not be entirely identical with the pertinent requirements of the federal law, many of them, as discussed below, are closely analogous to their federal law counterparts." *Steward* , 315 F.R.D. 472, 479 (W.D. Tex. 2016); *see also id.* at 486-87 (discussing the close nexus between various outcomes and federal statutory or regulatory requirements).

The State publicized and characterized the QSR as a tool to measure compliance with federal law. FOF ¶ 58. As recently as July 2017, HHSC issued an Information Letter to all service providers declaring that the QSR would continue to be used to ensure that individuals with IDD are receiving: (1) federally required PASRR screening and evaluations; (2) services in the most integrated residential settings consistent with their choice; and (3) if residing in nursing facilities, the specialized services needed to maintain their level of functioning and increase their independence. FOF ¶ 69.

B. The Outcomes and Outcome Measures Assess Compliance with Federal Law.

The QSR includes six outcomes – each of which measures a different requirement of federal law.[5] *See Steward,* 315 F.R.D. at 482-83. According to Ms. du Pree, the parties' joint

[5] The six outcomes address: 1) diversion, 2) nursing facility specialized services, 3) transition, 4) community services, 5) service coordination, and 6) service planning. Each outcome is stated in language that mirrors federal law. For instance, Outcome 2 measures whether: "Individuals in the Target Population in nursing facilities will receive specialized services with the frequency, intensity and duration necessary to meet their appropriately-identified needs, consistent with informed choice." FOF ¶ 87. Similarly, the outcome measures in Outcome 2 all evaluate compliance with various requirements of PASRR and the ADA, including whether individuals have an appropriately constituted service planning team (2-1, 2-2), receive a comprehensive

expert and the State's own consultant, meeting all of the QSR outcomes and outcomes measures is necessary to have an effective diversion, specialized services, and transition program that satisfies the requirements of PASRR and the ADA. FOF ¶¶ 58-59, 107-09. The former commissioner of two state IDD agencies, Ms. Elin Howe, concurred.[6] FOF ¶¶ 79-82, 89, 92-93, 95, 96, 99-104, 108-09.

Ms. du Pree repeatedly expressed her professional opinion to senior state officials that each of the six outcomes were consistent with and required by federal law. FOF ¶¶ 84, 89, 96, 100, 103. At the parties' request, she drafted each of the outcome measures to reflect the requirements of federal law. FOF ¶¶ 63, 64, 74, 76. She authored the indicators, which are used to determine compliance with each outcome measure, based upon the specific requirements of federal law. FOF ¶¶ 75-76. Thus, as described in the testimony of Ms. du Pree, each of the QSR's outcomes and outcome measures were designed to assess compliance with federal law. FOF ¶¶ 76, 84-86, 89-94, 96, 98, 100, 103.

C. The QSR Process Is a Reliable Measure of Compliance with Federal Law.

The QSR process includes a review of a random sample of three groups of Medicaid-eligible individuals with IDD who are age 21 and older: (1) those who currently reside in a

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assessment of all habilitative needs (2-4), receive all needed specialized services (2-5), have coordinated and consistent service plans from the nursing facility and LIDDA (2-8), are admitted to a nursing facility that can provide all needed specialized services (2-11), and receive information to make an informed choice about whether to remain in a nursing facility (2-6, 2-7). FOF ¶¶ 73, 74, 90-93, 369, 370, 393.

[6] Compliance with each outcome is based upon the average of scores for each outcome measure, which in turn is based upon a binary score (Met/Not Met) for each indicator within the outcome measure. FOF ¶¶ 119-20. This structure is almost identical to the one employed by CMS to certify nursing facilities and Intermediate Care Facilities (ICFs). FOF ¶¶ 117, 481. So even if a particular indicator (or in CMS' terms, a "probe") does not literally track the language of a regulation, compliance with federal law requires that the findings for indicators, outcome measures, and outcomes (or probes, tags, and conditions of participation, in CMS' certification process) result in an aggregate score of at least 85%. *See* FOF ¶¶ 481-82; *see also* FOF ¶ 123.

nursing facility (the Nursing Facility Target Population); (2) those who have been diverted from admission to a nursing facility into a community-based, Medicaid program (the Diversion Target Population); and (3) those who have transitioned from a nursing facility into a community-based, Medicaid program (the Transition Target Population). FOF ¶ 110. The sampling methodology, the protocol instrument, and the scoring methodology were developed by Ms. du Pree, in conjunction with state employees and with approval of state officials.[7] FOF ¶¶ 111-12, 121, 123. The independent professionals who initially conducted the QSR were approved by the State, and the state employees who subsequently conducted the QSR were hired and supervised by the State. FOF ¶¶ 114,116.

The State elected to continue the QSR in virtually the same form, even after the termination of the Interim Agreement and even after assessing compliance with the IA's provisions was no longer required. FOF ¶ 63. In all respects, the State adopted, implemented, and controlled the QSR process, and continued to use it as an evaluation tool of its own compliance with federal law. FOF ¶¶ 65-68, 124-25.

D. The Findings of the QSR Prove Ongoing Violations of PASRR and the ADA.

Ms. du Pree conducted the QSR in 2015, 2016, and 2017. FOF ¶ 64. The findings for these three annual QSRs demonstrated that the State is not complying with its obligations under both PASRR and the ADA. FOF ¶¶ 139-40, 145-46.[8] For example, the QSR findings for the Nursing Facility Target Population under Outcome 2—which measures whether people with

[7] The sampling process was primarily created by an HHSC statistician, who advised Ms. du Pree on all technical sampling issues to ensure that the sample was random, that its results were statistically reliable, and that its findings were generalizable to each of the relevant Target Populations. FOF ¶¶ 110, 111.

[8] Since the 2017 QSR data and report includes information that post-dated the fact cut-off, Plaintiffs' and the United States' expert Michael Neupert calculated the 2017 scores based upon QSR data and reviews that were completed prior to September 1, 2017. FOF ¶¶ 133-34.

IDD in nursing facilities receive specialized services with the frequency, intensity, and duration to meet their individual needs—for the three years the QSR was conducted were only: 36% (2015), 28% (2016), and 32% (2017).[9] FOF ¶ 141. The QSR findings for Outcome 3—which measures whether individuals with IDD in nursing facilities receive transition services consistent with informed choice—*actually decreased* over the three years that the QSR was conducted: 40% (2015), 35% (2016), and 28% (2017). FOF ¶ 142. The QSR findings for Outcome 5—which measures whether individuals with IDD in nursing facilities receive needed service coordination—remained low over these three years: 49% (2015), 45% (2016), and 37% (2017). FOF ¶ 143. And the QSR findings for Outcome 6—which measures whether individuals with IDD in nursing facilities receive needed service planning—were only: 29% (2015), 22% (2016), and 31% (2017). FOF ¶ 144. The findings of the 2015, 2016, and 2017 QSRs demonstrate that Texas is not meeting most outcomes and outcome measures, which are necessary for effective diversion, specialized services, and transition programs. FOF ¶ 145. For Outcome Measure 2-5, less than 20%—only 1 in 5 individuals with IDD in nursing facilities—were receiving PASRR compliant services. *Id*; FOF ¶ 380, 440.

IV. The Client Review Measured Compliance with Federal Law and Its Findings Are Reliable Evidence of Ongoing Violations of Federal Law.

A. The Client Review Was Based Upon a Random Sample that Generated Reliable Findings of All Individuals with IDD in Nursing Facilities.

Dr. Sally Rogers, a nationally-recognized researcher, whose sampling work has been

[9] While the QSR evaluates whether the State provided all needed specialized services, in the requisite frequency, intensity, and duration, it does not technically apply all of the CMS active treatment requirements concerning consistency, continuity, and carry-over. As a result, the QSR findings for Outcome Measures 2-5 and 2-8, although disturbingly low, probably overstate the percentage of individuals who are receiving services in compliance with the active treatment standard in the PASRR regulations.

accepted by other federal courts[10], drew a random sample of all individuals with IDD who lived in nursing facilities within an 80 mile radius of eight metropolitan areas in Texas, which included urban, suburban, and rural areas. FOF ¶¶ 162-164, 170. Consistent with accepted practices in research involving human subjects, each person or their guardian was then asked to consent to participate in the client review and to release relevant records from the nursing facility and LIDDA.[11] FOF ¶ 173-74. Every person in the review was evaluated by one of four IDD professionals who had extensive experience in evaluating services for similarly-situated individuals, and who had conducted similar client reviews in several other states, including Texas. FOF ¶¶ 185-191. Each expert helped develop a set of evaluation criteria, with guidelines to ensure consistent application that they all used to conduct their reviews and render their findings. FOF ¶¶ 192, 193. These criteria reflected core federal requirements and accepted professional standards for obtaining informed choices from people with IDD in institutions. FOF ¶¶ 192,193.

After training by the review coordinator and satisfying an inter-rater reliability test, each IDD professional met with the individual, the guardian where available, the service coordinator, and relevant nursing facility staff. FOF ¶¶ 185, 194. They reviewed medical records before, during, and after their onsite visits, then drafted narratives for each individual, and aggregated their findings for all individuals who they reviewed. FOF ¶¶ 197-198, 209. Finally, the review coordinator consolidated the findings for all fifty-four individuals in the client review to generate

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[10] *See Kenneth R. v. Hassan*, 293 F.R.D. 254, 261-62 (D.N.H. 2013); *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 51 (D. Mass. 2006).

[11] Fifty-four individuals were ultimately included in the current client review. This resulted in a 90% confidence level and a margin of error of 11.07%. FOF ¶ 176. Together with the 27 other individuals included in the initial client review, conducted as part of the preliminary injunction hearing, FOF ¶ 160, a total of 81 individuals were evaluated through both client reviews.

statewide and system-wide findings. FOF ¶ 209. As Dr. Rogers testified, these consolidated findings could be generalized to all people with IDD in nursing facilities in Texas, and certainly to the 71% of individuals who lived within 80 miles of the eight metropolitan areas. FOF ¶ 179.

Evidence from similar client reviews has been accepted as probative of federal law violations in several other cases involving individuals with disabilities, including an almost identical case in Massachusetts. *Rolland v. Patrick,* 483 F. Supp. 2d 107, 115 (D. Mass. 2007) (holding that findings from review sample were convincing evidence of noncompliance); *Rolland v. Cellucci,* 198 F. Supp. 2d 25, 35, 40-42 (D. Mass. 2002)(concluding that review of 39 individuals in nursing facilities reasonably showed that none were receiving active treatment, that the defendants' challenge to certain expert opinions did not undermine this basic finding, and that a margin of error of 14% was acceptable given the prevalence of this deficiency)(D. Mass 2002).

Other courts have similarly relied upon client reviews to conclude that findings applicable to individuals in the review are generalizable to the larger population or class and constitute evidence of systemic patterns or deficiencies. *Kenneth R. v. Hassan*, 293 F.R.D. 254, 261-62 (D.N.H. 2013); *Disability Advocates, Inc. v. Paterson*, 653 F. Supp. 2d 184, 262-263 (E.D.N.Y. 2009); *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 51 (D. Mass. 2006) (finding that clinical review, "even with its limitations, provides substantial, useful information regarding the unmet medical needs of the plaintiff class" and relying on client review in making liability determination). As the *Rosie D.* court noted in finding liability:

> Logistical, financial, and ethical restrictions, for example, reduced Plaintiffs' ability to extract and analyze a sample of class members that was identified in accordance with the strictest academic requirements for perfect randomness. Nevertheless, the thirty-five children analyzed were chosen in a reasonably fair manner designed to minimize bias. The credible evidence demonstrated that the vast majority of this group needed, but was not receiving, clinical interventions such as comprehensive assessments, service

> coordination, crisis intervention, and [] supports that Defendants concede are required under the Medicaid statute. This evidence . . . was vividly probative.

Id. at 29-30. The court relied upon a client review as evidence of a federal law violation, despite the state's criticisms:

> Defendants' criticisms of the clinical review, directed at sample size, absence of academically approved standards of randomization, and possible reviewer bias failed to undercut the import of the evidence provided by the review . . . . With infinite funds, infinite time and infinite access to data, perhaps a more technically sound study might have been fashioned. As one portion of the evidence offered by Plaintiffs, however, this study—even with its limitations of time and cost—vividly supports Plaintiffs claims.

Id. at 51. The same is true here.

B. The Client Review Is a Reliable Measure of Whether Texas Is Complying with PASRR and ADA.

The client review relied on federal regulations, CMS standards, and established professional standards to measure compliance with federal PASRR and ADA requirements. FOF ¶ 193. It sought to determine whether or not adults with IDD in nursing facilities: (1) had received a comprehensive functional assessment of all habilitative areas that accurately identified all of the individual's strengths, needs, and preferences; (2) were receiving all needed specialized services with the appropriate intensity, frequency, and duration to address all areas of need; (3) were receiving active treatment; (4) had a professionally-appropriate Individual Service Plan (ISP) and transition plan that was developed based upon a comprehensive person-centered assessment and that includes all needed services and supports to successfully transition to the community; (5) were appropriate for and would benefit from living in an integrated setting with appropriate community services and supports; and (6) had made an informed choice to remain in a segregated nursing facility. FOF ¶ 169.[12]

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[12] An "informed choice" includes providing adequate, individualized information in a form that accommodates an individual's cognitive needs, that is a meaningful choice among actual options

These six compliance criteria, as well as the subsidiary criteria about choice, are drawn directly from federal law. The first four are explicitly set forth in federal PASRR regulations and its cross reference to federal active treatment standard. 42 C.F.R. §§ 483.120(b), 483.440(a), (c), (d)-(f). The latter two are drawn directly from the ADA's integration mandate, as applied by the Supreme Court in *Olmstead v. L.C.*, 523 U.S. 587 (1999). Because the standards used in the client review are based upon the requirements of federal law, the findings of the review are a reliable measure of the State's compliance with that law.

C. The Findings of the Client Review Prove Ongoing Violations of PASRR and the ADA.

The consolidated findings of the client review are highly consistent and compelling. For the 54 people with IDD in this review, the four IDD professionals found that: (1) None of the 54 individuals received a Comprehensive Functional Assessment; (2) None of the 54 individuals was receiving all necessary specialized services; (3) None of the 54 individuals was receiving active treatment; (4) Only one of the 54 individuals had a professionally appropriate Individual Service Plan (ISP); (5) Fifty-three of 54 individuals are appropriate for and would benefit from living in the community; and (6) Forty-six of 54 individuals or their guardians have not made an informed choice to remain in a nursing facility.[13] FOF ¶¶ 210-215. Thus, virtually all individuals in the client review were not being provided the level of care required by the Medicaid Act, and most were not being provided an opportunity to learn about and make an

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that are or can be made available, and with reasonable efforts to accommodate preferences and address barriers that limit such options.

[13] In addition (a) only two of 54 individuals had an ISP that included a specific description of transition options in Phase II of Section 9; (b) only one individual or their guardian had visited community living or support providers; and (c) only three individuals had barriers to living in the community addressed. Moreover, 72% of individuals expressed an interest in learning more about the community; and 52% of individuals were interested in transitioning to the community. FOF ¶¶ 216-219.

informed choice about where to live and whether to remain in a segregated setting, as required by the ADA.[14]

V. HHSC Does Not Provide Specialized Services and Active Treatment, as Required by Federal Law.[15]

A. The NHRA Requires that States Provide All Needed Specialized Services to People with IDD in Nursing Facilities.

The NHRA was enacted in response to a U.S. GAO Report finding that individuals with IDD were being warehoused in nursing facilities and not provided any habilitative services. *Rolland v. Romney,* 318 F.3d 42, 45-46 (1st Cir. 2003) (describing legislative history and purpose of the NHRA); COL ¶¶ 1-3. Congress mandated not only that States create a pre-admission screening and evaluation program to prevent the unnecessary admission to nursing facilities of individuals with IDD who could be served in alternative placements, but also required States to provide necessary "specialized services" to address all of the habilitative needs of such individuals. 42 C.F.R. §§ 483.114(b)(2) (State must determine if individual needs specialized services); 483.116(b)(2) (State must arrange or provide for needed specialized services); 483.120(b) (State must ensure specialized services are provided by qualified IDD staff and result in a continuous program of treatment and training); 483.130(n) (State must provide assurances that specialized services can and will be provided to individual who is admitted to a nursing facility).[16] COL ¶¶ 5, 7, 17-18. The Secretary explicitly considered, and rejected,

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[14] In most respects, the consolidated findings from the client review mirror the findings of the initial review, resulting in conclusive determinations that virtually no one with IDD in Texas nursing facilities is receiving a comprehensive functional assessment, no one is receiving all needed specialized services, and no one is receiving active treatment.

[15] Section V of this Memorandum reflects the position of the Plaintiffs, as the United States did not assert a claim under the NHRA.

[16] Federal regulations make clear that a State cannot delegate its statutory obligations and its ultimate responsibility to comply with the NHRA. 42 C.F.R. § 483.106(e).

concerns from States that the scope of this obligation was not achievable or appropriate or that something less than active treatment was required. 57 Fed. Reg. 56450-01 at *56476 (Nov. 30, 1992); COL ¶¶ 19-21.

Congress' mandate and the Secretary's implementation of that directive are unequivocal, unconditional, and enforceable. *Rolland,* 318 F.3d at 56*; Grammar v. John J. Kane Regional Centers-Glen Hazel,* 570 F.3d 520, 532 (3rd Cir. 2009); *Steward v. Abbott,* 189 F. Supp. 3d 620, 634-39-38 (W.D. Tex. 2016); *Dunakin v. Quigley,* 99 F. Supp. 3d 1297, 1314-18 (W.D. Wash. 2015); COL ¶ 6.

B. The NHRA and Its Implementing Regulations Require that States Provide Active Treatment, as Described by 42 C.F.R. § 483.120(b) and § 483.400(a)-(f), to People with IDD in Nursing Facilities.

Cognizant of the well-established federal requirement to provide people with IDD with a program of active treatment in Intermediate Care Facilities with IDD (ICF) and community settings, Congress adopted this same requirement for nursing facilities. *See* 135 Cong. Rec. S13057-03, *513238, 1989 WL 195142 ("If a resident is found to be mentally ill or mentally retarded and requires nursing facility care, the individual may reside in a facility, but the State is required to provide active treatment if the individual is found to need it."). COL ¶¶ 5, 7. The Secretary's regulations implemented this Congressional directive to meet the federal active treatment standard applicable to ICFs. 42 C.F.R. § 483.120(a)(2) (requiring active treatment as defined in the ICF regulations, 42 C.F.R. § 483.440(a)); COL ¶¶ 17-18.

As mandated by Congress and directed by the Secretary, active treatment means the same thing for residents of nursing facilities as it does for residents of institutional or community programs for individuals with IDD. 57 Fed. Reg. 56450-01at *56474 (active treatment, as defined for nursing facilities, is identical to active treatment in ICFs). States must guarantee

individuals with IDD a "continuous, aggressive program of active treatment," and not merely something analogous to it. 57 Fed. Reg. 56450-01 at *56475. *See also Rolland v. Cellucci,* 138 F. Supp. 2d at 110, 115-17 (D. Mass. 2001) (rejecting argument that active treatment for individuals with IDD in nursing facilities means something different than for individuals with IDD in other settings); *Rolland,* 198 F. Supp. 2d at 32 (rejecting argument that services only need to be "analogous to active treatment").

The Secretary considered and rejected several arguments by the States as to the meaning and application of the federal active treatment standard. When States protested that a continuous program of active treatment might require them to fund qualified IDD staff at nursing facilities twenty-four hours a day, the Secretary agreed that this is the intent and clear effect of the regulation. 57 Fed. Reg. 56450-01 at *56476; COL ¶¶ 21-22. When the States argued they should be able to compel nursing facilities to provide some portion of the specialized services mandated by the statute and regulations, the Secretary disagreed.

> Response: Commenters who believed that NFs [nursing facilities] were prohibited by the proposed rule from providing specialized services misunderstood our intent in stating that specialized services is not a NF responsibility. We meant to prevent NFs from being required by States to provide specialized services, not to bar them from providing it if they choose to do so and are staffed and equipped to provide these services.

57 Fed. Reg. 56450-01 at *56480.

Active treatment is both defined and described by the Secretary in the ICF regulations, 42 C.F.R. § 483.440(a)-(f); COL ¶ 23-24. While the definition of active treatment is set forth in subsection (a), the components of active treatment – including conducting necessary assessments, convening the service planning team, identifying service goals and objectives, developing the service plan, describing necessary services, and monitoring and implementing the service plan – are set forth in subsections (c)-(f). COL ¶¶ 23-27. CMS requires compliance with all of these subsections in order to constitute a program of active treatment. COL ¶¶ 24, 32. It

inspects and only certifies programs that satisfy all of these elements. It authorizes federal funding only for programs that meet all of these requirements. And there is a consensus amongst IDD professionals, IDD professional associations, and IDD professional accreditation bodies that active treatment cannot be achieved absent compliance with all the provisions set forth in subsections (c)-(f). FOF ¶¶ 99-100, 102-103.

This authoritative construction of the statute by the agency directed by Congress to interpret and implement the statute is entitled to considerable deference. COL ¶ 22. Courts have adopted CMS' definition and implementation of active treatment. *Rolland,* 318 F.3d at 57; *Rolland*, 483 F. Supp. 2d at 114 (holding that active treatment is not confined to the definition set forth in § 483.440(a)(1) but extends to all subsections of the regulation, including §§ 483.440(a)-(f)); *Rolland,* 138 F. Supp. 2d at 115-117; *Rolland,* 198 F. Supp. 2d at 32; COL ¶¶ 23-34.[17]

C. Texas Does Not Provide All Needed Specialized Services and Active Treatment to People with IDD in Nursing Facilities.

Texas does not claim to, attempt to, or pretend to provide active treatment to individuals with IDD in nursing facilities. FOF ¶ 487. HHSC officials admit that agency policies, procedures, practices, training, and monitoring do not require or expect LIDDAs or nursing facilities to provide active treatment to individuals with IDD in nursing facilities. FOF ¶¶ 485, 489-92, 496. The findings from the initial and current client review confirm this omission – not one of the eighty-one individuals in either review was receiving active treatment. FOF ¶¶ 497, 500. The QSR for 2017 found that only 35% of individuals in the Nursing Facility Target Population have an appropriate service planning team, most do not receive all needed

[17] That the PE and documentation regulation, 42 C.F.R. § 483.136(a) uses the term "analogous to active treatment" does not either modify or undermine the command in § 120(a)(2) that services "must result in treatment which meets the requirements of § 483.440(a)(1)" – active treatment. *See Rolland,* 198 F. Supp. 2d at 32, n. 6 (citing *Rolland,* 138 F. Supp. 2d at 116).

assessments, and less than 20% received all needed specialized services – all of which are foundational requirements for active treatment. FOF ¶¶ 141-45; Ex. P/PI 254 at 7. Thus, Texas violates federal law by not providing active treatment, as required by 42 C.F.R. § 120(a)(2) and 483.440(a)-(f), to all individuals with IDD in nursing facilities.

VI. Thousands of Adults with IDD in Texas Are Unnecessarily Segregated, or at Serious Risk of Unnecessary Segregation, in Nursing Facilities, in Violation of Federal Law.

Nursing facilities in Texas are institutional, segregated settings, where adults with IDD do not have regular opportunities to interact with their peers without disabilities. COL ¶¶ 93-95; FOF § III.B. Because adults with IDD who are living in or at serious risk of entering these segregated facilities are qualified, appropriate for, and do not oppose community services, the State has violated, and is continuing to violate, the ADA and Section 504[18] by failing to place these adults into community service settings. 28 C.F.R. § 35.130(d); *Olmstead*, 527 U.S. at 602, 607 (citing 42 U.S.C. § 12132).

A. People with IDD in Nursing Facilities Are Qualified for the State's Long-Term Care Services and Appropriate to Receive Those Services in the Community.

All Medicaid-eligible adults with IDD in, or at serious risk of entering, nursing facilities meet the essential eligibility criteria for the State's long-term care services system, including home and community based waiver services like the HCS waiver program, because they are Medicaid-eligible adults who have IDD and meet an institutional level of care. COL ¶¶ 89, 92. They therefore are appropriate and qualified for community-based services.[19] COL ¶¶ 89, 92; 40

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[18] Because proof of liability under the ADA encompasses liability under Section 504, the discussion of the ADA herein incorporates Section 504 by reference. COL ¶ 144.

[19] People with IDD living in nursing facilities in Texas and those receiving services in community settings, both in Texas and across the country, are not materially different with respect to their needs or preferences. COL ¶¶ 90-92; FOF ¶¶ 586-589. The experts who

Tex. Admin. Code § 9.155 (2016). In fact, the State's community services, such as the HCS waiver and other programs, are specifically designed to meet the needs of people with IDD who meet an institutional level of care, including those who live in nursing facilities, as Defendants' own witnesses have explained.[20] FOF ¶ 41-43, 571, 585.

B. People with IDD in and at Serious Risk of Entering Texas Nursing Facilities Do Not Oppose Community Based Services.

People with IDD who qualify for State-provided services must receive them in the most integrated setting appropriate to their individual needs, unless they make an informed choice to remain in a segregated setting. COL ¶¶ 96-99. Many people with IDD receiving services in Texas nursing facilities have indicated that they want to pursue or explore moving to the community. These people clearly do not oppose community services. Further, the vast majority of people with IDD in Texas' nursing facilities also cannot be said to knowingly oppose community settings because they have not made an informed choice to remain in an institution, and the State has not provided them the opportunity and information necessary to enable them to do so.

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conducted the client review found that, based on their experience working with individuals with IDD and their knowledge of community services, 98% of all individuals reviewed were appropriate to live in the community. FOF ¶¶ 204, 206, 214, 590-594. Community service providers in Texas and Texas' own data, officials, and experts confirmed that people with IDD, including those with complex needs, successfully live in the community, and that they are not significantly different from those living in nursing facilities. FOF ¶¶ 569-570, 572-585.

[20] It is well established that determinations of appropriateness for community services are not delegated to the state's treatment professionals. COL ¶ 91. Even so, Defendants did not try to show that the treating professionals of people with IDD in nursing facilities have determined that they are inappropriate for community services. *E.g.*, FOF ¶ 597. In fact, the only evidence from those treating professionals supports the conclusion that individuals with IDD are appropriate for community services. FOF ¶ 94 (just five people reviewed in 2016 QSR had SPTs recommending continued nursing facility placement); *see also* FOF ¶ 599. Moreover, Defendants' officials and experts admitted that people with IDD can be served in the community. *Supra* n.19.

1. Many People in Nursing Facilities Have Expressed a Desire to Move to the Community.

People do not oppose community placement when they are asking to move to the community or expressing interest in moving to the community. COL ¶ 98. The 2016 QSR showed that just under half of the people with IDD in Texas nursing facilities expressed interest in transitioning. FOF ¶ 621. The client review showed that 52% of the people reviewed were interested in moving to the community.[21] FOF ¶¶ 219, 622-623. People with disabilities and their families echoed such interest. FOF § IV.B.[22]

This evidence refutes the State's assertions that everyone who wants to move to the community has already moved. Indeed, the only evidence Defendants presented on this point were statements that HHSC had not denied a *formally submitted request* for a waiver slot in recent years. Trial Tr. 3462:2-3464:23, Nov. 6, 2018 (Blevins); Trial Tr. 3777:20-3778:1, Nov. 9, 2018 (Turner); *see also* FOF ¶ 757. Awaiting an affirmative request for community placement is not sufficient for a state to satisfy its obligations under *Olmstead*. COL ¶ 100.

2. Many People with IDD in Nursing Facilities Have Not Made an Informed Choice to Remain in a Segregated Setting.

For people with IDD who have not decided to receive services in the community, the ADA requires that states provide sufficient information and opportunities that allow them to make an informed choice whether to remain in a nursing facility. COL ¶¶ 100-104. This reflects the fundamental principle under the ADA that people with IDD have the right to receive services

[21] A state official even testified that she believed that people with disabilities were being institutionalized in Texas nursing facilities when they do not want or need to be in a nursing facility. FOF ¶ 624.

[22] *Olmstead* recognizes that the ADA does not require a person to accept an accommodation they do not want. COL ¶ 97. For example, it is possible that some people may make an informed choice not to leave a nursing facility. However, as the client review experts as well as the QSR found here, there is considerable evidence that this is not happening for individuals with IDD in Texas nursing facilities. FOF § IV.A-D.

in an integrated community setting, where appropriate, and should not have to forego that right to receive needed state services. COL ¶¶ 80, 83, 96-97; *Messier v. Southbury Training Sch.*, 562 F. Supp. 2d 294, 337 (D. Conn. 2008) ("The ADA's preference for integrated settings is not consistent with a procedure in which remaining at [the institution] is the default option for residents."). It is well established that states must provide effective assistance and communication for people with disabilities, particularly people with IDD, in a way that they understand and is suited to their individual needs, in order to ensure that they do not improperly or unknowingly waive their rights and that they have an equal opportunity to participate in services and procedures. COL ¶¶ 104-105, 109-110. Concluding that people with IDD oppose community placement when they have not received, in a form that accommodates their disabilities, information and opportunities necessary to allow them to make an informed choice would thwart the express purpose of the integration mandate and *Olmstead*.

Thus, for institutional residents with disabilities, or their guardians, who have not decided whether to move to the community, states are required to provide adequate, individualized information about community services in a form that accommodates their disabilities which may include: periodically offering them and educating them about particular, concrete community options, providing them with the opportunity to experience community services and activities, and ensuring they understand the options available. COL ¶¶ 98-104, 106. Absent such information and opportunities, courts will not find that the person opposes community placement under *Olmstead*. Further, an individual cannot be said to oppose community placement where they have not expressed a preference, where they have expressed ambivalence or indecision, or

where they have declined a community placement without receiving sufficient information. COL ¶¶ 98-99.[23]

For example, in *Disability Advocates, Inc. v. Paterson*, the court considered whether 4300 adults with serious mental illness who were living in private "adult homes" licensed by the state opposed community placement under *Olmstead*. 653 F. Supp. 2d 184 (E.D.N.Y. 2009), *vacated on other grounds*, 675 F.3d 149 (2d Cir. 2012). Although the state assigned case managers to provide community placement information to residents, the evidence showed that residents were not adequately informed about community options. *Id.* at 261. And an assessment of a portion of residents showed that just over half had "expressed an interest" in community placement and about 75% "did not express a preference for living in" the institution. *Id.* at 262. The court further found that the state itself had recognized the importance of "informed choice" and that state witnesses had testified that people tended to choose community options when adequately informed of them. *Id.* at 263-64. Further, the court recognized that long-term institutionalization can lead to learned helplessness, making it common for people to be "reluctant or ambivalent" about transition without additional assistance and information. *Id.* at 265-66. Because the court was convinced "that many would choose to live in [a community setting] if given an informed choice" and "accurate information," the court concluded that the adult home residents were not opposed to moving to a more integrated setting. *Id.* at 267.

Similarly, in *Messier*, the court examined the state's process for assessing whether residents were interested in transition to the community. 562 F. Supp. 2d at 332-34, 339. All residents had an interdisciplinary team (IDT) that, by regulation, was responsible for considering

[23] Notably, under Texas law, guardians are required to select the most integrated setting for the individual as part of the basic bill of rights included in Texas' guardianship law. COL ¶ 99 n.4.

community placement. *Id.* at 328. But in practice, the IDT did not make individualized recommendations about community placements. *Id.* The court discounted reports of guardians' positive responses to IDT questions whether their ward would "like to remain," because the answers were ambiguous and made without adequate information about alternative placement options. *Id.* at 331-33, 337. Even after the state enhanced its IDT process, the court found that some guardians still were "not familiar with what resources would be available" and documentation showed guardian statements that were ambivalent or undecided. *Id.* at 340-42. The court ultimately found that the state's processes for informing guardians about community placement options, and inquiring about their choices, were not consistent with *Olmstead*'s requirements.

Courts also have made clear that states must do more than just wait for a person to affirmatively request community placement in order to comply with *Olmstead*. COL ¶¶ 100-101. And, any process to inform about community placement options must address the person's specific needs and accommodate her cognitive disabilities. *See, e.g.*, COL ¶¶ 104, 108-110.

Texas has not ensured that people with IDD in nursing facilities have made an informed choice to remain in a segregated setting and knowingly forgo the opportunity to live and receive services in an integrated setting. In fact, most people with IDD in Texas nursing facilities have *not* made an informed choice to remain. Many have expressed interest in leaving the nursing facility, in learning more about community options, or, at the very least, have expressed ambivalence or indecision, just as in *Messier* and *Disability Advocates, Inc.*[24] *See* FOF § IV. And virtually none have received the information or experiences necessary to make an informed decision to remain in the nursing facility. FOF §§ IV.C.5-10.

[24] Similar to the results of the assessment conducted in *Disability Advocates, Inc.*, 72% of individuals in the client review expressed interest in learning more about transition. FOF ¶¶ 219, 622.

Nor does Texas adequately identify or address barriers to transition, including concerns about community living: although all should have had barriers to living in the community identified and addressed, this occurred for just 6% of all individuals in the client review. FOF ¶¶ 218, 796-797; *see also* FOF § IV.C.10. The evidence shows that Texas' process is similar to those rejected in *Disability Advocates, Inc.* and *Messier*. As a result, 85% of people in the client review had not made an informed choice to remain in a nursing facility.[25] FOF ¶¶ 215, 807; *see also* § IV.D. With adequate information and opportunities to make an informed choice, most people with IDD in and at serious risk of entering Texas nursing facilities likely would not oppose community placement. *See, e.g.*, FOF ¶¶ 735, 776, 794, § III.D, § IV.B; *cf. Disability Advocates, Inc.*, 653 F. Supp. 2d at 263-64, 267. And without information sufficient to allow individuals with IDD to make a decision about available community services, the mere claimed existence of waiver slots is not meaningful. *Olmstead* directs courts to consider whether individuals *do not oppose* the community, not whether they have asked to leave the nursing facility. COL ¶¶ 96-97. Accordingly, the Court should find that adults with IDD in Texas nursing facilities do not oppose community placement.

VII. The State Can Reasonably Accommodate Placement in the Community

To prove a violation of the ADA's integration mandate, *Olmstead* requires a *prima facie* showing that the state can reasonably accommodate placement and services in the community. COL ¶¶ 112-114. Plaintiffs and the United States have met their burden of identifying reasonable modifications in policies, practices, or procedures that would enable people with IDD to avoid unnecessary segregation or institutionalization. The fact that these modifications, set

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[25] These findings about the lack of opportunities to make an informed choice belie Defendants' position that everyone who wants to leave the nursing facility can leave.

forth below, align with the state's own policies or nationally recognized practices is *prima facie* evidence of their reasonableness. *See, e.g.*, COL ¶ 116.

A. The State Can Reasonably Modify its Processes for Preventing the Unnecessary Admission of People with IDD to Nursing Facilities.

Diversion is a fundamental objective and requirement of the ADA, Section 504, and PASRR. COL ¶¶ 3, 5, 11-14, 81-84; *see also*, *e.g*., FOF ¶¶ 238-241, 277. National standards, CMS directives and trainings, Texas policy and regulations, and other trial evidence also underscore the importance of diversion – and PASRR's diversion mechanisms in particular – in preventing unnecessary segregation. *See* FOF ¶¶ 238-244, 279, 285-291. However, as implemented, the State's process denies the vast majority of people the opportunity to avoid unnecessary admission to a nursing facility.[26] FOF ¶¶ 276, 292-309; *see also* FOF ¶¶ 271-274. Requiring that LIDDAs conduct PEs prior to admission in most cases, in order to prevent people with IDD from being unnecessarily segregated in nursing facilities, is a reasonable modification to Texas's service system.[27] *See* COL ¶¶ 115, 122; FOF ¶¶ 310, 1093-1095.

Similarly, it is reasonable for the state to ensure that community providers serving individuals with IDD take proactive steps to identify and address conditions that might lead to unnecessary hospitalization and nursing facility admission. COL ¶¶ 115, 122; FOF ¶¶ 318-319, 1094; *see infra*, § VII.C. It is also reasonable to develop systemic outreach efforts to the entities that commonly refer people with IDD to nursing facilities, in order to promote early

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[26] As a result, the vast majority of people with IDD who are referred to nursing facilities do not have the benefit of a community living options discussion until after admission. FOF ¶¶ 294, 734.

[27] The fact that CMS has approved these excepted categories under the NHRA does not relieve Texas from complying with the ADA, whose integration mandate is independent from PASRR. Texas may violate the ADA even while satisfying CMS-approved state plans, waiver services, and amendments. *See* COL ¶ 77.

identification and intervention when people are at serious risk of admission, and to require the LIDDAs to intervene and arrange additional supports in a timely manner. *See* COL ¶¶ 115, 122; FOF ¶¶ 280, 311-314, 1094. The evidence shows that this has not happened in Texas. FOF ¶¶ 308, 315-317, 320-325, 880, 847-848.

B. The State Can Reasonably Modify its Outreach, Education, and Choice Processes to Ensure Each Person with IDD or Guardian Makes an Informed Choice about Whether to Enter or Remain in a Nursing Facility.

Professional standards and Texas policy require the provision of sufficient information and opportunities to ensure that people with IDD can make an informed choice about whether they oppose community placement. *See generally* FOF § IV.C. It is a reasonable modification of Texas's service system to require: (1) individualized information about community options that accommodates cognitive and other disabilities; (2) opportunities to participate in community events with non-disabled people, receive LIDDA specialized services that allow them to learn about the community, visit community programs, and meet with families and peers who have transitioned; (3) concrete service options and supports that meet their needs and preferences, developed through person-centered transition planning; and (4) assistance to address fears, concerns, prior negative experiences, the impact of extended periods of institutionalization, and other barriers to living in the community. *See* FOF § VII.B. That these steps are necessary was confirmed repeatedly and consistently by Plaintiffs' and the United States' experts and HHSC's own consultant, experts, officials, and policies. §§ IV.C.1-4; IV.C.9.a. However, these actions rarely, if ever, occur in Texas. FOF §§ IV.C.5-8, IV.C.9.b-d, IV.C.10, ¶¶ 424, 462-467, 505, 521-522.

C. Ensuring an Appropriate Service Array and System Capacity Is a Reasonable Modification.

Timely access to community supports and services that enable people with IDD to avoid

unnecessary segregation in nursing facilities is essential to compliance with the integration mandate of *Olmstead*. *See* FOF ¶¶ 832-834, 1226-1227.[28] It is well established, and Texas's own policies, documents, and state officials acknowledge that people with all levels of need can be served in the community. FOF ¶¶ 574, 596, 1112-1125, 1285-1318, 1340-1374, 1396-1413; *see generally* FOF § III.C. Thus, Texas can modify and expand its system to serve all qualified people with IDD in nursing facilities.

It is standard in the field for states to conduct a gap analysis of its community service system and develop a plan to address service gaps. *See* FOF ¶¶ 947, 1127, 1232-1233. However, the State has not analyzed whether there is sufficient statewide provider and LIDDA capacity to meet the needs of individuals with IDD and has not fully identified service gaps that impede the prompt diversion or transition of people with IDD from nursing facilities. *See* FOF ¶¶ 860-861, 955, 1240-1242. It is a reasonable modification for Texas to do this analysis and take actions to address identified deficiencies, including the lack of community services for people with high medical needs, people who need wheelchair accessible homes, and people who would like to live in particular areas of the State. *See* FOF ¶¶ 836-839, 857-859, 873-874.

In addition, Texas can and should provide people with IDD in nursing facilities access to the same community supports that are available to people with IDD in its state supported living centers, including sufficient level of need (LON) classifications and access to increased reimbursement for people with high medical needs. FOF ¶¶ 841-846, 851-856. Similarly, Texas can and should provide additional supports to avoid unnecessary hospitalization or nursing

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[28] Where, as here, a state already offers community services to some people with IDD, providing those same services to additional people with IDD is a reasonable modification of its IDD system. COL ¶ 127.

facility admission and require residential providers and LIDDAs to implement crisis plans for all individuals who have complex conditions. FOF ¶¶ 318-325, 847-848.

D. The State Can Reasonably Modify Its Monitoring, Oversight, and Training.

Finally, Defendants can, and should, reasonably modify their policies and procedures to provide sufficient training for LIDDA and nursing facility staff, oversight, and monitoring of community providers and LIDDAs in order to ensure that their IDD system meets its intended goals. It is reasonable for Texas to modify its policies and procedures in order to provide effective training,[29] to utilize and analyze the information it already collects,[30] and to collect additional data in order to provide sufficient oversight and monitoring[31]. These modifications are reasonable, feasible, and have been successful in other states, FOF § VII.D, but Texas has not made them.

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[29] For example, HHSC trainings for LIDDA staff provide almost no guidance about how to accomplish diversions or about how to hold a community living options discussion, identify or address concerns about community living, and conduct other activities crucial to informed choice and transition planning. FOF ¶¶ 882-898, 901-904. Additionally, trainings for nursing facility staff are not sufficient to address the needs of individuals with IDD. FOF ¶¶ 1079-1085.

[30] HHSC fails to utilize information it already collects to monitor or improve performance. For example, HHSC does not take *any* action based on the QSR findings or recommendations. FOF ¶¶ 963, 966-967, 972-984, 988-989. Additionally, no one at HHSC is responsible for reviewing – let alone analyzing or taking action based on – the LIDDA Quarterly reports. FOF ¶¶ 928, 1013-1015, 1017-1019. And the State fails to utilize data from the CAO annual reviews or the quarterly reports to identify any trends across LIDDAs. FOF ¶¶ 1007, 1013-1014.

[31] For example, HHSC fails to review LIDDAs that fail to accomplish any diversions or transitions, although HHSC officials agree that these failings require targeted review. FOF ¶¶ 935-936, 939-41. Similarly, the state has not tracked readmissions of individuals who were diverted, does not review admissions or readmissions to determine whether anyone could have been diverted, and does not track whether LIDDAs are identifying barriers to diversion. FOF ¶¶ 931-934, 958-959. And the state fails to track critical measures relating to choice, such as how many individuals have made community visits or had peer meetings, or whether the person facilitating the CLO conversation has developed specific strategies to address an individual's concerns about community living. FOF¶¶ 917, 923-925, 960; *see generally* FOF § V.D.1.

VIII. The Modifications Would Not "Fundamentally Alter" the State's Services, Programs, or Activities.

Defendants did not present evidence that modifications would "fundamentally alter" the State's services, programs, or activities as required to avoid liability under the ADA and Section 504. *See* COL ¶ 126. They failed to do so despite their knowledge of the relief agreed to in the Interim Agreement in this case, ECF No. 180; Plaintiffs' and the United States' extensive interrogatory responses on remedy, *see* ECF No. 509; and Defendants' ready access to their own cost and related data regarding services for people with IDD in nursing facilities and community settings. Defendants have failed to demonstrate that any of the requested modifications would fundamentally alter the State's service system.

Even if Defendants had properly raised a fundamental alteration defense, it could not succeed because they do not have an effectively working *Olmstead* Plan. To successfully raise a fundamental alteration defense, Defendants must prove that they have a "comprehensive, effectively working plan for placing qualified persons with . . . disabilities in less restrictive settings." *Frederick L. v. Dep't of Pub. Welfare of Pa. (Frederick L. III)*, 422 F.3d 151, 155-59 (3d Cir. 2005); *see also Olmstead*, 527 U.S. at 605-06; COL ¶ 128. An *Olmstead* Plan must demonstrate a specific and measurable commitment to action, including goals, benchmarks, and timeframes for which a public entity can be held accountable. *See* COL ¶¶ 129-132. But Defendants have not shown that they have any effectively working "*Olmstead* Plan" – nor could they, given the contrary evidence. *See* FOF § VIII.

Texas's *Olmstead* Plan—its "Promoting Independence Plan," *see* FOF ¶ 1135—does not have specific, measurable goals related to *any* population, particularly individuals with IDD in nursing facilities. FOF ¶ 1137; Ex. P/PI 1002. Further, the State intentionally dissolved the primary oversight mechanism of its Promoting Independence Plan – the Promoting

Independence Advisory Committee (PIAC) – after it heralded the role that the PIAC played in drafting and monitoring its Plan but then largely ignored the PIAC's recommendations.[32] *See* FOF ¶¶ 1140, 1216-1218, 1222-1223. And the Plan is clearly *not* effectively working, as the number of individuals with IDD in nursing facilities has not declined, despite evidence that these individuals are interested in moving to the community. *See* FOF §§ VIII.B, IV.A, IV.B.

A. The State Has Not Demonstrated a "Measurable Commitment to Deinstitutionalization."

"[T]here is wide-spread agreement that one essential component of an 'effectively working' plan is a measurable commitment to deinstitutionalization."*Day v. District of Columbia*, 894 F. Supp. 2d 1, 28 (D.D.C. 2012) (collecting cases); *see also* COL ¶ 129. Texas has not demonstrated such a commitment for individuals with IDD in or at serious risk of admission to nursing facilities. The commitment must be more than "[g]eneral assurances and good-faith intentions," which "are simply insufficient guarantors in light of the hardship daily inflicted upon [individuals] through unnecessary and indefinite institutionalization." *Frederick L. III*, 422 F.3d at 158. Even when a state has made an "announced commitment to deinstitutionalization," the state's "failure to articulate this commitment in the form of an adequately specific comprehensive plan for placing eligible [individuals] in community-based programs by a target date places the 'fundamental alteration defense' beyond its reach." *Id*. at 158-59. Accordingly, a public entity must prove that it "at a bare minimum" has developed and

[32] The PIAC was responsible for overseeing the initiatives within the State's *Olmstead* Plan, making recommendations for new initiatives, and providing overall oversight of the State's compliance with the *Olmstead* decision. FOF ¶¶ 1216-1217, 1220. But the State failed to accept many of the PIAC's recommendations. FOF ¶ 1140. In addition, Defendants dissolved the PIAC even though they had the discretion to maintain it. FOF ¶¶ 1222-1223. The State's disregard of many key PIAC recommendations and abolition of the entire body demonstrate Texas's lack of measureable commitment to move individuals with IDD from nursing facilities to community settings.

is implementing an *Olmstead* Plan that demonstrates a specific and measurable commitment to action, including goals, benchmarks, and timeframes for which the entity can be held accountable. *Id*. at 156-60; *see also Jensen v. Minn. Dep't of Human Services*, 138 F. Supp. 3d 1068, 1071 (D. Minn. 2015); COL ¶¶ 129 & 131. Additionally, a Plan should clearly identify and focus on specific groups of people who are in each type of segregated setting, and include specific, measurable goals and benchmarks for each group. *See* COL ¶ 132; FOF ¶ 1132.

The State's *Olmstead* Plan does not include any goals, benchmarks, or timelines for addressing the unnecessary segregation of people with IDD in nursing facilities.[33] FOF ¶ 1137. Texas has not even analyzed information about the needs of people residing in nursing facilities, the reasons people enter nursing facilities, or the gaps in its community service system. *See* FOF ¶¶ 860-861, 955, 958-961, 1234-1235, 1237-1242. Texas never analyzed the number of people who could be served in alternate settings or who wanted to live in the community, and never set goals for deinstitutionalizing those people beyond repeating the number of waiver slots they had received from the legislature for the current biennium in its revised Promoting Independence Plan. *See* FOF ¶¶ 960, 1137, 1146, 1215, 1236, 1243. The lack of long-term goals for deinstitutionalization and the lack of benchmarks or timelines in Texas's *Olmstead* Plan, in conjunction with its failure to conduct system-level planning, leaves only Texas's "general assurances and good-faith intentions," which are insufficient to establish that it has an effectively working *Olmstead* Plan.

[33] Prior to this litigation, the State's *Olmstead* Plan did not even address people with IDD living in nursing facilities who needed access to the HCS waiver. FOF ¶¶ 1143-1144. Even after the Interim Agreement was entered, the Plan was simply modified in 2014 to reflect only the number of slots allocated by the legislature. FOF ¶ 1146. And the most recent update to the Plan in August 2017 drastically diminished diversion and transition expectations based solely on new waiver slots funded for the biennium. FOF ¶ 1215. The Plan has never contained long-term goals or any mechanisms for reaching a particular number of diversions and transitions.

B. Texas's Olmstead Plan Is Not Reducing the Population of People with IDD in Nursing Facilities and Thus Is Not Effectively Working.

A key inquiry as to whether a jurisdiction has a comprehensive, effectively working *Olmstead* Plan is whether it actually moves the affected people from institutional to integrated settings at a reasonable pace. *See* COL ¶¶ 130 & 132. Courts have considered a steady or only slightly declining census of the relevant group of individuals in particular facilities as evidence that a jurisdiction does not have an effectively working *Olmstead* Plan. *See, e.g.*, *Day*, 894 F. Supp. 2d at 28 (considering the number of individuals with disabilities who transitioned from nursing facilities in assessing the effectiveness of jurisdiction's *Olmstead* plan where putative class was individuals with disabilities housed in nursing facilities). And, in cases finding states to have a comprehensive, effectively working *Olmstead* Plan, courts have relied on a significant decrease in the institutionalized population and evidence that the state is "genuinely and effectively in the process of deinstitutionalizing disabled persons 'with an even hand.'" *See Arc of Wash. State Inc. v. Braddock*, 427 F.3d 615, 620-22 (9th Cir. 2005) (quoting *Olmstead*, 527 U.S. at 605-06).

Here, the relevant census is individuals with IDD in nursing facilities. Both sides' experts agreed that a decrease in the census of people with IDD in nursing facilities would reflect a system that is effective and working as intended. FOF ¶¶ 1148-49. But the uncontroverted evidence here is that the census of people with IDD in Texas nursing facilities is flat, and that this population has been "left behind" compared to other populations of individuals with disabilities. FOF ¶¶ 1151, 1122-1123. More particularly, Dr. O'Connor testified that the census of individuals with IDD in Texas nursing facilities stayed relatively constant from 2013 to 2017, and had actually *increased* by 13.6% from June 2016 to August 2017. FOF ¶¶ 1151, 1153-1154. Defendants presented no contradictory testimony. Thus, the uncontroverted evidence that the

census has not declined, in conjunction with substantial evidence that many individuals with IDD in nursing facilities either affirmatively want to leave or desire more information about living in the community, establishes that Texas does not have an *Olmstead* Plan that is comprehensive *or* effectively working.[34]

The State has underutilized its waiver slots and failed to take sufficient action to improve waiver slot utilization. FOF ¶¶ 1173, 1177-1188. When it received significantly fewer nursing facility transition and diversion slots than it had used during the previous biennium, state officials purposefully suppressed demand for slots to avoid exceeding the low number of slots available. FOF ¶ 1212. And, as expert Kyle Piccola opined, Texas has a system that forces individuals into crisis and the risk of institutional placement due to inadequate waiver services. FOF ¶ 1167. And since many people in nursing facilities have not made an informed choice to remain in a segregated nursing facility, *see* Section VI.B, *supra,* the purported availability of waiver slots for those who request them is not sufficient to show that Defendants have an effectively working *Olmstead* Plan. *See* FOF ¶ 1244.

In summary, Defendants have neither met their burden of establishing a fundamental alteration defense, nor have they shown that they have a comprehensive, effectively working *Olmstead* Plan.

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[34] Defendants' fundamental alteration defense also fails because they have not shown that they have a waiting list that moves at a reasonable pace. *See Olmstead*, 527 U.S. at 605-06. In fact, the uncontroverted evidence has established that Texas's interest list for Medicaid waivers, including the HCS waiver, has increased significantly in recent years. FOF ¶¶ 1158-1161. As of August 31, 2017, individuals – including the majority of those with IDD at serious risk of entering nursing facilities – had to wait more than twelve years to be considered for a slot. FOF ¶¶ 1161-1162. A wait of twelve years is additional evidence precluding the State from making a fundamental alteration defense.

IX. Conclusion

Based on the foregoing, Plaintiffs urge the Court to enter a declaratory judgment that Defendants are violating the NHRA, and Plaintiffs and the United States urge the Court to enter a declaratory judgment that Defendants are violating the ADA and Section 504. The Court should direct the parties to meet and confer for up to thirty days about the process for developing a proposed remedial order, and to submit their proposal for that process to the Court at the end of the thirty-day period. The remedial order should address the steps Defendants shall take to: (1) enable individuals with IDD referred to nursing facilities to be accurately identified, appropriately screened, and provided services in order to avoid unnecessary institutional placements and be diverted from nursing facility admission whenever appropriate; (2) receive all needed specialized services and a program of active treatment consistent with federal standards set forth in 42 C.F.R § 483.440(a)-(f) if admitted to a nursing facility; (3) be provided information, opportunities, services, and supports that would allow them to make an informed choice whether to enter or remain in a segregated nursing facility; (4) and be offered timely access to the State's community service system if they are appropriate for and do not oppose receiving services in an integrated setting. Taking into account the Parties' submissions, the Court should enter appropriate injunctive relief. *See* COL ¶¶ 159-161.

DATED: January 18, 2019

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on January 18, 2019, a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's CM/ECF System.

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