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.	§	CIV. NO. 5:10-CV-1025-OG
GREG ABBOTT, Governor, *et al.*,	§	
Defendants.	§	

PLAINTIFFS' SUPPLEMENTAL MEMORANDUM OF LAW AND FACT IN SUPPORT OF SECOND AMENDED MOTION FOR CLASS CERTIFICATION

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TABLE OF CONTENTS

Page

I. INTRODUCTION 1
II. SUPPLEMENTAL STATEMENT OF FACTS 4
A. The Complaint 4
B. Defendants' Systemic Policies and Practices that Harm Members of the Class 5
C. The Court Approved Interim Settlement Agreement and the Parties' Nearly Completed Comprehensive Agreement Describe A Systemic Remedy to These Common Deficient Policies, Systemic Practices, and Federal Law Violations. 15
III. THE PROPOSED CLASS MEETS THE STANDARDS FOR CLASS CERTIFICATION UNDER RULE 23 OF THE FEDERAL RULES OF CIVIL PROCEDURE. 18
A. The Proposed Class 18
B. The Standards for Class Certification 21
C. The Plaintiffs Have Presented Sufficient Evidence to Support Their Motion. 26
D. The Proposed Class Meets the Requirements of Rule 23(a). 28
1. The Class Is So Numerous that Joinder of All Members Is Impractical. 28
2. The Members of the Class Share Common Questions of Law and Fact. 31
3. The Claims of the Named Plaintiffs Are Typical of Those of the Class. 45
4. The Class Representatives Fairly and Adequately Represent the Interest of the Class. 48
E. This Action Meets the Requirements of Rule 23(b)(2). 51
IV. DISABILITY RIGHTS TEXAS, THE CENTER FOR PUBLIC REPRESENTATION, AND SIDLEY AUSTIN LLP SHOULD BE APPOINTED CO-CLASS COUNSEL PURSUANT TO RULE 23(G). 56
V. CONCLUSION AND REQUESTED RELIEF 59

TABLE OF AUTHORITIES

Page(s)

Cases

Adamson v. Bowen,
855 F.2d 668 (10th Cir. 1988) 34

Amgen Inc., v. Conn. Ret. Plans & Tr. Funds,
133 S. Ct. 1184 (2013) 27

Anderson v. Pa. Dep't of Pub. Welfare,
1 F. Supp. 2d 456 (E.D. Pa. 1998) 35

Appleyard v. Wallace,
754 F.2d 955 (11th Cir. 1985) 34, 45, 46

Arnold v. United Artists Theatre Circuit, Inc.,
158 F.R.D. 439 (N.D. Cal. 1994) 33

Arthur v. Sallie Mae, Inc.,
No. C10-0198JLR, 2012 WL 90101 (W.D. Wash. Jan. 10, 2012) 25

Bertulli v. Indep. Ass'n of Cont'l Pilots,
242 F.3d 290 (5th Cir. 2001) 48

Blum v. Yaretsky,
457 U.S. 991 (1982) 23

Califano v. Yamasaki,
442 U.S. 682 (1979) 33

Castano v. Am. Tobacco Co.,
84 F.3d 734 (5th Cir. 1996) 21

Chambers v. City & Cnty. of San Francisco,
No. 06-cv-6346, slip. op. (N.D. Cal. July 12, 2007) 20

Churchill v. Cigna Corp.,
No. 10-6911, 2011 WL 3563489 (E.D. Pa. Aug. 12, 2011) 38

City of San Antonio v. Hotels.com,
No. SA-06-CA-381-OG, 2008 WL 2486043 (W.D. Tex. May 27, 2008) 32, 45, 47

Colbert v. Blagojevich,
No. 07 C 4737, 2008 WL 4442597 (N.D. Ill. Sept. 29, 2008)....................................20

Coley v. Clinton,
635 F.2d 1364 (8th Cir. 1980) 51

Comcast Corp. v. Behrend,
133 S. Ct. 1426 (2013)....................................27

Conn. Office of Prot. & Advocacy for Persons with Disabilities v. Connecticut,
706 F. Supp. 2d. 266 (D. Conn. 2010)....................................12, 19

Connor B. ex rel. Vigurs v. Patrick,
272 F.R.D. 288 (D. Mass. 2011)....................................38

Connor B. ex. rel. Vigurs v. Patrick,
278 F.R.D. 30 (D. Mass. 2011)....................................24, 36

Corey H. v. Bd. of Educ. Chi.,
No. 92 C 3409, 2012 WL 2953217 (N.D. Ill. July 19, 2012), *appeal dismissed*
528 F. App'x 666 (7th Cir. 2013) 41

Curtis v. Comm'r, Maine Dep't. of Human Servs.,
159 F.R.D. 339 (D. Me. 1994)....................................34, 47

In re Deepwater Horizon,
739 F.3d 790 (5th Cir.), *cert. denied,* 135 S. Ct. 754 (2014)....................................26, 32

In re Deepwater Horizon,
785 F.3d 1003 (5th Cir. 2015) 47

DeHoyos v. Allstate Corp.,
240 F.R.D. 269 (W.D. Tex. 2007) 47, 48

Dockery v. Fischer,
No. 3:13-cv-326-WHB-JCG, 2015 WL 5737608 (S.D. Miss. Sept. 29, 2015) 55

Doe v. Charleston Area Med. Ctr., Inc.,
529 F.2d 638 (4th Cir. 1975) 29

Dunakin v. Quigley,
-- F. Supp. 3d --, No. C14-0567JLR, 2015 WL 1619065 (W.D. Wash. Apr. 10, 2015), *23(f) review denied*, *Dunakin v. Quigley*, No. 15-80076 (9th Cir. Aug. 10, 2015) .... *passim*

Ellis v. Costco Wholesale Corp.,
657 F.3d 970 (9th Cir. 2011) 24

In re Enron Corp. Secs.,
529 F. Supp. 2d 644 (S.D. Tex. 2006) 22

In re Ferrero Litig.,
278 F.R.D. 552 (S.D. Cal. 2011) 25

Fisher v. Okla. Health Care Auth.,
335 F.3d 1175 (10th Cir. 2003) 35

Fontenot v. McGraw,
777 F.3d 741 (5th Cir. 2015) 49

Friends of the Earth, Inc. v. Laidlaw Envtl. Servs. (TOC), Inc.,
528 U.S. 167 (2002)....................11

Garcia v. Tyson Foods, Inc.,
255 F.R.D. 678 (D. Kan. 2009)....................58

Gen. Tel. Co. of Sw. v. Falcon,
457 U.S. 157 (1982)....................26, 27, 33, 45, 48

Gray v. Golden Gate Nat'l Recreational Area,
279 F.R.D. 501 (N.D. Cal. 2011), *reconsideration denied in part by*
866 F. Supp. 2d 1129 (N.D. Cal. 2011) 20

Gray v. Golden Gate Nat'l Recreational Area,
866 F. Supp. 2d 1129 (N.D. Cal. 2011) 24

Green v. Mansour,
474 U.S. 64 (1985)....................34

Hamilton v. First Am. Title Ins. Co.,
266 F.R.D. 153 (N.D. Tex. 2010), *vacated on other grounds*,
423 F. App'x 425 (5th Cir. 2011) 58

Hassine v. Jeffes,
846 F.2d 169 (3d Cir. 1988)....................33

Henderson v. Thomas,
289 F.R.D. 506 (M.D. Ala. 2012)....................24

Herweg v. Ray,
455 U.S. 265 (1982)....................23

Holmes v. Cont'l Can Co.,
706 F.2d 1144 (11th Cir. 1983) 51

Holmes v. Godinez,
No. 11 C 2961, 2015 WL 5920750 (N.D. Ill. Oct. 10, 2015) 21

Hoptowit v. Ray,
682 F.2d 1237 (9th Cir. 1982), *abrogated on other grounds by,*
Sandin v. Conner, 515 U.S. 472 (1995)..51

Ibarra v. Tex. Emp't Comm'n,
598 F. Supp. 104 (E.D. Tex. 1984), *rev'd on other grounds*, 823 F.2d 873 (5th
Cir. 1987) 30

Jack v. Am. Linen Supply Co.,
498 F.2d 122 (5th Cir. 1974) 31

Jamie S. v. Milwaukee Pub. Sch.,
668 F.3d 481 (7th Cir. 2012) 38, 40, 41

Johnson v. General Mills, Inc.,
276 F.R.D. 519 (C.D. Cal. 2011)..25

Jones v. Diamond,
519 F.2d 1090 (5th Cir. 1975) 29

Jordan v. Los Angeles Cty.,
669 F.2d 1311 (9th Cir. 1982), *vacated on other grounds*, 459 U.S. 810 (1982)....................30

Hutchinson ex. rel. Julien v. Patrick,
683 F. Supp. 2d 121 (D. Mass. 2010), *aff'd* 636 F.3d 1 (1st Cir. 2011).................................20

Kincade v. Gen. Tire & Rubber Co.,
635 F.2d 501 (5th Cir. 1981) 22

Lane v. Kitzhaber,
283 F.R.D. 587 (D. Or. 2012)...20

Ledet v. Fischer,
548 F. Supp. 775 (M.D. La. 1982)...29

Lightbourn v. Cty. of El Paso,
118 F.3d 421 (5th Cir. 1997) 32, 34

Long v. Benson,
No. 08-cv-26, 2008 WL 4571904 (N.D. Fla. Oct. 14, 2008)..19

M.A.C. v. Betit,
284 F. Supp. 2d 1298 (D. Utah 2003) 35

M.D. v. Perry,
294 F.R.D. 7 (S.D. Tex. 2013) .... *passim*

M.D. ex. rel. Stukenberg v. Perry,
675 F.3d 832 (5th Cir. 2012) 38, 39

M.R. v. Dreyfus,
663 F.3d 1100 (9th Cir. 2011), *amended by,* 697 F.3d 702 (9th Cir. 2012) 35

Mabary v. Home Town Bank, N.A.,
771 F.3d 820 (5th Cir. 2014) *op. withdrawn* (Jan. 8, 2015) 49

Makin ex rel. Russell v. Hawaii,
114 F. Supp. 2d 1017 (D. Haw. 1999) 35

McCuin v. Sec'y of Health & Human Servs.,
817 F.2d 161 (1st Cir. 1987) 29

McReynolds v. Merrill Lynch, Pierce, Fenner & Smith, Inc.,
672 F.3d 482 (7th Cir. 2012) 36, 41

Milonas v. Williams,
691 F.2d 931 (10th Cir. 1982) 34

Montanez v. Gerber Childrenswear, LLC,
No. CV 09-7420 DSF, 2011 WL 6757875 (C.D. Cal. Dec. 15, 2011) 25

Morrow v. Washington,
277 F.R.D. 172 (E.D. Tex. 2011) .... *passim*

Mullen v. Treasure Chest Casino, LLC,
186 F.3d 620 (5th Cir. 1999) 22, 45

N. Am. Acceptance Corp. Sec. Cases v. Arnall, Golden & Gregory,
593 F.2d 642 (5th Cir.), *cert. denied*, 444 U.S. 956 (1979) 50

N.B. v. Hamos,
26 F. Supp. 3d 756 (N.D. Ill. 2014) 20

Neff v. VIA Metro. Transit Auth.,
179 F.R.D. 185 (W.D. Tex. 1998) 28, 35, 48, 56

Olmstead v. L.C. ex. rel. Zimring,
527 U.S. 581 (1999)....................12, 14, 35, 36

Oster v. Lightbourne,
No. C 09-4668 CW, 2012 WL 685808 (N.D. Cal. Mar. 2, 2012) 24, 38

P.P. v. Compton Unified Sch. Dist.,
No. CV 15-3726-MWF, 2015 WL 5754472 (C.D. Cal. Sept. 29, 2015)....................24

Parkinson v. Freedom Fidelity Mgmt., Inc.,
No. CV-10-345-RHW, 2012 WL 72820 (E.D. Wash. Jan. 10, 2012) 25

Pashby v. Cansler,
279 F.R.D. 347 (E.D.N.C. 2011) 24

Phillips v. Joint Legis. Comm.,
637 F.2d 1014 (5th Cir. 1981) 28, 31

Radaszewski ex. rel. Radaszewski v. Maram,
383 F.3d 599 (7th Cir. 2004) 35

Risinger ex rel. Risinger v. Concannon,
201 F.R.D. 16 (D. Me. 2001)....................45, 47

Rodriguez v. Carlson,
166 F.R.D. 465 (E.D. Wash. 1996)....................50

Rolland v. Cellucci,
191 F.R.D. 3 (D. Mass. 2000)....................17

Rolland v. Cellucci,
No. 98-30208-KPN, 1999 WL 34815562 (D. Mass. Feb. 2, 1999),
23(f) review denied, First Circuit Docket 99-8089 (Mar. 2, 1999).................... *passim*

Rolland v. Patrick,
562 F. Supp. 2d 176 (D. Mass. 2008), *aff'd sub. nom. Voss v. Rolland*, 592
F.3d 242 (1st Cir. 2010)....................17, 54, 57

Rolland v. Patrick,
No. 98-30208-KPN, 2008 WL 4104488 (D. Mass. Aug. 19, 2008)....................19, 44, 51, 52

Rosario v. Livaditis,
963 F.2d 1013 (7th Cir. 1992) 32

Rosie D. v. Romney,
410 F. Supp. 2d 18 (D. Mass. 2006) 23

San Antonio Hispanic Police Officers' Org., Inc. v. City of San Antonio,
188 F.R.D. 433 (W.D. Tex. 1999) 31

Suttles v. Specialty Graphics, Inc.,
No. A-14-CA-505 RP, 2015 WL 590241 (W.D. Tex. Feb. 11, 2015) 49

Thorpe v. District of Columbia,
303 F.R.D. 120 (D.D.C. 2014), *leave to appeal denied by*
In re District of Columbia, 792 F.3d 96 (D.C. Cir. 2015) 19, 24

United States v. Texas,
No. 09-cv-00490-ss (W.D. Tex. 2009) (Settlement Agreement, Docket No. 2, available at
http://www.justice.gov/sites/default/files/crt/legacy/2010/12/15/TexasStateSchools_settle_06-26-09.pdf, entered by Order Granting Motion, Docket No. 4)....................54

Van Meter v. Harvey,
272 F.R.D. 274 (D. Me. 2011) 19

Voss v. Rolland,
592 F.3d 242 (1st Cir. 2010) 50

Wal-Mart Stores, Inc. v. Dukes,
131 S. Ct. 2541 (2011) .... *passim*

Williams v. Blagojevich,
No. 05-C-4673, 2006 WL 3332844 (N.D. Ill. Nov. 13, 2006) 20

Yaffe v. Powers,
454 F.2d 1362 (1st Cir. 1972) 29, 33, 51

Zeidman v. J. Ray McDermott & Co.,
651 F.2d 1030 (5th Cir. 1981) 29, 30, 49, 52

Rules, Statutes and Other Authorities

Fed. R. Civ. P. 23 .... *passim*

42 U.S.C. § 1396r(e)(7) 4, 5, 18, 59

Advisory Committee Note on Rule 23,
39 F.R.D. 69, 102 (1966) 51, 52

I. INTRODUCTION

This case – like many similar cases across the country that have been certified as class actions – seeks to end the common harm caused to class members with intellectual and developmental disabilities or related conditions ("I/DD") as a result of Defendants' unlawful operation, administration, and funding of their developmental disability service system. The Defendants have (1) segregated class members in nursing facilities, (2) failed to provide class members with community and waiver services necessary to allow them to live in integrated settings, and (3) denied class members active treatment while they reside in nursing facilities. The Named Plaintiffs, the Coalition of Texans With Disabilities, Inc. and the Arc of Texas, Inc. seek to require Defendants to fulfill their obligations under federal law by, among other things: (1) providing qualified persons with I/DD in nursing facilities with the necessary services and supports to enable them to live in integrated community settings; (2) modifying Texas's developmental disability community service system to accommodate the needs of persons in nursing facilities; (3) implementing an effective screening and assessment process that will accurately identify individuals with I/DD who are referred to nursing facilities, including whether they can be appropriately served in the community; and (4) for those who require nursing facility care, determining their need for specialized services and providing them with those services with sufficient frequency, intensity, and duration to constitute active treatment. [1]

[1] Plaintiffs filed their original Motion for Class Certification, and accompanying Memorandum, on January 19, 2011. Docket Nos. 13 and 14. On July 9, 2012, Plaintiffs filed their First Amended Motion for Class Certification and Supporting Memorandum of Law, Declarations and

Certification of classes in this type of case is not only common, but is virtually without exception. Civil rights cases such as this one were the driving force behind the creation of the class action mechanism, which provided the ability to address situations where the government is acting in a way to deny rights under federal law to groups of individuals. The drafters of Rule 23 recognized that it is more efficient—and sometimes only possible—to have a few individuals bring claims on behalf of a wider group. Cases regarding the integration mandate of the ADA, cases dealing with the requirements of the Medicaid Act with respect to persons in institutions, and cases disputing the appropriate services in a state or private facility – all of which are at issue here – have almost unanimously resulted in courts certifying a class, with nearly identical classes certified by other federal courts. *See* Ex. 1, ADA Case List; Ex. 2, Institutional Case List. Therefore, this case is appropriate for class treatment.

Exhibits. Docket Nos. 94, 96-98. On September 12, 2012, the Court heard extensive oral argument on Plaintiffs' First Amended Motion for Class Certification. Docket No. 142. Following oral argument, at the Court's invitation, the Parties filed supplemental briefing on the First Amended Motion for Class Certification in November of 2012. Docket Nos. 147-51.

On July 19, 2013, Plaintiffs filed the Second Amended Complaint and Second Amended Motion for Class Certification ("Second Amended Complaint"). Docket No. 174. Plaintiffs' amended pleading and motion did not introduce new substantive claims. Instead, Plaintiffs' pleadings and motion added new individual Named Plaintiffs, updated addresses of the original Named Plaintiffs, and substituted new official capacity Defendants. Defendants have not responded to Plaintiffs' Second Amended Motion for Class Certification, which was pending at the time the Court stayed the litigation on August 26, 2013.

This memorandum incorporates an analysis of recent decisions of the United States Supreme Court, Courts of Appeal and lower courts on class certification that have been issued since the Second Amended Motion and supplemental briefing were filed. It also incorporates information about Named Plaintiffs that was added to the Second Amended Complaint. Finally, with this memorandum, Plaintiffs provide additional data and information in support of their Second Amended Motion for Class Certification.

Plaintiffs have submitted extensive evidence in support of their pending motion for class certification that demonstrates Defendants' common violations that are applicable to the class as a whole, and for which there is a common remedy that can be achieved through the issuance of a single injunction. Specifically, as detailed below in Part II, this evidence includes: state and federal reports, data, and documents pertaining to Defendants' systemic policies, practices and procedures, all of which are attached to the Declaration of Garth A. Corbett, Docket No. 97; the Declaration of Mike Bright, Docket No. 96; the Declaration of Karen McGowan, Docket No. 98; the Supplemental Declaration of Garth A. Corbett in Support of Supplemental Memorandum in Support of Amended Motion for Class Certification, Docket No. 147 ("Supplemental Corbett Decl."), and are incorporated by reference into this Memorandum and referred to as the "earlier declarations in support of class certification"; and the Declaration of Garth Corbett Regarding Supplemental Exhibits in Support of Plaintiffs' Second Amended Motion for Class Certification ("Third Corbett Decl."), the Declaration of Edwin Marino, Jr., Regarding Supplemental Exhibits in Support of Plaintiffs' Second Amended Motion for Class Certification ("Marino Decl.") and the Declaration of Ernesto Sanchez Regarding Supplemental Exhibits in Support of Plaintiffs' Second Amended Motion for Class Certification ("Sanchez Decl.") which are attached hereto. In addition, Plaintiffs have submitted the reports of the mutually agreed upon Expert Reviewer, Kathryn du Pree.[2] *See* Third Corbett Decl., Exs. A-C.

[2] The Expert Reviewer reports, attached to the Third Declaration of Garth Corbett ("Expert Reviewer reports"), are discussed in more detail in Part II.A, *infra*.

This evidence, combined with the great weight of authority in favor of certifying classes in cases like this, strongly support the Court's certification of the proposed class of all Medicaid-eligible persons over twenty-one years of age with I/DD in Texas who currently or will in the future reside in nursing facilities, or who are being, will be, or should be screened for admission to nursing facilities pursuant to 42 U.S.C. § 1396r(e)(7) and 42 C.F.R. § 483.112, *et seq*.

II. SUPPLEMENTAL STATEMENT OF FACTS

A. The Complaint

Eric Steward, Linda Arizpe, Patricia Ferrer, Zackowitz Morgan, Maria Hernandez, Vanisone Thongphanh, Melvin Oatman, Richard Krause, Leonard Barefield, Johnny Kent, Tommy Johnson and Joseph Morrell (collectively, the "Named Plaintiffs"),[3] the Coalition of Texans With Disabilities, Inc. and the Arc of Texas, Inc. have filed a class action complaint seeking declaratory and injunctive relief under Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. § 12132 *et seq.*, Section 504 of the Rehabilitation Act, 29 U.S.C. § 794a, and

[3] Since the filing of the Second Amended Complaint, several of the Named Plaintiffs, Andrea Padron, Leon Hall, Michael McBurney and Benny Holmes, have died. Docket Nos. 190, 185, 171.

Subsequent to the filing of the original Complaint, Named Plaintiffs, Eric Steward, Patricia Fererr, Linda Arizpe and Leonard Barefield moved out of the nursing facilities into small home settings or their family homes in the community. Even though they are now living in the community, they had been in nursing facilities, qualified for nursing facility care and screened under the PASRR process and now have a significant likelihood of returning to nursing facilities if their conditions change or if problems arise in their community placement. Therefore, they continue to be appropriate class representatives. The parties' Interim Settlement Agreement ("IA"), Docket No. 180, recognized this period of risk following departure from a nursing facility. *Id.* at 4 ("Individuals remain in the Target Population [and covered by the provisions of the IA] . . . until one year after transition or diversion from a nursing facility.").

the Nursing Home Reform Amendments (NHRA) to the Medicaid Act, 42 U.S.C. § 1396r(e)(7). The Named Plaintiffs seek relief on behalf of themselves and thousands of similarly-situated Medicaid-eligible individuals with I/DD in Texas who reside in or who are, will be, or should be screened for admission to nursing facilities ("the Class"). Because of Defendants'[4] failure to comply with Title II of the ADA and its implementing regulations, Section 504 of the Rehabilitation Act and its implementing regulations, and the NHRA and their implementing regulations, as demonstrated through the State's own data and its policies and practices, the Named Plaintiffs and the Class are or have been unnecessarily segregated in nursing facilities, are or have been denied access to publicly-funded services in the most integrated settings, and are not provided the necessary specialized services required to meet the federal standard of active treatment. This systemic failure constitutes a standardized course of conduct that results in common injury to all members of the Class.

B. Defendants' Systemic Policies and Practices that Harm Members of the Class

As set forth in the various policies, reports, data, findings, and other evidence incorporated in the earlier declarations in support of class certification and the Third Corbett Declaration, the Marino Declaration and the Sanchez Declaration, Defendants continue to plan, operate, administer, and fund a developmental disability service system that: (1) unduly relies on segregated nursing facilities; (2) does not offer integrated community living and support opportunities to all qualified

[4] Defendants include Greg Abbott, Governor of the State of Texas, Chris Traylor, Executive Commissioner of the Texas Health and Human Services Commission, and Jon Weizenbaum, Commissioner of the Texas Department of Aging and Disability Services ("DADS").

nursing facility residents with I/DD; (3) does not comply with federal requirements for screening, assessing, and serving persons with I/DD in nursing facilities; and (4) has failed to shift from a segregated to an integrated system, despite numerous promises to do so over the past two decades.

According to Defendants' own data, there are approximately 4,000 adults with I/DD currently confined in nursing facilities in Texas.[5] Moreover, based on Plaintiffs' best estimate, there are hundreds of individuals with I/DD who are screened for admission to Texas nursing facilities annually. Third Corbett Decl., ¶ 6. Additionally, there is an even larger, but not precisely known, number of individuals with I/DD who will be or should be screened before admission to a nursing facility in the future.

The State recently attempted to remedy these deficiencies with its redesign of its Pre-admission Screening and Resident Review ("PASRR") process. This change was made in order

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[5] In a 2009 response to a Freedom of Information Act Request, DADS stated that there are at least 5,765 persons with I/DD confined in nursing facilities in Texas who had a preadmission screen in the past several years. *See* Docket No. 97 (Corbett Decl., Ex. 1 (Resp. to FOIA request dated Oct. 26, 2009)) at ¶ 1. While DADS has subsequently reported that it believes that the 5,765 number overstates the actual population, and that, instead, it believes the number to be approximately 4,000, there is no dispute that the class members currently in nursing facilities number in the thousands.

The United States Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) collects detailed information on a quarterly basis from all Medicaid-funded nursing facilities in the country regarding the health characteristics of their residents. This resident information is aggregated and reported on CMS' website in its Minimum Data Set (MDS), http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MDSPubQIandResRep/activeresreport.html. Based upon the MDS Active Resident Report for the Third Quarter 2010, there are in excess of 4,500 individuals with mental retardation residing in Texas nursing facilities. *See* Docket No .97 (Corbett Decl., Ex. 2, MDS Active Resident Rep. for persons with I/DD). More recent data, based upon an updated version of the MDS 3.0, is not yet available on CMS' website.

to try to correct federal law deficiencies found by the Office of the Inspector General of the Department of Health and Human Services ("DHHS OIG"),[6] including the plainly inadequate screening, assessment, and service components of its nursing facility program for individuals with I/DD, as well as the documented violations of the NHRA described in the Second Amended Complaint. In May 2013 and June 2014, Defendants launched Phase I and Phase II of its PASRR redesign. Third Corbett Decl., Ex. D (Texas PASRR overview for Nursing Facilities). Despite these purported improvements, the Expert Reviewer's reports confirm that there are likely hundreds of other individuals with I/DD currently living in nursing facilities who have not been accurately identified due to inadequacies in Texas's PASRR process. *See* Rev. of Individuals with Positive PL-1 and Negative PE, September 2015 ("PASRR Level II Review"), Third Corbett Decl., Ex. A (finding that 64% of the determinations that a person did not have an intellectual disability as a result of a PASRR Level II evaluation were based upon insufficient information). These documented PASRR deficiencies are based upon a single process that affects all class members.

The State's practices for complying with the NHRA regulations on specialized services, 42 C.F.R. §§ 483.116, -120, -126, -130, -132, and -134 are similarly deficient, and affect all individuals with I/DD in nursing facilities. In 2012, Texas amended its State Medicaid Plan to provide some additional support services to nursing facility residents with I/DD. 40 Tex. Admin.

[6] *See* Docket No. 97-3 (Rep. of the Off. of Inspector Gen., Preadmission Screening and Resident Review for Younger Nursing Facility Residents with Mental Retardation, OEI-07-05-00230 (Jan. 2007)).

Code § 17.102(41); *see also* 40 Tex. Admin. Code §§ 17.101, *et seq*., 19.2701, *et seq.* This limited expansion is insufficient to ensure that Defendants actually provide all individuals with I/DD in nursing facilities with a program of active treatment, as required by federal law. 42 C.F.R. § 483.120(b). *See infra* at pp. 11 – 13*; see generally* Marino Decl. and Sanchez Decl.

Defendants' systemic failures to provide necessary specialized services, to conduct reliable screenings and professionally-adequate assessments, and to offer qualified persons with I/DD in nursing facilities the opportunity to move to integrated community settings have been confirmed by the three separate Expert Reviewer reports included in the Third Corbett Declaration.

Pursuant to the terms of the IA, the parties jointly selected Kathryn du Pree as the Expert Reviewer to develop compliance measures and protocols for assessing Defendants' compliance with the service system provisions of the IA and the related requirements of federal law. The Expert Reviewer and the parties developed and agreed upon specific compliance standards that included six Outcomes which pertain to the direct provision of federally-mandated services to individuals with I/DD, as well as one Outcome that relates to Texas's quality assurance system.[7]

[7] The six Outcomes pertaining to the provision of services include:

Outcome 1: Individuals in the Target Population ("TP") will be appropriately identified, evaluated, and diverted from admission to nursing facilities;

Outcome 2: Individuals in the TP in nursing facilities will receive specialized services with the frequency, intensity, and duration necessary to meet their appropriately identified needs, consistent with their informed choice;

Outcome 3: Individuals in the TP in nursing facilities who are appropriate for, and do not oppose, transition to the community, transition services, and placement in the most integrated setting necessary to meet their appropriately-identified needs, consistent with

With the assistance of the Expert Reviewer, the parties also negotiated and agreed to approximately 90 corresponding Outcome Measures to determine if each Outcome had been met. *See* Status Rep. on the Implementation of the QSR PASRR Rev. Process (the "May 2015 Report"), Third Corbett Decl., Ex. C (detailing a list of all 90 Outcome Measures agreed to by the parties). The Outcomes and Outcome Measures were the mutually agreed upon means of assessing implementation of the systemic changes set forth in the IA, changes that correspond with the violations of federal law alleged by the Named Plaintiffs and the systemic injunctive relief sought in their Second Amended Complaint. The Expert Reviewer then created a detailed process for implementing these compliance standards, including a sampling methodology, a protocol questionnaire, a scoring system, and a reporting format – all of which were mutually agreed upon by the parties.

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their informed choice;
Outcome 4: Community Members will receive services in the most integrated setting, with frequency, intensity, and duration necessary to meet their appropriately-identified needs, consistent with their informed choice;
Outcome 5: Individuals in the TP who do not refuse coordination from trained service coordinators with the frequency necessary to meet the individual's appropriately; identified needs, consistent with their informed choice. The seventh outcome and related outcome measures addresses quality assurance systems that was not included as part of the Expert Reviewer's Report; and
Outcome 6: Individuals in the TP will have a service plan, developed by an interdisciplinary service planning team through a person-centered process that identifies the services and supports necessary to meet the individual's appropriately identified needs, achieve the desired outcomes, and maximize the person's ability to live successfully in the most integrated setting consistent with their informed choice.

There was also a seventh outcome that addressed quality assurance issues.

The Expert Reviewer issued her first compliance report in May 2015. *See* May 2015 Report, Third Corbett Decl., Ex. B. In doing so, the Expert Reviewer exercised independent judgment with respect to determinations about the implementation of the IA and compliance with its provisions. IA Part V.II.B (expert reviewer "will be knowledgeable regarding best practices" and "will be independent"). In the May 2015 Report, the Expert Reviewer found that Defendants failed to meet compliance goals in each area that she assessed, including, but not limited to, the areas of the provision of specialized services, provision of community services and planning, and transition planning. *See generally* May 15, 2015 report, Third Corbett Decl., Ex. B.

In September 2015, the Expert Reviewer issued a second report containing the results of her most current assessment of the State's progress in achieving the Outcomes and Outcome Measures that were developed and mutually agreed to by the Parties. *See* "STATUS REPORT on IMPLEMENTATION of the QSR PASRR REVIEW PROCESS – September 25, 2015 ("September 25, 2015 Report"), Third Corbett Decl., Ex. C. As with the May 2015 Report, the Expert Reviewer again found that Defendants failed to meet compliance goals in all areas that she assessed, including, but not limited to the areas of the provision of specialized services, provision of community services and planning, and transition planning. *See* September 25, 2015 Report, Third Corbett Decl., Ex. C.

Additionally, on September 25, 2015, the Expert Reviewer issued a report on her evaluation of the timeliness and adequacy of Defendants' PASRR Level II evaluations of

members of the putative class to determine whether they had I/DD or related conditions and whether they were in need of specialized services. *See* PASRR Level II Review, Third Corbett Decl., Ex.A. The Expert Reviewer found that Defendants do not timely and adequately identify individuals with I/DD, which results in Defendants' failure to identify significant numbers of individuals with I/DD. *See generally id.*

The Expert Reviewer's findings, as set forth in her May 2015 and September 25, 2015 Reports, as well as her PASRR Level II Review, demonstrate a systemic failure on the part of Defendants to comply with Title II of the ADA, the NHRA, and the Medicaid Act, which constitutes a standardized course of conduct that results in common injury to all members of the plaintiff class. Specifically, the May 2015 Report and the September 25, 2015 Report provide significant evidence of Defendants' common practices of operating a discriminatory service system for people with I/DD, which results in their unnecessary segregation in nursing facilities, as well as their common practice of denying people with I/DD who are in nursing facilities the specialized services and active treatment that they have been determined to need by their own professionals.[8]

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[8] To the extent that the Expert Reviewer's reports indicate that Defendants have shown improvements in complying with the law in any aspect of their course of conduct toward the plaintiff class, this improvement is directly attributable to the fact that the IA was in place as an enforceable order of this Court. Now that the IA has been terminated, there are no assurances that any such improvements will be sustained and nothing to prevent Defendants from returning to their previous practices. Nor does the voluntary cessation of illegal conduct result in mootness or a lack of standing for the plaintiff class where the defendants are free to resume their unlawful behavior or the harm suffered by the plaintiffs are otherwise capable of repetition yet evading review. *Friends of the Earth, Inc. v. Laidlaw Envtl. Servs. (TOC), Inc*., 528 U.S. 167, 189 (2002) ("[i]t is well settled that a defendant's voluntary cessation of a challenged practice does not deprive a federal court of its power to determine the legality of the practice.");

Consistent with the assessments of the state DHHS OIG, the Expert Reviewer concluded that most individuals with I/DD in nursing facilities could live in integrated community settings with appropriate services and supports, but instead, are being subjected to prolonged institutionalization. *See* September 25, 2015 Report, Third Corbett Decl., Ex. C, at 14, Outcome Measure 3-7, and at 15, Outcome Measure 3-8, (finding that 80% of the individuals reviewed who were living in a nursing facility were not provided with the necessary services that they were identified to need in order to transition to the community and that 85% of the individuals living in nursing facilities reviewed did not have the requisite service plan that included all of the services and supports that they needed to transition to the community).

Moreover, almost all of these individuals require and are entitled to receive specialized services appropriate to their individual needs, in order to promote independence and growth while they remain confined in nursing facilities. The frequency, intensity, duration, and scope of these specialized services must meet the federal standards for active treatment. Nevertheless, almost none of the adults with I/DD in nursing facilities receive appropriate specialized services, much less specialized services that satisfy the criteria for active treatment. *See* Docket No. 97-1 ("DADS FOIA Response") at ¶ 5(finding that fewer than 1% of individuals with I/DD in Texas

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Olmstead v. L.C. ex. rel. Zimring, 527 U.S. 581, 594 n.6 (1999) (finding that when a mentally disabled patient files a lawsuit challenging her confinement in a segregated institution, her postcomplaint transfer to a community program will not moot the action); *see also Morrow v. Washington,* 277 F.R.D. 172, 199 (E.D. Tex. 2011) ("A long line of Supreme Court cases stands for the proposition that the 'voluntary cessation' of allegedly illegal conduct does not deprive the tribunal of power to hear and determine the case"); *Conn. Office of Prot. & Advocacy for Persons with Disabilities v. Connecticut*, 706 F. Supp. 2d. 266, 286 (D. Conn. 2010).

nursing facilities receive specialized services that they need); *see also* September 25, 2015 Report, Third Corbett Decl., Ex. C, at 11, Outcome 2-5 (finding, in relevant part, that only 15% of the individuals in nursing facilities reviewed "receive[d] all of the specialized services identified in their individual service plans ("ISPs"), including transition services and opportunities to learn about community options such as opportunities to visit community programs, in the frequency, intensity, and duration specified in the ISP…"); *see also id*. at 4, Outcome 2 (finding that that 69% of the individuals with I/DD residing in nursing facilities reviewed were not receiving the specialized services with the frequency, intensity, and duration necessary to meet their appropriately-identified needs, consistent with their informed choice).

The Expert Reviewer reports show that Defendants' practices unlawfully restrict the types of specialized services that a person can receive by limiting these services. *See, e.g.*, *id.* at 6, Outcome Measure 1-3 (finding only 52% compliance rate with the requirement that the PASRR Level II appropriately assess whether the needs of an individual can be met in the community and adequately identifies the specialized services the person needs if he/she is admitted to a nursing facility) and at 8, Outcome Measure 1-13 (finding that only 49% of the individuals placed a nursing facility for fewer than 90 days received all of the specializes services that the state's evaluators determined that they needed).

In addition, DADS' Advisory Committee on Promoting Independence [9] has again recommended that substantial efforts be made to accommodate the needs of persons with I/DD in

[9] In 2000, Texas established what it refers to as the "Promoting Independence Initiative" in

nursing facilities and facilitate their transition to the community, noting that "[i]ndividuals with intellectual and developmental disabilities (IDD) continue to wait as long as 12 years for services." Sept. 2014 Promoting Indep. Advisory Comm. Stakeholder Rep., Third Corbett Decl., Ex. E at 3, Recommendation 1. Additionally, the state Developmental Disability Council has again acknowledged that there are many individuals who are segregated in institutions and who could safely live in the community. *See* December 1, 2014 Texas Biennial Disability Report, Third Corbett Dec., Ex. F at 2 (the state's lack of capacity "leav[es] many individuals to wait years for needed support"); *see also* "Administrators Statement" from DADS Legislative Appropriations Request (LAR) to the 84th Legislature in 2015, Third Corbett Decl., Ex. G, at 4; Docket No. 97-4 (Tex. 2010 Biennial Disability Rep.) at 10-13. Despite these acknowledgements and recommendations, nursing facility residents with I/DD have limited access to Texas' largest community service program, the Home and Community Services (HCS) waiver. *See* December 1, 2014 Texas Biennial Disability Report , Third Corbett Decl., Ex. F at 28-29; *see also* Docket No. 97-8 (description and eligibility criteria for Texas's waiver programs) at 2; Docket No. 96 (Bright Decl.), ¶ 10.

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response to the decision in *Olmstead* to support individuals with disabilities to live and participate fully in the community. As part of the initiative, an Advisory Committee was established to identify, discuss and make recommendations to Texas on the community service needs for people with disabilities in Texas. The Advisory Committee, which meets regularly, is comprised of administrators from the state as well as treatment professionals, care providers, families and persons with disabilities. *See* "What is Promoting Independence?" Texas Department of Aging and Disability Services, https://www.dads.state.tx.us/providers/pi/ (last visited Nov. 12, 2015).

Finally, the United States Department of Justice, the agency charged by Congress with the enforcement of the ADA, assessed the issues raised in this case and concluded that "Texas is in violation of the Americans with Disabilities Act and the Rehabilitation Act as it relates to issues pending in the *Steward v. [Abbott]* litigation." *See* Docket No. 97-10 (DOJ Findings Letter, dated June 15, 2011). DOJ's "determination that the State of Texas unnecessarily institutionalizes individuals with developmental disabilities in nursing facilities and places individuals who live in the community at risk of placement in nursing facilities," *id,* standing alone, is compelling evidence of a single practice that is causing a common injury to all persons with I/DD in nursing facilities, and which can be remedied by a single injunction.

C. The Court Approved Interim Settlement Agreement and the Parties' Nearly Completed Comprehensive Agreement Describe A Systemic Remedy to These Common Deficient Policies, Systemic Practices, and Federal Law Violations.

In an effort to resolve this case and to begin to address Defendants' systemic and discriminatory course of conduct, the parties entered into the IA.[10] The IA identifies the specific relief over a two-year period (2013-2015) that was necessary to begin to address the common harm imposed on the class by Defendants' systemic and unlawful conduct. In the IA, the parties expressly recognized that the IA's reforms were "for a limited time period," IA, at 2, and that the parties were "still seeking to resolve all issues in the Lawsuit pursuant to a 'Comprehensive Agreement.'" *Id.* As this Court is aware, the parties negotiated for over a year after the

[10] In entering into the IA, as is typical, Defendants did not admit to the violations of law claimed by Plaintiffs, but did agree to implement the systemic corrections to their disability service system set forth in the IA.

execution of the IA but were unable to finalize the Comprehensive Agreement. Tr. of June 16, 2015 Status Conference, Docket No. 210, ("Status Conf. Tr."), at 7, lines 5-6, at 9, line 25 – 10, line 22, and at 14, lines 3-8.

The IA sets forth specific systemic reforms to Defendants' policies, procedures, and practices for providing services to the "target population,"[11] as defined in the IA, to be implemented during 2013-2015. The IA, approved by this Court in August 2013, ordered the following systemic reforms:

- Expansion of community services, including increased numbers of slots for Home and Community Service (HCS) waivers, that would allow hundreds of individuals segregated in nursing facilities to move to integrated community settings;
- Service Planning Teams and a Service Planning Process led by Service Coordinators to develop person-centered evaluation, planning, and services and supports that would allow individuals to move from segregated nursing institutions to the community;
- Integrated day and employment services in the community for people leaving nursing facilities;
- An outreach and education program for persons in nursing facilities to learn about community living options;
- Transition planning and support activities to facilitate the transition from nursing facilities to the community;

[11] Under the IA, the "target population" was defined as "individuals with IDD 21 years of age or older who: a. are in a nursing facility for more than 90 days; or b. are determined by a PASRR Level I screening to be in need of a PASRR Level II evaluation or are in a nursing facility for 90 days or less. . . . Individuals remain in the Target Population for as long as they are in a nursing facility and until one year after transition or diversion from a nursing facility through enrollment in community-based Medicaid services." IA Part II.N. This definition overlaps with the proposed class definition.

- Nursing facility diversion activities, policies, and personnel to prevent the unnecessary admission to nursing facilities; and

- Provision of specialized services and active treatment to persons in nursing facilities.

Similar provisions would be part of a final, single injunction to "resolve all issues" [12] that would be entered as the remedy in this case, after a finding of liability.[13]

In order to evaluate the State's progress in implementing the specific commitments and systemic reforms in the IA, the parties agreed to six Outcomes and 90 Outcome Measures. These compliance standards made the IA an efficient, effective, and precise interim remedial order that, if fully implemented over a longer period of time, had the potential to cure the federal law violations that they set out to address – essentially the hallmark of a systemic injunction that affords class members appropriate relief.[14] The systemic reforms required by the IA correspond

[12] For a final order on systemic relief, as the IA acknowledged, the scope of the relief provided will need to be both broadened and extended out for more years in order to obtain full relief for the Class.

[13] Cases similar to this action have been resolved through a single injunction applicable to the class as whole. For example, in *Rolland v. Cellucci*, a class action brought on behalf of individuals with developmental disabilities unnecessarily segregated in nursing facilities that was virtually identical to this case, the Court approved a class-wide settlement that afforded systemic relief resolving the plaintiff class' claims in a single injunction. *Rolland v. Cellucci*, 191 F.R.D. 3, 13 (D. Mass. 2000) (approving class action settlement in case brought on behalf of individuals with developmental disabilities in or at risk of being admitted to nursing facilities); *Rolland v. Patrick*, 562 F. Supp. 2d 176 (D. Mass. 2008) (approving new settlement agreement), *aff'd sub. nom. Voss v. Rolland*, 592 F.3d 242 (1st Cir. 2010).

[14] For a final order on systemic relief, Plaintiffs anticipate that the scope of the relief provided will need to be broadened, and last for several more years in order to obtain full relief for the Class.

with, although are not as extensive as, the systemic injunctive relief sought by the Plaintiffs in the Second Amended Complaint–to restrain and enjoin the defendants from: (i) failing to provide appropriate, integrated community services and supports for all class members, consistent with their individual needs; (ii) failing to make modifications to the rules and requirements for community based services, supports and programs; (iii) failing to provide habilitative and community-based services available to all eligible class members, promptly and in the most integrated settings appropriate; (iv) failing to provide PASRR reviews and evaluations; and (v) failing to assess class members' needs for specialized services and to provide those services in a manner sufficient to constitute a program of active treatment.

III. THE PROPOSED CLASS MEETS THE STANDARDS FOR CLASS CERTIFICATION UNDER RULE 23 OF THE FEDERAL RULES OF CIVIL PROCEDURE.

A. The Proposed Class

Plaintiffs seek to certify a class of all Medicaid-eligible persons over twenty-one years of age with I/DD[15] in Texas who currently or will in the future reside in nursing facilities, or who are being, will be, or should be screened for admission to nursing facilities pursuant to 42 U.S.C. § 1396r(e)(7) and 42 C.F.R. § 483.112, *et seq*. A nearly identical class was certified in a similar case raising similar claims under the ADA and NHRA in Massachusetts relating to persons with I/DD in

[15] The class definition utilizes the phrase "intellectual or developmental disabilities or a related condition," abbreviated herein as I/DD, because this is the current terminology in most federal legal provisions, although the 1990 PASRR regulations, 42 C.F.R. § 483.102(b)(3) and the Second Amended Complaint use the now outdated term "mental retardation or related condition."

nursing facilities in that state. *Rolland v. Cellucci*, No. 98-30208-KPN, 1999 WL 34815562, at *2 (D. Mass. Feb. 2, 1999) (certifying class comprised of "all adults with mental retardation or other developmental disabilities in Massachusetts who reside in nursing facilities on or after October 29, 1998, or who are or should be screened for admission to nursing facilities pursuant to 42 U.S.C. § 1396r(e)(7) and 42 C.F.R. § 483.112 *et seq.*"), *23(f) review denied*, First Circuit Docket 99-8089 (Mar. 2, 1999); *Rolland v. Patrick,* No. 98-30208-KPN, 2008 WL 4104488 (D. Mass. Aug. 19, 2008) (refusing to decertify the class based upon alleged differences in the needs and conditions of persons in nursing facilities). In Massachusetts, the district court found that the plaintiff class met all of the requirements of Rule 23(a), and found that a Rule 23(b)(2) class action is particularly appropriate for the kind of civil rights action seeking systematic governmental reform such as this action. *Rolland*, 1999 WL 34815562, at *9.

Courts have certified similar classes in other ADA Title II cases brought on behalf of nursing facility residents. *See Dunakin v. Quigley*, -- F. Supp. 3d -- , No. C14-0567JLR, 2015 WL 1619065, at *30 (W.D. Wash. Apr. 10, 2015), *23(f) review denied*, *Dunakin v. Quigley*, No. 15-80076 (9th Cir. Aug. 10, 2015) (certified class of nursing home residents with I/DD); *Thorpe v. District of Columbia*, 303 F.R.D. 120 (D.D.C. 2014), *leave to appeal denied by In re District of Columbia*, 792 F.3d 96, 98 (D.C. Cir. 2015) (certifying a class of individuals with physical disabilities in, or at risk of institutionalization in, nursing facilities)); *Van Meter v. Harvey,* 272 F.R.D. 274 (D. Me. 2011); *Conn. Office of Prot. and Advocacy*, 706 F. Supp. 2d at 266; (certifying a class of individuals with mental illness unnecessarily segregated in nursing

facilities in violation of the ADA); *Long v. Benson,* No. 08-cv-26, 2008 WL 4571904, at *3 (N.D. Fla. Oct. 14, 2008) (class of Medicaid-eligible adults with disabilities who were living in nursing facilities “who could and would live in the community with appropriate community-based supports”.); *Colbert v. Blagojevich*, No. 07 C 4737, 2008 WL 4442597 (N.D. Ill. Sept. 29, 2008) (class of Medicaid-eligible adults with disabilities needless segregated in nursing facilities); *Hutchinson ex. rel. Julien v. Patrick,* 683 F. Supp. 2d 121 (D. Mass. 2010), *aff’d* 636 F.3d 1, 6 (1st Cir. 2011) (affirming fee award for class based upon district court's approval of settlement agreement under Fed. R. Civ. P. 23(e)); *Chambers v. City & Cnty. of San Francisco,* No. 06-cv-6346, slip. op. at 1-4 (N.D. Cal. July 12, 2007) (class of current and past Medicaid-eligible nursing home residents seeking injunctive relief for violations of Title II’s integration mandate); *Williams v. Blagojevich*, No. 05-C-4673, 2006 WL 3332844 (N.D. Ill. Nov. 13, 2006) (class of Medicaid-eligible individuals with mental disabilities unjustifiably institutionalized in nursing facilities certified); *see also N.B. v. Hamos*, 26 F. Supp. 3d 756, 776 (N.D. Ill. 2014) (class certification in action seeking injunctive relief for violations of Title II based on the denial of community-based services); *Lane v. Kitzhaber*, 283 F.R.D. 587, 590 (D. Or. 2012) (certifying a class of persons with I/DD in segregated employment workshops, and rejecting defendants’ claims that class members’ different abilities, skills, needs, and preferences preclude certification); *Gray v. Golden Gate Nat’l Recreational Area*, 279 F.R.D. 501 (N.D. Cal. 2011) (certified class of people with mobility and vision disabilities claiming barriers in access to recreation area), *reconsideration denied in part by* 866 F. Supp. 2d 1129, 1142 (N.D. Cal. 2011).

The propriety of class certification in cases like this is illustrated by the large number of class actions that have been certified against governmental agencies at both the state and federal levels. *See*, *e.g.*, 7 Newberg on Class Actions § 23:1 (4th ed. 2002); *see* Ex. 1, ADA Case List; Ex. 2, Institutional Case List. Because class members are less likely to be able to institute legal proceedings on their own behalf, class relief becomes even more important. Without the procedural benefits provided by the class action mechanism, the Named Plaintiffs and others similarly situated would be unable to effectively seek the relief to which they are entitled. For similar reasons as in the cases cited above, this Court should find that the plaintiffs have met the requirements of Rule 23(a) and should certify a Rule 23(b)(2) class as requested herein.

B. The Standards for Class Certification

"The party seeking certification bears the burden of proof" that the class sought meets all of the requirements under Rule 23. *Castano v. Am. Tobacco Co.*, 84 F.3d 734, 740 (5th Cir. 1996). *See also Holmes v. Godinez*, No. 11 C 2961, 2015 WL 5920750, at *26 (N.D. Ill. Oct. 10, 2015) (citing *Comcast Corp. v. Behrend*, 133 S. Ct. 1426, 1432 (2013) (*quoting Wal-Mart Stores, Inc. v. Dukes*, 131 S. Ct. 2541, 2551 (2011) ("[C]ertification is proper only if 'the trial court is satisfied, after a rigorous analysis, that the prerequisites of Rule 23(a) [and Rule 23(b)] have been satisfied.'")).

In *Wal-Mart Stores, Inc. v. Dukes*, 131 S. Ct. 2541 (2011), the Supreme Court confirmed that class certification is appropriate when there is at least one common question of law and fact, *id.* at 2541, 2556 ("We quite agree that for purposes of Rule 23(a)(2) '[e]ven a single [common]

question'will do.") (citations omitted), and that the contention is "of such a nature that it is capable of classwide resolution – which means that determination of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke." *Id.*, at 2551. Here, Plaintiffs have presented extensive evidence that their claims satisfy *Wal-Mart*'s heightened commonality requirement and that their claims may be remedied through the single stroke of providing the requested community services in integrated settings and specialized services in nursing facilities.

Rule 23(a) has four distinct criteria: (1) the class must be so numerous that joinder of all members is impracticable; (2) the members of the class must share common questions of law *or* fact; (3) the claims or defenses of the named representatives must be typical of those of the class; and (4) the persons representing the class must be able to fairly and adequately represent the interests of the class. Fed. R. Civ. P. 23(a); *see also Mullen v. Treasure Chest Casino, LLC*, 186 F.3d 620, 623 (5th Cir. 1999).

Once all four elements of Rule 23(a) are established, a class action may be maintained if it satisfies at least one of the three subdivisions of Rule 23(b). *In re Enron Corp. Secs.*, 529 F. Supp. 2d 644, 672 n.40 (S.D. Tex. 2006) (citing *Horton v. Goose Creek Indep. Sch. Dist.*, 690 F.2d 470, 484 n.25 (5th Cir. 1982), *cert denied*, 463 U.S. 1207 (1983)). For purposes of this case, the relevant subpart is Rule 23(b)(2), which requires that the defendants act or refuse to act on grounds generally applicable to the class, therefore making declaratory or injunctive relief appropriate. "In fact, the 1966 Notes to Rule 23(b)(2) lists civil rights actions 'where a party is charged with discriminating unlawfully against a class, usually one whose members are incapable of specific enumeration' as

examples of appropriate Rule 23(b)(2) actions. FED. R. CIV. P. 23(b)(2) 1966 Advisory Committee's Note." *Morrow,* 277 F.R.D. at 196; *see also Kincade v. Gen. Tire & Rubber Co.*, 635 F.2d 501, 506 n.6 (5th Cir. 1981) ("(s)ubdivision (b)(2) was added to Rule 23 in 1966 primarily to facilitate the bringing of class actions in the civil rights area"); *Morrow*, 277 F.R.D. at 197 (quoting *Daniels v. City of New York*, 198 F.R.D. 409, 414 (S.D.N.Y. 2001) ("Rule 23(b)(2) certification is 'especially appropriate where a plaintiff seeks injunctive relief against discriminatory practices by a defendant.'")).

In almost every case involving persons who allege noncompliance with Title II of the ADA or the requirements of the Medicaid Act by government officials, such as the case here, courts have certified a class. This is particularly true with respect to cases involving the integration mandate of the ADA. *See* Ex. 1, ADA Case List. In addition, in almost every case involving persons with mental disabilities who challenge the lack of appropriate services in a state or private facility, courts throughout the nation have certified classes under Rule 23. *See* Ex. 2, Institutional Case List. Finally, courts traditionally certify classes in cases concerning adults and children who allege violations of their federal statutory rights under Title XIX of the Social Security Act, 42 U.S.C. §1396(a) (the Medicaid Act). *See, e.g.*, *Herweg v. Ray*, 455 U.S. 265, 271 (1982); *Blum v. Yaretsky*, 457 U.S. 991, 993 (1982); *Rosie D. v. Romney,* 410 F. Supp. 2d 18, 22 (D. Mass. 2006).

ADA Title II integration cases customarily focus on the standardized conduct of the defendants and do not depend on individualized determinations of either liability or remedy. Thus, courts frequently, and almost without exception, certify ADA classes, precisely because

the Title II claims focus on the defendants' systemic practices, not the individual plaintiffs' conditions.[16] *See* Ex. 1, ADA Case List. In several ADA or Rehabilitation Act post-*Wal-Mart* cases, courts have certified classes, re-certified classes, or refused to decertify classes. *See Dunakin*, 2015 WL 1619065, at *1 (class certification involving Medicaid-certified nursing facilities); *Thorpe*, 303 F.R.D. at 152 (certifying a class of Medicaid-eligible individuals with physical disabilities living in nursing facilities seeking to live in the community with appropriate community supports); *Henderson v. Thomas*, 289 F.R.D. 506, 508 (M.D. Ala. 2012) (certifying a class of 80 prisoners alleging Title II discrimination claims based upon their HIV status); *Oster v. Lightbourne*, No. C 09-4668 CW, 2012 WL 685808, at *6 (N.D. Cal. Mar. 2, 2012) (certifying a class of persons whose services will be "limited, cut, or terminated" under California's home-care program, in violation of the ADA, the Rehabilitation Act, and the Medicaid Act); *Pashby v. Cansler,* 279 F.R.D. 347, 356 (E.D.N.C. 2011) (same); *Gray v. Golden Gate Nat'l Recreational Area,* 866 F. Supp. 2d 1129, 1142 (N.D. Cal. 2011) (denying request to decertify class based upon the Ninth Circuit's decision in *Ellis v. Costco Wholesale Corp.*, 657 F.3d 970 (9th Cir. 2011)).[17]

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[16] An exception, not relevant here, is in *P.P. v. Compton Unified School District*, No. CV 15-3726-MWF, 2015 WL 5754472 (C.D. Cal. Sept. 29, 2015), where the court denied, without prejudice, the plaintiffs' motion to certify a class of students with disabilities. The Court found that the plaintiffs had not presented sufficient evidence to show numerosity or to establish that their claims were typical of the class, but invited the plaintiffs to refile their class certification motion with additional evidence. *Id*. at *9, *19,*24.

[17] Courts have also continued to certify classes in a variety of civil rights and other contexts, and refused to de-certify existing classes after *Wal-Mart*. *See Morrow*, 277 F.R.D. at 192-94

ADA Title II classes routinely have been certified precisely because they raise a common question susceptible to a common solution through a single injunction: the modification of the public entity's program to provide services in the most integrated setting. Like those cases, the Second Amended Complaint here seeks a single injunction that would require the defendants to make reasonable modifications to their community service system, in order to ensure that all class members have access to community services in the most integrated setting. Thus, the Court can, "in a single stroke," ensure that eligible class members have the opportunity to leave nursing facilities and live in the community.[18] *See Wal-Mart*, 131 S. Ct. at 2541. Thus, there is a

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(certifying a class of motorists who alleged they had been targeted by police because of they were members of racial or ethnic minority groups)*; Connor B. ex. rel. Vigurs v. Patrick*, 278 F.R.D. 30, 31 (D. Mass. 2011) (following the *Wal-Mart* decision, court declined to de-certify class of foster children harmed by systemic deficiencies in state's foster care system); *Johnson v. General Mills, Inc.*, 276 F.R.D. 519, 521 (C.D. Cal. 2011) (unlike *Wal-Mart*, injury results from a common core of salient facts); *In re Ferrero Litig.*, 278 F.R.D. 552, 558 (S.D. Cal. 2011) (plaintiffs need not prove a common class-wide injury at class certification stage; rather, they need only to demonstrate that there is a common contention that is capable of class wide resolution); *Montanez v. Gerber Childrenswear, LLC*, No. CV 09-7420 DSF, 2011 WL 6757875, at *3 (C.D. Cal. Dec. 15, 2011) (unlike *Wal-Mart,* there is common control over the challenged practice); *Parkinson v. Freedom Fidelity Mgmt., Inc.,* No. CV-10-345-RHW, 2012 WL 72820, at *4 (E.D. Wash. Jan. 10, 2012) (certifying class for violations of state Consumer Protection Act and Debt Adjusting Statute, although plaintiffs suffered different statutory violations in different ways by different debt collectors); *Arthur v. Sallie Mae, Inc.*, No. C10-0198JLR, 2012 WL 90101, at *7 (W.D. Wash. Jan. 10, 2012) (commonality only requires a single question of law or fact).

[18] As discussed in Part III.D.2, *infra*, that the state may ultimately make individualized decisions concerning which persons want to leave nursing facilities and what community services each person needs does not undermine class certification, since the state-operated process for making these decisions is not part of the federal court proceedings. Instead, these decisions are properly made in an individualized service planning process, subject to state administrative law, similar in many respects to the treatment planning process currently used by Defendants.

virtually unbroken line of decisions granting class certification in Title II cases challenging systemic practices of institutionalizing persons with disabilities in violation of federal statutory and constitutional provisions. Those conclusions and the reasoning of those cases are equally applicable here, and should weigh heavily in the Court's analysis regarding certification of the plaintiff class.

C. The Plaintiffs Have Presented Sufficient Evidence to Support Their Motion.

Well before *Wal-Mart*, courts were required to conduct a "rigorous analysis" of the evidence submitted in support of a class certification motion. *See Gen. Tel. Co. of Sw. v. Falcon,* 457 U.S. 157, 160 (1982) ("[*S*]*ometimes* it may be necessary for the court to probe behind the pleadings before coming to rest on the certification question.") (emphasis added); *see also In re Deepwater Horizon*, 739 F.3d 790, 811 (5th Cir.) ("In order to meet the commonality requirements of Rule 23(a)(2), the parties *may potentially* need to provide evidence to demonstrate that a contention is common, but not that it is correct.") (emphasis added), *cert. denied,* 135 S. Ct. 754 (2014). That test, and the quantum of evidence needed to satisfy that test, has not been enlarged nor made more demanding by *Wal-Mart.* 131 S. Ct. at 2551-52. Further, neither *Falcon* nor *Wal-Mart* ever suggests that information set forth in the Complaint was irrelevant or inadequate. Rather, the Supreme Court in *Wal-Mart* affirmed *Falcon's* understanding that "*sometimes* it may be necessary for the court to probe behind the pleadings before coming to rest on the certification question." *Wal-Mart*, 131 S. Ct. at 2551-52. (quoting *Falcon*, 457 U.S. at 160 (emphasis added)).

Clarifying and applying its decision in *Wal-Mart*, the Supreme Court rejected the argument that a court must demand affirmative proof from the plaintiffs concerning the merits of their claims. *Amgen Inc., v. Conn. Ret. Plans & Tr. Funds*, 133 S. Ct. 1184, 1194-95 (2013). Speaking for the Court, Justice Ginsburg declared that:

> Although we have cautioned that a court's class-certification analysis must be "rigorous" and may "entail some overlap with the merits of the plaintiff's underlying claim," *Wal–Mart Stores, Inc. v. Dukes*, 564 U.S. ——, —— (2011) (slip op., at 10) (internal quotation marks omitted), Rule 23 grants courts no license to engage in free-ranging merits inquiries at the certification stage. Merits questions may be considered to the extent—but only to the extent—that they are relevant to determining whether the Rule 23 prerequisites for class certification are satisfied.

Amgen Inc., 133 S. Ct. at 1194-95. Establishing class requirements, including commonality, does not require a "mini trial" on the merits to determine the answers to the common questions, *id*. at 1201, even after *Comcast Corp.*, 133 S. Ct. at 1433. Thus, the rigorous analysis required at the class certification stage can and should be conducted based upon allegations in the complaint, supplemented by available and preliminary evidence of those allegations, so that the class determination does not devolve into a preliminary trial of the entire case.

The Court now has a considerable quantum and scope of evidence, which is more than sufficient to allow it to undertake a "rigorous analysis" of the relevant facts, claims, and defenses. This case is in the unique posture of having three reports from an expert selected by both parties whose reports have been shared with both parties. These reports provide direct evidence of common practices that negatively impact a large portion of the class. Since *Wal-Mart* has not altered *Falcon's* longstanding requirement concerning the evidence needed to

certify a class, nor the scope of analysis which the court must conduct to evaluate that evidence, the Plaintiffs' Second Amended Complaint, exhibits, documents, reports, records, supplemental declarations, new declarations concerning the status of the Named Plaintiffs, and the Expert Reviewer's reports are plainly sufficient for the Court to perform its task and certify a class in this case. Specifically, as more fully described below, the State's own data proves numerosity; its PASRR and specialized services policies and practices, taken together with the Inspector General's Report, the Expert Reviewer's recent PASRR report, and her findings of broad systemic deficiencies in Texas' nursing facilities and community services in her two Quality Service Reviews illustrate both commonality and typicality; and the facts in the Second Amended Complaint plus the new declarations document the adequacy of the Named Plaintiffs as representatives of the class. Finally, the IA itself demonstrates how a single injunctive remedial order may provide partial relief to the Class. The IA also acknowledges the need to broaden and extend this order to "resolve all issues in the Lawsuit pursuant to a comprehensive agreement," in order to provide full relief to the Class.

D. The Proposed Class Meets the Requirements of Rule 23(a).

1. <u>The Class Is So Numerous that Joinder of All Members Is Impractical.</u>

Rule 23(a)(1) of the Federal Rules of Civil Procedure has two components: assessing the number of class members and evaluating the practicability of joining them individually in the case.

For the purpose of satisfying the first component, the plaintiffs need not establish the precise number or identity of class members. *See, e.g.*, *Phillips v. Joint Legis. Comm.*, 637 F.2d 1014, 1022 (5th Cir. 1981) ("The plaintiffs nonetheless established at a certification hearing that there

were at least 33 such applicants; there may have been many more."). This is particularly true where only declaratory and injunctive relief is sought. *See, e.g.*, *Neff v. VIA Metro. Transit Auth.*, 179 F.R.D. 185, 193 (W.D. Tex. 1998) (certifying class of individuals with disabilities seeking injunctive relief); *McCuin v. Sec'y of Health & Human Servs.*, 817 F.2d 161, 167 (1st Cir. 1987) ("[W]here only declaratory and injunctive relief is sought for a class, plaintiffs are not required to identify the class members once the existence of the class has been demonstrated"); *Doe v. Charleston Area Med. Ctr., Inc.*, 529 F.2d 638, 645 (4th Cir. 1975) (size of class can be speculative where only equitable relief is requested); *Rolland*, 1999 WL 34815562, at *3; *Ledet v. Fischer*, 548 F. Supp. 775, 781-82 (M.D. La. 1982).

Furthermore, in civil rights cases, the membership of a class is often "incapable of specific enumeration." *Yaffe v. Powers*, 454 F.2d 1362, 1366 (1st Cir. 1972). In such circumstances, as in the present matter, a class action may proceed if the plaintiffs "demonstrate some evidence or reasonable estimate of the number of purported class members." *Zeidman v. J. Ray McDermott & Co.*, 651 F.2d 1030, 1038 (5th Cir. 1981); *see also* 7 Newberg on Class Actions § 23.2 ("Courts generally have not required detailed proof of class numerousness in government benefit class actions when challenged statutes or regulations are of general applicability to a class of recipients, because those classes are often inherently very large.").

The proposed class in this case, which consists of at least 4,000 members, is sufficiently numerous to make joinder impracticable. Frequently, proposed classes consisting of only a fraction of this number are certified under Rule 23(a)(1) because joinder would be impractical. *See Jones v.*

Diamond, 519 F.2d 1090, 1100 n.18 (5th Cir. 1975) (class of 48 individuals found sufficient); *Morrow*, 277 F.R.D. at 190-91 (putative class of 136 individuals satisfied the numerosity requirement); *Rolland*, 1999 WL 34815562, at *1-2 (nearly identical class certified with approximately 1500 members).

While the sheer size of this class clearly makes joinder impracticable, other factors – such as the geographic distribution of the plaintiffs, the ability of the plaintiffs to bring their own separate actions, and the type of relief sought – support a finding that joinder is impracticable. *See Zeidman*, 651 F.2d at 1038; *Jordan v. Los Angeles Cty.*, 669 F.2d 1311, 1319-20 (9th Cir. 1982), *vacated on other grounds*, 459 U.S. 810 (1982).

In the instant case, the class representatives seek injunctive and declaratory relief on behalf of themselves and thousands of Texans with I/DD who are or will be institutionalized in nursing facilities throughout the state. This geographic dispersion of class members makes joinder impracticable. *See Ibarra v. Tex. Emp't Comm'n*, 598 F. Supp. 104, 108 (E.D. Tex. 1984) (500-member class certified where class members "dispersed throughout Texas"), *rev'd on other grounds*, 823 F.2d 873 (5th Cir. 1987). Importantly, the combined impact of class members' poverty and disabilities severely limits their access to attorneys and their resulting ability to bring individual actions for declaratory or injunctive relief, making class certification particularly appropriate. *See Rolland*, 1999 WL 34815562, at *3 (quoting *Armstead v. Pingree*, 629 F. Supp. 273, 279 (M.D. Fla. 1986) ("' Considering plaintiffs' confinement [in nursing facilities], their

economic resources, and their mental handicaps, it is highly unlikely that separate actions would follow if class treatment were denied.'")).

Furthermore, joinder is impracticable in the instant case because the class includes not only current nursing facility residents, but also individuals who will be or should be screened prior to admission to a nursing facility in the future, whose identity cannot be presently determined. Where "[t]he alleged class also includes unnamed, unknown future" class members who will allegedly be harmed by the defendants' conduct and policies, the Fifth Circuit has held that joinder is "certainly impracticable." *Jack v. Am. Linen Supply Co.*, 498 F.2d 122, 124 (5th Cir. 1974). *see also Phillips*, 637 F.2d at 1022 ("[T]he requirement of Rule 23(a)(1) is clearly met, for joinder of unknown individuals is certainly impracticable") (internal quotations omitted); *San Antonio Hispanic Police Officers' Org., Inc. v. City of San Antonio*, 188 F.R.D. 433, 442 (W.D. Tex. 1999). For the above reasons, the proposed class satisfies the numerosity requirement of Rule 23(a)(1).

2. The Members of the Class Share Common Questions of Law and Fact.

a. The Common Questions of Law and Fact

Here, there are several questions that are common to all class members including, but not limited to:

(1) whether the Defendants are violating the ADA and Section 504 of the Rehabilitation Act by: (a) failing to offer integrated community services to individuals with I/DD in nursing facilities who can live in a community setting with appropriate supports; (b) failing to offer community services to individuals with I/DD who are being, will be or should be screened for

admission to nursing facilities, in order to divert the unnecessary admission of those individuals who can be appropriately served in a community setting; and (c) failing to plan , operate, administer, and fund their developmental disability service system for persons with I/DD in a manner that accommodates persons in nursing facilities who qualify for and do not oppose community living; and

(2) whether Defendants are in violation of the NHRA and the Medicaid Act by: (a) failing to establish a screening and assessment program that accurately identifies individuals with I/DD and then determines if individuals with I/DD can be appropriately placed in a community setting or should be admitted to a nursing facility; (b) failing to conduct professionally acceptable assessments to determine what specialized services such individuals require; and (c) failing to promptly provide an array of specialized services to all individuals with I/DD in nursing facilities who need them, in a manner that satisfies the federal standard for active treatment.

In order for a class to be certified, Rule 23(a)(2) requires that the proposed class members have at least *one* factual *or* legal issue in common, the resolution of which will affect all or a significant number of putative class members. *In re Deepwater Horizon*, 739 F.3d at 811; *M.D. v. Perry,* 294 F.R.D. 7, 28 (S.D. Tex. 2013); *Lightbourn v. Cty. of El Paso*, 118 F.3d 421, 426 (5th Cir. 1997); *Rosario v. Livaditis*, 963 F.2d 1013, 1017-18 (7th Cir. 1992); *City of San Antonio v. Hotels.com*, No. SA-06-CA-381-OG, 2008 WL 2486043, at *5 (W.D. Tex. May 27, 2008) (holding

that commonality requires that "there is at least *one* issue that will affect all or a significant number of putative class members" (emphasis in original)).

Pursuant to *Wal-Mart*'s invigorated commonality standard, Plaintiffs must show that their claims depend upon a "common contention…of such a nature that it is capable of class wide resolution." 131 S. Ct. at 2551. As shown below, after *Wal-Mart*, courts have continued to certify classes, particularly those seeking injunctive relief under the ADA, when a state's common practice or policy impacts the whole class.

Class actions are particularly appropriate where, as here, governmental policies and practices have a broad impact upon a class of recipients, and the scope of the relief is dictated by the nature of the violation. *See Califano v. Yamasaki*, 442 U.S. 682, 702 (1979); *Morrow*, 277 F.R.D. at 193, (quoting *Wal-Mart*, 131 S. Ct. at 2557 ("As *Wal-Mart* emphasized '[c]ivil rights cases against parties charged with unlawful, class-based discrimination are prime examples' of what (b)(2) classes are meant to capture.")).

There is no requirement that "all questions of law and fact involved in the dispute be common to all members of the class." *Arnold v. United Artists Theatre Circuit, Inc.*, 158 F.R.D. 439, 448-49 (N.D. Cal. 1994). Nor does Rule 23(a)(2) require all putative class members to share identical claims; rather, the rule requires only "that complainants' claims be common and not in conflict." *Hassine v. Jeffes*, 846 F.2d 169, 176-77 (3d Cir. 1988). Only where there are *no* common questions of fact or law should certification be denied. *Yaffe*, 454 F.2d at 1366.

Similarly, the requirement that there be a substantial question of law or fact common to all class members does not mean that each class member must be identically situated. *Falcon*, 457 U.S. at 155. Commonality is not defeated by the presence of individual differences among class members. *See Lightbourn*, 118 F.3d at 426 (class of individuals with different disabilities requiring different accommodations was certified because all were impacted by the same governmental inaction); *Adamson v. Bowen*, 855 F.2d 668, 676 (10th Cir. 1988) (Rule 23(a) requires that "common questions of law or fact exist, only in class actions sought to be certified under Rule 23(b)(3) must such questions predominate"); *Appleyard v. Wallace*, 754 F.2d 955, 958 (11th Cir. 1985) ("The similarity of the legal theories shared by the plaintiffs and the class at large is so strong as to override whatever factual differences might exist and dictate a determination that the named plaintiffs' claims are typical of those of the members of the putative class."), *disagreed with on other grounds Green v. Mansour*, 474 U.S. 64 (1985); *Milonas v. Williams*, 691 F.2d 931, 938 (10th Cir. 1982) ("Regardless of their source of funding or, indeed, their individual disability or behavioral problems, all of the boys at the school were in danger of being subjected to the four enjoined 'behavior-modification' practices. In our view, the typicality and commonality requirements of Fed. R. Civ. P. 23(a)(3) have been met."). In fact, "allegations of similar discriminatory practices generally meet the commonality requirement." *Lightbourn*, 118 F.3d at 426 (citing *Shipes v. Trinity Indus.*, 987 F.2d 311, 316 (5th Cir. 1993)); *see also Curtis v. Comm'r, Maine Dep't. of Human Servs.*, 159 F.R.D. 339, 341 (D. Me. 1994) (where "a question of law refers

to standardized conduct of the defendant towards . . . the proposed class, commonality is usually met").

Courts have broadly applied Rule 23 to class actions seeking injunctive and declaratory relief to remedy the denial of a legal entitlement or the application of a governmental policy or practice that infringes that right. *See Neff*, 179 F.R.D. at 193 ("Given that the class members are affected by the general policy and that policy is the focus of this litigation, the Court finds the commonality requirement has been satisfied."); *Morrow*, 277 F.R.D. at 193 (plaintiffs offered significant proof that police department operated a general policy of discrimination in conducting traffic stops.); *Anderson v. Pa. Dep't of Pub. Welfare*, 1 F. Supp. 2d 456, 461 (E.D. Pa. 1998) ("Commonality is easily established in cases seeking injunctive relief.").

In this action, the Class seeks only injunctive and declaratory relief. The Class here has demonstrated the common thread or "glue" which unites their common factual and legal claims: all members of the plaintiff class are or will be subject to, segregation as a result of Defendants' standardized conduct.[19] Defendants' standardized planning, administering, operating, and funding

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[19] Numerous courts have recognized the rights of those who may be institutionalized to state claims under the ADA's integration mandate. *See, e.g.*, *M.R. v. Dreyfus*, 663 F.3d 1100, 1116-17 (9th Cir. 2011) ("An ADA plaintiff need not show that institutionalization is 'inevitable' or that she has 'no choice' but to submit to institutional care in order to state a violation of the integration mandate. Rather, a plaintiff need only show that the challenged state action creates a serious risk of institutionalization."), *amended by,* 697 F.3d 702 (9th Cir. 2012); *Radaszewski ex. rel. Radaszewski v. Maram*, 383 F.3d 599, 612-15 (7th Cir. 2004); *M.A.C. v. Betit*, 284 F. Supp. 2d 1298, 1309 (D. Utah 2003); *Fisher v. Okla. Health Care Auth.*, 335 F.3d 1175, 1177-78, 1182 (10th Cir. 2003) ("*Olmstead* does not imply that disabled persons who, by reason of a challenge to that state policy, stand imperiled with segregation, may not bring a challenge to that state policy under the ADA's integration regulation without first submitting to institutionalization."); *Makin ex rel. Russell v.*

of their developmental disability service system all deny persons with I/DD in nursing facilities the community services necessary to avoid their segregation and to allow them to live in the most integrated setting. As a result, the Class is suffering because of a common course of conduct by Defendants, from which arises a set of common claims and contentions.[20]

b. Courts have certified classes post-Wal-Mart where common policies and practices are being challenged, despite individual differences between class members.

Cases decided post-*Wal-Mart* recognize that while *Wal-Mart* provides "guidance on how existing law should be applied to expansive, nationwide class actions," it does not preclude injunctive relief designed to remedy overarching deficiencies in a state service system. *Connor B.*, 278 F.R.D. at 33; *see also M.D.*, 294 F.R.D. at 38-39 ("[*Wal-Mart*] involved a far-flung class action where the plaintiffs' claims were based on sexual discrimination . . . Plaintiffs' claim here is different. On behalf of the General Class, Plaintiffs make out a claim that caseworkers carry excessive caseloads, which results in class members being deprived of their Fourteenth Amendment rights."). Certification remains appropriate for classes seeking injunctive and compensatory relief

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Hawaii, 114 F. Supp. 2d 1017, 1033 (D. Haw. 1999).

[20] *See* Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.*, at *http://www.ada.gov/olmstead/q&a_olmstead.htm* ("[T]he ADA and the *Olmstead* decision extend to persons at serious risk of institutionalization or segregation and are not limited to individuals currently in institutional or other segregated settings. Individuals need not wait until the harm of institutionalization or segregation occurs or is imminent . . . a plaintiff could show sufficient risk of institutionalization to make out an *Olmstead* violation if a public entity's failure to provide community services or its cut to such services will likely cause a decline in health, safety, or welfare that would lead to the individual's eventual placement in an institution.").

when common questions exist regarding the discriminatory impact of a defendant's policies and those questions may most efficiently be resolved on a class-wide basis. *See McReynolds v. Merrill Lynch*, *Pierce, Fenner & Smith, Inc*., 672 F.3d 482, 488-92 (7th Cir. 2012) (reversing denial of class certification in disparate impact case where common questions exist regarding company policies and their contributory effect on alleged employment discrimination, even if individual employee decisions may also be a factor).

Neither an assessment of commonality for the purposes of class certification, nor even a determination of liability under federal law, require this Court to evaluate the individual clinical conditions, support needs, or the residential preferences of each one of the thousands of persons with I/DD in Texas who are in or who are, will be, or should be screened for admission to, nursing facilities. Those decisions will be made by the State's PASRR clinical reviewers, as well as the clinical teams that include developmental disability professionals, the individual with I/DD, and his family member or guardian, which develop the treatment plans, transition plans, and Individual Service Plans for each class member. This Court can determine that a violation of federal law has occurred, and remedy that common legal violation with an order directing Defendants' conduct, without the type of individualized liability determinations at issue in *Wal-Mart*. It is both unnecessary and unrealistic for the Plaintiffs to prove that each individual class member's support needs or preferences are identical. This is not the standard of proof required for class certification before or after *Wal-Mart*.

Class action cases interpreting *Wal-Mart* confirm that commonality may exist even where class members are not identically situated. *See*, *e.g.*, *Dunakin*, 2015 WL 1619065, at *29. In a case nearly identical to this one, the district court found that the plaintiff was not asking the court to make separate determinations concerning the individual services that are appropriate for each class member, but rather that class members were seeking:

> implementation of appropriate policies, practices, and procedures by Defendants to ensure that putative class members are screened and evaluated as required by the NHRA and the PASRR regulations, informed that they may be eligible for community-based services, and provided with appropriate services by Defendants with reasonable promptness. In other words, [plaintiff] does not ask the court to order individualized remedies for the various class members; instead, he asks the court for an order requiring Defendants 'to develop a system of evaluation and implementation of corresponding services that complies with federal standards.

Id. (quoting *Van Meter,* 272 F.R.D. at 282) (citation omitted); *see also Oster*, 2012 WL 685808, at *5 (rejecting defendants' challenge under *Wal-Mart* that class members do not satisfy commonality because they suffer different service reductions); *Churchill v. Cigna Corp*., No. 10-6911, 2011 WL 3563489, at *3-4 (E.D. Pa. Aug. 12, 2011) (plaintiff class denied the benefit of treatment for Autism Spectrum Disorder stated common claims as well as "'common answers apt to drive the resolution of the litigation'" regardless of their different conditions, treatment needs, and abilities to benefit from ABA therapy (quoting *Wal-Mart*, 131 S. Ct. at 2551)); *Connor B. ex rel. Vigurs v. Patrick*, 272 F.R.D. 288, 296 (D. Mass. 2011) (that harms suffered by unnamed class members differs from that experienced by named plaintiffs does not undermine commonality or typicality).

c. Both M.D. v, Perry and Jamie S. v. Milwaukee School Systems support class certification here.

Defendants previously opposed class certification, largely relying on two cases: *M.D. ex. rel. Stukenberg v. Perry*, 675 F.3d 832 (5th Cir. 2012) and *Jamie S. v. Milwaukee Public School,* 668 F.3d 481 (7th Cir. 2012). In fact, both cases actually support class certification, as underscored by their subsequent history and application.

In *M.D.*, the Fifth Circuit concluded that the district court initially failed to explain how systemic deficiencies in Texas's child welfare system which arose from three separate and unrelated constitutional claims gave rise to a common solution that would address the claims of all class members.[21] At the same time, the Fifth Circuit identified a number of practices that could well satisfy commonality, such as the lack of sufficient staffing or a statewide deficiency in its child welfare system. As the Fifth Circuit explained:

> Rather, the class claims could conceivably be based upon an allegation that the State engages in a pattern or practice of agency action or inaction – including a failure to correct a structural deficiency within the agency….

[21] Moreover, the appeals court was understandably troubled by the lack of coherence between three quite different claims under three quite different constitutional provisions, particularly since the substantive due process one appeared to require an individualized inquiry of harm. *Id.* at 843. It suggested that the district court should consider the possibility of subclasses for each claim, since each presented a quite different contention, and different answer to the contention. *Id.* at 848. Here, of course, there are really only two claims, one involving segregation in nursing facilities made under two related statutes, the ADA and the Rehabilitation Act, and the other involving admission to and treatment in nursing facilities, made under the Nursing Home Reform Amendments and other related provisions of the Medicaid Act. In no sense do the common questions in this case involve the type of "super-claim" that the Fifth Circuit found so troubling in *M.D.*

M.D., 675 F.3d at 847.

As recognized by Plaintiffs in previous briefs and oral argument,[22] the Fifth Circuit in *M.D.* vacated the lower court's class certification and remanded for proceedings in light of the intervening Supreme Court ruling in *Wal-Mart*. *M.D.,* 675 F.3d at 849. As predicted by Plaintiffs, on remand, the district court certified a class of 12,196 children in long-term foster care, and the Fifth Circuit denied interlocutory review. *M.D.*, 294 F.R.D. at 66. In its decision on remand, the district court succinctly identified the ramifications of *Wal-Mart* for class certifications in the Fifth Circuit:

> Post *Wal-Mart*, establishing commonality entails two things: that there exists a common policy or practice, possibly an implicit one, that is the alleged source of the harm to class members, and that there are common questions of law or fact that will be dispositive of the class members claim.

M.D., 294 F.R.D. at 28-29.

Here, Defendants' failure to plan, administer, and fund their developmental disability services system in a manner that provides the integrated residential and other services necessary to avoid segregation leads logically and ineluctably to an injunction to provide those services, which would, in a single stroke, address the claims of and harms suffered by each class member. As long as the district court is not involved in individualized determinations of liability and

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[22] *See* Pls.' Mem. of Law in Support of Am. Mot. for Class Certification, Docket No. 94-1, at 22-23; Pls.' Suppl. Mem. of Law in Support of Am. Mot. for Class Certification, Docket No. 148, at 4-7; Tr. of Sept. 12, 2012 hearing ("Tr."), Docket No. 142, at 109, line 12 – 110, line 13,

remedy and can issue a single injunction that can remedy the structural deficiency, as is the case here, *M.D.* strongly supports class certification. *See id.*

Jamie S. also supports certification since, unlike the facts in that case, the Court has no role in the individualized clinical decisions for each class member. The Seventh Circuit, in *Jamie S.*, was understandably troubled by the combination of two factors that are not present here. First, the Individuals with Disabilities Education Act ("IDEA") requires, on its face, individualized determinations of each child's education needs and precludes judicial relief without the exhaustion of all administrative remedies. The putative class in *Jamie S.* unsuccessfully sought to circumvent the exhaustion requirement for IDEA claims by challenging a systemic deficiency in Milwaukee's child find practices. The Seventh Circuit found that the class definition was fatally flawed and could not be invoked to accomplish such circumvention. *Jamie S.*, 668 F.3d. at 493-96. The claims here impose no such exhaustion limitations and do not require such individualized determinations.

Second, and perhaps more importantly, the remedy ordered by the district court in *Jamie S.* established an individualized child review process that substituted for the city's "so-called child find requirements of the [Individuals with Disabilities Education Act]" process and resulted in the issuance of separate injunctive orders for each child. *Id.* at 485. The Seventh Circuit concluded that these separate injunctions demonstrated that the remedial order did not generate a common answer and a single injunction that applied to the class as a whole.[23] *Id.* at 498-99; *see*

[23] *McReynolds v. Merrill Lynch, Pierce, Fenner & Smith, Inc*. demonstrates that the Seventh

Corey H. v. Bd. of Educ. Chi., No. 92 C 3409, 2012 WL 2953217, at *5 (N.D. Ill. July 19, 2012), *appeal dismissed* 528 F. App'x 666, 668 (7th Cir. 2013) (denying defendant's motion to decertify class more than ten years after entering into original consent decree and in so doing, identifying limits of *Jamie S.* and *Wal-Mart*: "The two cases represent nothing more than the application of Rule 23 to specific sets of facts or, perhaps, to a specific type of claim under two distinct federal laws—Title VII and the IDEA—both of which provide for individual equitable relief in addition to injunctive relief."). The class claims here do not require an inquiry into individualized relief. Instead, they require the Court to determine whether it is appropriate to issue a single injunction requiring Defendants to end their segregation of persons with I/DD in nursing facilities, and instead, to provide community support services that would allow these individuals to live in the most integrated setting.

As a direct result of Defendants' actions and inactions, Plaintiffs are segregated in nursing facilities when they could live in integrated community settings, and are not being accurately screened or assessed, in violation of their rights under the ADA and the NHRA. Additionally, Plaintiffs are not receiving specialized services and active treatment, as required by 42 C.F.R. §§ 483.126 and 483.440(a)-(f). This standardized conduct is the common problem that is susceptible

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Circuit found nothing in *Jamie S.* to preclude a finding of commonality or preclude class certification when there is *no* judicially-mandated process for affording individualized relief. The same Circuit only a few weeks later, and post-*Wal-Mart*, certified a class of African-American employees who alleged racial discrimination in employment promotion and compensation practices. *McReynolds*, 672 F.3d at 492 (certifying a class for liability purposes because this phase of an employment discrimination case, as opposed to the damage claims, can be resolved by a single injunction and does not require individualized remedial orders).

to a common answer: an injunction requiring Defendants to modify their developmental disability service system for persons with I/DD to accommodate the needs of nursing facilities residents, and to modify their PASRR screening, assessment, and treatment program to ensure that persons are not inappropriately admitted to nursing facilities, and, if so admitted, receive needed specialized services.[24]

In short, the Named Plaintiffs have established commonality precisely because they identify both a common contention – that Defendants' planning, administration, and funding of their developmental disability system denies persons with I/DD in nursing facilities the ability to live in the most integrated setting and to receive active treatment while in a nursing facility – as well as a common injury – discriminatory segregation. The common contention, moreover, is "of such a nature that it is capable of class wide resolution." *Wal-Mart*, 131 S. Ct. at 2551. Here, as in most ADA Title II and Medicaid cases, the challenge is directed to the public entity's failure to administer and fund a developmental disability service system that provides medically necessary services which allow persons with I/DD to live in the most integrated setting. This failure is the common contention that is susceptible to a common answer, through a single injunction that would

[24] Plaintiffs in *Dunakin*, 2015 WL 1619065, at *26, alleged violations of the NHRA based upon inadequate PASRR assessments in Washington nursing facilities. Plaintiffs here claim that Defendants, both previously and under their newly published policy, systematically and erroneously screen out nursing facility residents at both the PASRR Level I review and PASRR Level II evaluations. Plaintiffs in both cases have been harmed "due to flawed PASRR policies and procedures", *id.*, and Plaintiffs' claims here have been supported by the independent evidence from the Expert Reviewer. *See* Third Garth Decl., Ex. 1-3. *See generally* Second Amended Complaint, ¶¶ 75-113,

require the entity to remedy this deficiency and accommodate the needs of all persons with I/DD who are in segregated settings. The injuries to this class can be redressed by a modification to the Defendants' developmental disability service system that would afford persons with I/DD in nursing facilities access to community services and specialized services, such that they may receive active treatment to avoid regression, deterioration, isolation and segregation. This modification can be achieved through a single injunction providing relief to the class as a whole. *Id.* at 2560. Therefore, the Plaintiffs have presented both the common questions and the "common answers apt to drive the resolution of the litigation." *Id.* at 2551. Consistent with precedent in class actions alleging systemic civil rights violations, the Court should find there are questions of law and fact common to the class.

In fact, Defendants have already entered into a systemic injunction that provides system-wide relief. The IA represented a common answer to Defendants' systemic failures. The IA ordered specific systemic relief to all of the members of the Class, which began to address many of the federal law violations. Also, the three Expert Reviewer reports issued pursuant to the IA demonstrate how Defendants' policies and practices can be measured for compliance with such specific and systemic relief.

Differences between class members' abilities and disabilities have no bearing on Defendants' systemic failure to provide class members with the required screening and necessary specialized services and on systemic relief to cure this failure.[25] *See Rolland*, 2008 WL 4104488, at

[25] Like other Medicaid Act and ADA integration cases, this action does not require the Court to

*4 ("[A]ny identified factual differences between the named Plaintiffs and some of the class they sought to represent did not undermine commonality and, in particular, did not preclude certification of a class of persons with mental retardation who were challenging Defendants' practices."). Factual distinctions between class members simply have no relevance to, nor impact on, the systemic nature of the relief requested in the Second Amended Complaint or the prosecution of this case. *Risinger ex rel. Risinger v. Concannon*, 201 F.R.D. 16, 20-21 (D. Me. 2001). Therefore, the proposed class satisfies the commonality requirement of Rule 23(a)(2).

3. The Claims of the Named Plaintiffs Are Typical of Those of the Class.

The third component of Rule 23(a) requires that the proposed class representatives' claims for relief be typical of the claims of the absent class members. The test for "typicality" asks whether the class representatives "possess the same interest and suffer the same injury" as other class members, but it does not require that the claims of the named plaintiffs be identical to the claims of the other class members. *Falcon*, 457 U.S. at 156; *see also Mullen*, 186 F.3d at 625 (test for typicality "focuses on the similarity between the named plaintiffs' legal and remedial theories and the theories of those whom they purport to represent"). "[T]he critical inquiry is whether the class representative's claims have the same essential characteristics of those of the putative class. If the claims arise from a similar course of conduct and share the same legal theory, factual differences

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engage in individualized determinations of the appropriateness of community placement or the need for particular specialized services. Those determinations are best left to existing or new remedial processes. The failure to utilize an effective screening process and the dearth of specialized services can be established without resort to individual treatment determinations by the Court.

will not defeat typicality." *M.D.*, 294 F. R. D. at 61 (particularities regarding circumstances that are not relevant to the claims do not undermine typicality). Additionally, most courts agree that " the test for typicality is not demanding." *Mullen*, 186 F.3d at 625; *Morrow*, 277 F.R.D. at 194; *Hotels.com*, 2008 WL 2486043, at *6.

For example, in *Appleyard*, a class action was brought in Alabama challenging the state's Medicaid level of care admission criteria on behalf of individuals who were denied Medicaid nursing facility benefits. *Appleyard*, 754 F.2d. at 956. The district court refused to certify the class based on its findings that the named plaintiffs could not satisfy the typicality requirement due to the "vast factual differences surrounding the medical condition of each of the named Plaintiffs." *Id.* at 957. In reversing, the Eleventh Circuit held that these factual differences were irrelevant because they had nothing to do with the injunctive and declaratory relief requested by the plaintiffs on behalf of themselves and the class. *Id*. at 958. The Eleventh Circuit concluded that "[t]he similarity of the legal theories shared by plaintiffs and the class at large is so strong as to override whatever factual differences might exist and dictate a determination that the named plaintiffs' claims are typical of those of the members of the putative class." *Id.*

Similarly, the *Rolland* court considered the potential differences between the members of a class (nearly identical to the class proposed here) and found that

> [t]he fact that individual class members may have somewhat different needs, or may have entered the [segregated placements] through different processes, or may be entitled to or need different services, does not justify denying class certification . . . . *If anything, the requisite typicality is established precisely because Plaintiffs' claims are broadly typical of the class, namely, that they have not been appropriately placed in the community or provided certain medically necessary supportive services.*

1999 WL 34815562, at *7 (emphasis added).

The Named Plaintiffs satisfy the typicality requirement of Rule 23(a)(3) because their claims, and those of the unnamed class members, present similar factual situations including: (1) all have I/DD; (2) all are or will likely be confined in a nursing facility if their conditions worsen or if problems arise in their community living arrangement; (3) virtually all would benefit from living in the community; (4) most are qualified for the Defendants' community service system; (5) most would not oppose community placement; (6) all are entitled to appropriate screening and assessment to determine if they require a nursing level of care, could have their needs met in an appropriate community setting, and could benefit from specialized services; and (7) those identified as needing specialized services would benefit from being provided such services in the nursing facility. The requisite typicality exists because the Defendants are needlessly institutionalizing class members and denying necessary specialized services in violation of Title II of the ADA and the NHRA. *See Curtis*, 159 F.R.D. at 341 (typicality is met because "the representative Plaintiff is subject to the same statute and policy as the class members"); *Hotels.com*, 2008 WL 2486043, at *6 ("While each putative class member has its own ordinance, the claims arising thereunder, and the legal and remedial theories on which the claims are based, are the same.").

Finally, the Named Plaintiffs have a personal interest in this litigation which is reasonably related to the harm experienced by all class members. *See Risinger*, 201 F.R.D. at 22 (finding typicality where plaintiffs invoking same Medicaid Act provisions, allege same systemic

deficiencies, and sought same relief). Thus, the Named Plaintiffs satisfy the typicality requirement of Rule 23(a)(3).

4. The Class Representatives Fairly and Adequately Represent the Interest of the Class.

Rule 23(a)(4) requires that the representative plaintiffs in a class action fairly and adequately protect the interests of the entire class. In order to satisfy this requirement, two criteria must be met: (1) the class representatives must not have antagonistic or conflicting interests with the unnamed members of the class, and (2) the attorneys representing the class must be qualified and competent. *In re Deepwater Horizon*, 785 F.3d 1003, 1015 (5th Cir. 2015); *DeHoyos v. Allstate Corp.*, 240 F.R.D. 269, 282 (W.D. Tex. 2007); *Neff*, 179 F.R.D. at 194. Both elements of Rule 23(a)(4) are met in this case.

a. Adequacy of the Named Representatives

In order for the Named Plaintiffs to be deemed adequate to represent the class, their interests must coincide with those of the unnamed class members. *Neff*, 179 F.R.D. at 195; *see generally Falcon*, 457 U.S. 147. Additionally, the interests of the Named Plaintiffs must not be antagonistic to the unnamed class members. *See Bertulli v. Indep. Ass'n of Cont'l Pilots*, 242 F.3d 290, 296 (5th Cir. 2001); *DeHoyos*, 240 F.R.D. at 283.

In the present case, although all members of the Class may not have exactly the same treatment recommendations or needs, they all have suffered, or have a significant likelihood of again suffering, the same injuries as a result of the Defendants' policies and practices: segregation in a nursing facility and the denial of specialized services sufficient to provide active treatment. *See*

Second Amended Complaint ¶¶ 63-71, 72-148; Sanchez Decl.; Marino Decl. They all seek the same remedies: the provision of integrated community services and supports for those who are qualified for the Defendants' community service system; accommodations that would allow them to transition to the community; a screening and assessment process that accurately identifies individuals whose needs could be appropriately met in the community and that reliably determines the need for specialized services for persons who are admitted to a nursing facility; and the provision of specialized services that satisfy the federal standard for active treatment for those who are admitted to a nursing facility. *See generally id.* None of these claims are unique to any individual plaintiff. Rather, the claims raised and the relief sought, operate equally to benefit all class members.

Even if all of the Named Plaintiffs transition to the community before a class is certified in this case, because they have timely filed a motion for class certification prior to the Defendants' attempts to moot their claims, the Named Plaintiffs' claims are relate-back to the time of the filing of the Second Amended Complaint and, therefore, are not rendered moot. *Mabary v. Home Town Bank, N.A.*, 771 F.3d 820, 822 (5th Cir. 2014) *op. withdrawn* (Jan. 8, 2015) (even a class certification motion filed four days after receipt of offer of complete relief to individual plaintiff is sufficiently timely and diligent to prevent class claim from being mooted); *see also Suttles v. Specialty Graphics, Inc.*, No. A-14-CA-505 RP, 2015 WL 590241, at *5-6 (W.D. Tex. Feb. 11, 2015) (following the relating back rule in earlier-decided *Mabary* and declining to follow later-decided *Fontenot v. McGraw*, 777 F.3d 741 (5th Cir. 2015)); *Zeidman*, 651 F.2d at 1045 (where a

class certification motion is timely and diligently filed, a rejected Rule 68 offer made after the filing of the class certification motion, but before the court can decide the motion, that provides the named plaintiff complete relief, the claims "relate back" to the date of the complaint is filed and are not moot).

The purpose of the rule in the *Mabary - Zeidman* line of cases is to prevent the plaintiffs in this and other actions from being "picked off" by defendants seeking to moot their claims, in order to preclude class certification. *Zeidman*, 651 F.2d at 1050-51. Here, Plaintiffs filed their Motion for Class Certification well before Defendants ever sought to provide community living arrangements to all qualified individuals who are unnecessary segregated in nursing facilities – or even to anyone of the Named Plaintiffs – and thereby attempt to moot the Plaintiffs' claims. Significantly, until the IA was entered as an order of this Court, Defendants only offered community placements through new Home and Community-Based Services (HCS) waiver slots to the specific individuals identified as Named Plaintiffs.

The Named Plaintiffs' claims are not moot and they have the same interests as other class members who live in nursing facilities or who are or will be or should be screened for inappropriate admission to a nursing facility. Consequently, the Named Plaintiffs can fully and adequately represent the legal rights and seek the legal remedies to which all members of the putative class are entitled as required by Rule 23(a)(4).

b. Adequacy of Counsel

The factors that courts consider in determining the adequacy of the counsel in class actions include: the attorneys' professional skills, experience, and resources. *See N. Am. Acceptance Corp. Sec. Cases v. Arnall, Golden & Gregory*, 593 F.2d 642, 644 (5th Cir.), *cert. denied*, 444 U.S. 956 (1979); *Rodriguez v. Carlson*, 166 F.R.D. 465, 473 (E.D. Wash. 1996). Plaintiffs' counsel are well qualified to handle this action and will prosecute it vigorously on behalf the class. Disability Rights Texas (formerly Advocacy, Inc.) is the federally-designated Protection and Advocacy agency for persons with disabilities in Texas and is experienced in class action litigation on behalf of individuals with disabilities. The Center for Public Representation has been involved in complex class action litigation on behalf of institutionalized persons with disabilities for over forty years and has been lead counsel in numerous institutional reform lawsuits throughout the country, including a very similar case in Massachusetts. *See Voss v. Rolland,* 592 F.3d at 247-49 (recounting history of litigation). Sidley Austin LLP is a leading private law firm, internationally, nationally, and in Texas, and has litigated numerous class actions and other complex cases. Finally, Plaintiffs' counsel command the necessary resources to competently represent the class, and they have no other professional commitments which are antagonistic to, or which would detract from, their efforts to seek a favorable decision for the class in this case.

E. This Action Meets the Requirements of Rule 23(b)(2).

Courts have recognized that class actions certified under subsection (b)(2) of Rule 23 of the Federal Rules of Civil Procedure are particularly important in civil rights cases where injunctive relief is sought, as in the present case. *Morrow*, 277 F.R.D. at 197; *Yaffe*, 454 F.2d at 1366 ((b)(2) is

"uniquely suited to civil rights actions"); *Holmes v. Cont'l Can Co.*, 706 F.2d 1144, 1152 (11th Cir. 1983); *see also* Advisory Committee Note on Rule 23, 39 F.R.D. 69, 102 (1966). Certification of classes has been deemed "an especially appropriate vehicle for civil rights actions" seeking systemic reform. *See Coley v. Clinton*, 635 F.2d 1364, 1378 (8th Cir. 1980); *see also Hoptowit v. Ray*, 682 F.2d 1237, 1245 (9th Cir. 1982), *abrogated on other grounds by, Sandin v. Conner*, 515 U.S. 472 (1995). In cases seeking only equitable relief, class certification is necessary to make sure that mandatory relief runs to benefit all class members. *Rolland*, 2008 WL 4104488, at *6 (citing *Jane B. v. N.Y. City Dept. of Social Servs.*, 117 F.R.D. 64, 72 (S.D.N.Y. 1987)).

The elements of Rule 23(b)(2) are satisfied in this case, and class certification is appropriate, because it is a civil rights class action seeking declaratory and injunctive relief, which is exactly the type of litigation that the Federal Rules Advisory Committee anticipated would be certified under Rule 23(b)(2). *See* Advisory Committee Notes to Rule 23, 39 F.R.D. at 102; *Coley*, 635 F.2d at 1378. Defendants' planning, administration, operation, and funding of their community service and nursing facility systems for persons with I/DD; their failure to provide appropriate services in the community and/or placements in integrated settings; their failure to conduct effective screenings to prevent the unnecessary admission of persons with I/DD to nursing facilities; their failure to conduct professionally-acceptable assessments to determine if individuals who are admitted need specialized services; and their failure to provide active treatment to nursing facility residents all violate federal statutory rights common to both the Named Plaintiffs and the unnamed class members. Thus, Defendants are acting or refusing to act in a manner that equally affects and is "generally

applicable" to the entire class. Therefore, final injunctive and declaratory relief is appropriate, precisely because it will resolve the legality of the challenged actions and inaction for the class as a whole. In a case such as this, the "proposed class certification is eminently appropriate." *Rolland*, 2008 WL 4104488, at *6 (quoting *Rolland*, 1999 WL 34815562, at *9).

The Fifth Circuit also has recognized the importance of class certification where a defendant governmental agency may attempt to voluntarily perform a specific action sought in a lawsuit for an individual plaintiff in order to try to moot the representative plaintiff's claim. *E.g. Zeidman*, 651 F.2d at 1051. In *Zeidman*, the Fifth Circuit explained that "refusal to certify the class 'would mean that the (agency) could avoid judicial scrutiny of its procedures by the simple expedient of granting hearings to plaintiffs who seek, but have not yet obtained, class certification.'" 651 F.2d at 1051 (quoting *White v. Mathews*, 559 F.2d 852, 857 (2d Cir. 1977)). A similar risk exists here: Defendants could provide the Named Plaintiffs with HCS waiver slots and/or specialized services, thereby mooting the Named Plaintiffs' claims, while continuing to deny similar relief to the thousands of other similarly-situated persons. Moreover, given Defendants' targeted efforts to moot the Named Plaintiffs, that risk is not speculative; it has and will continue to occur, absent certification of a class.

This case, like most civil rights cases, primarily focuses on Defendants' conduct, and not Plaintiffs' needs. Plaintiffs challenge how Defendants fund, plan and administer their existing community service system. Plaintiffs claim that Defendants have engaged in a pattern of standardized conduct, the result of which is a failure to make sufficient community support

services available to persons with I/DD, leading to segregation in nursing facilities. This pattern and practice of standardized conduct by Defendants towards the putative class of persons who are currently segregated or who are, will be or should be screened for admission to nursing facilities is appropriate for, and susceptible to, a single injunction.

The Second Amended Complaint seeks an injunction to alter that conduct and to compel compliance with federal law, by reasonably modifying Texas's disability service system for persons with I/DD, so that Texas offers services in integrated settings for all qualified persons with I/DD. Second Amended Complaint, ¶ 6 and Second Prayer for Relief. The focus on Defendants' conduct in operating their disability services system, and the resulting systemic claims of discrimination, are what have led virtually every court that has considered class certification in ADA, Rehabilitation Act, and Medicaid Act cases to certify a class, despite the obvious difference in the abilities, disabilities, and needs of individual class members. At the proper level of analysis for class certification purposes, the focus is, and should be, on the adequacy of Defendants' actions and inactions in providing services in the most integrated setting for qualified persons with I/DD. Systemic injunctions, which describe the reforms to a State's service system and its segregated programs, are the well-tested and accepted method for curing federal law violations. *See Rolland v. Patrick*, 562 F. Supp. 2d 176 (D. Mass. 2008), *aff'd sub nom Voss v. Rolland*, 592 F.3d 242 (1st Cir. 2010); *United States v. Texas*, No. 09-cv-00490-ss (W.D. Tex. 2009) (Settlement Agreement, Docket No. 2, available at http://www.justice.gov/sites/default/files/crt/legacy/2010/12/15/TexasStateSchools_settle_06-26-

09.pdf, entered by Order Granting Motion, Docket No. 4, to remedy deficiencies in State-Supported Living Centers for individuals with disabilities).

At the September 12, 2012 oral argument, Defendants suggested that Plaintiffs could not articulate with sufficient specificity the injunctive relief that they are seeking. Counsel for Defendants argued:

> [Plaintiffs] haven't offered any such relief; a particular change to a waiver program, a particular change to the PASRR program. We have none -- none of that has been proposed here and that all -- again, that violates the particularity requirement of the Fifth Circuit.

Tr. at 138, lines 3-8*; see also* Defs.' Post-Sept. 12, 2012 Hr'g Br., Docket No. 151 at 8. These arguments are belied by the IA, an agreed-to remedial order that demonstrates with specificity the first phase (2 years) of injunctive relief that Plaintiffs seek in this case.

In any event:

> The precise terms of the injunction need not be decided at class certification, only that the class members' claim is such that a sufficiently specific injunction can be conceived; a plaintiff must present evidence and arguments 'sufficient to allow the district court to see how it might satisfy Rule 65(d)'s constraints and thus conform with Rule 23 (b)(2)'s requirement.

Dockery v. Fischer, No. 3:13-cv-326-WHB-JCG, 2015 WL 5737608, at *13 (S.D. Miss. Sept. 29, 2015) (quoting *Shook v. Bd. of Cty. Comm'rs*, 543 F.3d 597, 605 n.4 (10th Cir. 2008)).

Here, Plaintiffs have provided the Court with extensive evidence in support of class certification, and have demonstrated – by the example of the IA and the agreed-to standards (Outcomes and Outcome Measures) for assessing compliance - the specific details of a single

injunction. Third Corbett Decl., Exs. A-C. As can be seen in the IA and in the Expert Reviewer's three reports, the injunctive relief Plaintiffs seek are systemic changes to Defendants' policies and practices, *not* individual relief.[26]

Moreover, differences concerning an individual's disability do not preclude certification in cases where those class members have suffered a common injury and where that injury can be redressed by a single injunction requiring the Defendants to fund and operate their disability service system consistent with federal law. Rather, because the Second Amended Complaint seeks - and the ADA, Rehabilitation Act, and Medicaid Act violations can be remedied by - a single injunction like the IA, certification of the proposed class is appropriate under Rule 23(b)(2).

In this case, class certification pursuant to Rule 23(b)(2) is appropriate and necessary to ensure that any mandatory relief will extend to all individuals with I/DD who are or will be confined in, or who are, will be or should be screened for admission to nursing facilities in Texas.

IV. DISABILITY RIGHTS TEXAS, THE CENTER FOR PUBLIC REPRESENTATION, AND SIDLEY AUSTIN LLP SHOULD BE APPOINTED CO-CLASS COUNSEL PURSUANT TO RULE 23(G).

The Named Plaintiffs are jointly represented by Disability Rights Texas, the Center for Public Representation, and Sidley Austin LLP ("Sidley"), each of which brings unique resources,

[26] The Expert Reviewer's reports also support Plaintiffs on the merits of their claims. But it is not necessary to determine liability at this stage in order to determine that plaintiffs can articulate and have articulated the kind of specific relief for the class that they are seeking.

experience and skills to the case, and those three law firms should be appointed as class co-counsel pursuant to Rule 23(g).

Disability Rights Texas is the federally-designated protection and advocacy organization for the state of Texas and is charged with protecting the rights of individuals with disabilities throughout Texas. It has extensive knowledge of and experience with the workings of Texas's service array and service delivery systems for individuals with disabilities. It is also in direct contact with the Named Plaintiffs and numerous other class members through its ongoing outreach and intake processes. Disability Rights Texas has seven regional offices throughout Texas. Garth Corbett, the lead Disability Rights Texas attorney on this case, has over 28 years of experience representing individuals with disabilities and has litigated two class action cases, including *Neff*, 179 F.R.D. at 195 ("The Court had the opportunity to see counsel [Garth Corbett] in action and review the pleading and other legal memoranda submitted by counsel….The Court is confident counsel provided adequate representation for the class."). He is not counsel in any pending class actions.

The Center for Public Representation is a Massachusetts-based public interest law firm that focuses on systemic advocacy on behalf of individuals with psychiatric and intellectual disabilities. It provides litigation support and assistance to the National Disability Rights Network and the protection and advocacy organizations throughout the country. It has litigated dozens of class actions on behalf of institutionalized individuals, raising claims under the ADA, the NHRA, the Medicaid Act, Section 504, and the Due Process and Equal Protection Clauses of the Fourteenth Amendment. Mr. Schwartz and Ms. Dorfman, the two lead Center for Public Representation

attorneys, have been lead counsel in numerous class actions. Mr. Schwartz is a nationally-recognized expert concerning the rights of institutionalized individuals and has more than 40 years of experience representing individuals with psychiatric and intellectual disabilities. He is currently counsel in seven ongoing class actions, and was lead counsel in *Rolland v. Patrick*, a case that involves claims virtually identical to those at issue in this case. He has handled more than 15 additional cases involving class claims over the course of his career. Ms. Dorfman has over 20 years of experience representing individuals with disabilities and has litigated in excess of six class actions and more than five other large systemic reform cases raising claims under the ADA, Section 504 , the Medicaid Act, and the Due Process Clause of the United States Constitution. Ms. Toner is co-counsel on a large ADA class action in Oregon on behalf of over 2,000 individuals with I/DD, and assists on several other class action cases involving persons with disabilities. Ms. Staub has over twenty five years of litigation experience, including as co-counsel in three other class actions as well as lead counsel in numerous complex civil and civil rights matters.

Sidley is an international law firm with over 1,500 lawyers in 19 offices worldwide. The Dallas office has over 50 attorneys and specializes in complex litigation. Ms. Ostolaza is a partner in the firm and is formerly a co-head of the firm's nationwide complex commercial litigation practice. She concentrates in the trial and supervision of complex civil litigation. She has over 18 years of experience and has significant experience litigating class actions. She is supported in this case by several colleagues in the firm, each of whom also have experience with complex litigation

and class actions. Sidley adds expertise in the area of class actions, litigation and trial skills, and provides extensive litigation support capabilities.

There is no conflict among counsel. This is a Rule 23(b)(2) class action seeking only declaratory and injunctive relief. Any attorneys' fees for Plaintiffs' counsel will be awarded by the Court pursuant to federal fee-shifting statutes based upon the time reasonably expended by Plaintiffs' counsel. Pursuant to Rule 23(g), Plaintiffs request that this Court appoint Disability Rights Texas, Sidley, and the Center for Public Representation as co-class counsel in this case. *See Hamilton v. First Am. Title Ins. Co.*, 266 F.R.D. 153, 173 (N.D. Tex. 2010) , *vacated on other grounds*, 423 F. App'x 425 (5th Cir. 2011) (appointing co-class counsel); *Garcia v. Tyson Foods, Inc.*, 255 F.R.D. 678, 692 (D. Kan. 2009) (same).

V. CONCLUSION AND REQUESTED RELIEF

For the reasons set forth above, the Named Plaintiffs, the Coalition of Texans With Disabilities, Inc. and the Arc of Texas, Inc. respectfully request that the Court certify a plaintiff class consisting of all Medicaid-eligible persons over twenty-one years of age with I/DD in Texas who currently or will in the future reside in nursing facilities, or who are being, will be, or should be screened for admission to nursing facilities pursuant to 42 U.S.C. § 1396r(e)(7) and 42 C.F.R. § 483.112, *et seq*. In addition, the Named Plaintiffs respectfully request that this Court appoint Disability Rights Texas, the Center for Public Representation and Sidley, LLP, as co-class counsel in this action pursuant to Rule 23(g).

DATED: November 19, 2015.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I, Garth Corbett, hereby certify that all parties have been served through the Court's ECF system, or if such party does not accept service through the Court's ECF system, then by first class mail.

/s/ Garth A. Corbett
Garth A. Corbett

Exhibit 1
ADA Class Certification Cases

ADA Class Certification Cases

Case Name (Cite)	Certified Class	Defendants	Relief Sought
Alexander A. ex rel. Barr v. Novello, No. 99-CV-8418, 210 F.R.D. 27 (E.D.N.Y. 2002)	All New York State children institutionalized with psychiatric disabilities who have been or will be found by defendants to be appropriate for placement in a Residential Treatment Facility and who have not been or will not be provided with such placement with reasonable promptness	Commissioner of the NY State Department of Health; Commissioner of the NY State Office of Mental Health	Expand assessment for and provision of community services
A.M. v. Mattingly, No. 10-cv-02181 (E.D.N.Y. Jun. 8, 2010)	Children under the age of 18 who are in the custody of New York City Administration for Children's Services ("ACS") and who are currently admitted or will be brought to and admitted to acute psychiatric hospitals and who, once admitted and deemed ready for discharge, are not moved by ACS and/or one of its contract agencies to the least restrictive setting appropriate to their needs.	Commissioner of the New York City Administration for Children's Services	Prompt discharge, when appropriate, of children who are in the custody of ACS and New York City's foster care system from psychiatric hospitals to least restrictive settings

Exhibit 1

ADA Class Certification Cases

Case Name (Cite)	Certified Class	Defendants	Relief Sought
Arc/Connecticut et al. v. O'Meara and Wilson-Coker, No. 01-cv-1871 (D. Conn. Jan. 31, 2003)	All institutionalized persons or persons at risk of being institutionalized who are eligible for DMR services who have applied for and are eligible for the waiver program or would be eligible if they had the opportunity to apply	Commissioner of the CT State Department of Mental Retardation; Commissioner of the CT State Department of Social Services	Expand community placements to meet class needs
Ball et al v. Biedess et al., No. 00-cv-67 (D. Ariz. Aug. 7, 2000)	Elderly or persons with physical disabilities or developmental disabilities eligible for Arizona Long-Term Care System	Director of the AZ Health Care Cost Containment System; AHCCCS; State of Arizona	Increase payment for direct service professionals in the community in order to provide sufficient community services to meet class needs
Barthelemy v. Louisiana Dept. of Health and Hospitals, No. Civ.A. 00-1083 (E.D. La. Oct. 19, 2000)	All persons with disabilities who are institutionalized or who are at imminent risk of being institutionalized and who have applied for home and community-based waivers and who have not received such Medicaid-funded community-based services	LA Department of Health and Hospitals; Secretary of LA Department of Health and Hospitals	Provide services in the most integrated setting to give persons a choice between institutional and community services

ADA Class Certification Cases

Case Name (Cite)	Certified Class	Defendants	Relief Sought
Benjamin v. Department of Public Welfare, No. 09-cv-01182 (M.D. Pa. Sept. 2, 2009)	All persons who: (1) currently or in the future will reside in one of Pennsylvania's state-operated intermediate care facilities for persons with mental retardations; (2) could reside in the community with appropriate services and supports; and (3) do not or would not oppose community placement.	Department of Public Welfare of the Commonwealth of Pennsylvania and the Secretary of Public Welfare of the Commonwealth of Pennsylvania	Institutional improvement, improved community based services, and alternative placement
Benjamin H. v. Ohl, No. 3:99-0338, 1999 U.S. Dist. LEXIS 22454 (S.D. W.Va. Oct. 8, 1999)	All current and future West Virginia residents with developmental disabilities or mental retardation who are Medicaid-eligible and eligible for Intermediate Care Facility services and/or home and community-based waiver services	Secretary of the Department of Health and Human Resources	Development of community placements and housing options in sufficient number to meet class needs
Boulet v. Cellucci et al., No. 99-10617 (D. Mass. Jan. 29, 2001)	All individuals wait listed as of July 2000, regardless of whether the person was receiving or would be eligible to receive HCB waiver services	Governor of Massachusetts; Secretary of the Executive Office of Administration and Finance; Secretary of the Executive Office of Health and Human Services; Commissioner of the Division of Medical Assistance; and Commissioner of the Department of Mental Retardation	Development of community placements in sufficient number to meet class needs

ADA Class Certification Cases

Case Name (Cite)	Certified Class	Defendants	Relief Sought
Brooklyn Center for Indep. of the Disabled v. Bloomberg, 290 F.R.D. 409 (S.D.N.Y. Nov. 16, 2012)	"All people with disabilities as defined by the Americans with Disabilities Act who are within the City of New York and the jurisdiction served by the City of New York's emergency preparedness programs and services."	City of New York and its agencies that handle emergency preparedness	Injunctive and declaratory relief requiring that the City of New York adopt and maintain emergency preparedness procedures and policies that are accessible to people with disabilities.
Bryson v. Stephen, No. 99-CV-558-SM (D.N.H. June 26, 2000)	Individuals with acquired brain disorders who are currently institutionalized who are able to be discharged into a less restrictive community setting, or they are individuals who are in the community but who, in the absence of home and community-based services, are likely to be placed in an institution	NH Department of Health and Human Services; NH Division of Developmental Services	Expansion of home and community based services to meet class needs
Buchanan v. Hamos, 11 C 07866, 2014 WL 562637 (N.D. Ill February 13, 2014)	Children under the age of 21 with mental health or behavioral disorders.	Director of the Illinois Department of Healthcare and Family Services	Injunctive relief for violations of Title II's integration mandate by state agency, based on the denial of community-based services as an alternative to institutional placement.
Bzdawka v. Milwaukee County, No. 04-C-193, 238 F.R.D. 469 (E.D. Wis. 2006)	Institutionalized and disabled Milwaukee County residents who are now or will in the future be eligible to reside in an adult family home or community based residential facility	Milwaukee County; WI Department of Health and Family Services; Secretary for Department of Health and Family Services	Increase compensation for Homes for Independent Living and other providers of services to Family Care enrollees

ADA Class Certification Cases

Case Name (Cite)	Certified Class	Defendants	Relief Sought
Chambers v. S.F., No. 06-cv-6346, slip. op. at 1-4 (N.D. Cal. July 12, 2007)	All adult Medi-Cal beneficiaries who are: (1) residents of Laguna Honda Hospital and Rehabilitation Center; or (2) on waiting lists for Laguna Honda Hospital and Rehabilitation Center; or (3) within two years post-discharge from Laguna Honda Hospital and Rehabilitation Center; or (4) patients at San Francisco General Hospital or other hospitals owned or controlled by the City and County of San Francisco, who are eligible for discharge to Laguna Honda Hospital and Rehabilitation Center	City and County of San Francisco	Community placements and appropriate community-based services
Colbert v. Blagojevich, No. 07 C 4737, 2008 WL 4442597 (N.D. Ill. Sept. 29, 2008)	All Medicaid-eligible adults with disabilities in Cook County, Illinois, who are being, or may in the future be, unnecessarily confined to nursing facilities and who, with appropriate supports and services, may be able to live in a community setting.	Governor of the State of Illinois; Secretary of the Illinois Department of Human Services; Director of the Illinois Department of Healthcare and Family Services; and Director of the Illinois Department of Public Health	Development of community-based services and supports to enable individuals in nursing facilities in Cook County to move to more appropriate and integrated settings.

Case Name (Cite)	Certified Class	Defendants	Relief Sought
Persons With Disabilities v. Connecticut, 706 F. Supp. 2d 266 (D. Conn. 2010)	Individuals consisting of those who: (1) have a mental illness or have a record of such an illness or have been regarded as having such an illness and therefore have a disability within the meaning of 42 U.S.C. § 12102(2); (2) with appropriate supports and service, could live in the community; and (3) are institutionalized in either Chelsea Place Care Center in Hartford, Bidwell Care Center in Manchester, or West Rock Health Care Center in New Haven, or are at risk of entry into these facilities.	State of Connecticut; Commissioner of the Connecticut Department of Social Services, Commissioner of the Connecticut Department of Mental Health and Addiction Services, and Commissioner of the Connecticut Department of Public Health	Provide community-based services and supports to class members to enable them to relocate from nursing facilities to more integrated community settings and inform class members of their options regarding community-based services.
Connecticut Traumatic Brain Injury Assoc. v. Hogan, No. 2:90CV97 (D. Conn. July 6, 1990)	All persons with traumatic brain injury and mental retardation who are institutionalized or may be institutionalized at Norwich, Fairfield Hills Hospital and Conn. Valley Hospital.	Commissioner of the CT State Department of Mental Health; Commissioner of the CT State Department of Mental Retardation; Fairfield Hills Hospital M.D. Superintendent; Fairfield Hills Hospital Superintendent; Norwich Hospital Superintendent; Norwich Probate Court Honorable Judge; Newtown Probate Court Honorable Judge; William W. Backus Hospital.	Development of community placements for persons with mental retardation or traumatic brain injuries institutionalized in state hospitals for the mentally ill.

Case Name (Cite)	Certified Class	Defendants	Relief Sought
Dominguez v. Schwarzenegger, No. 09-cv-2306, 270 F.R.D. 477 (N. D. Cal. Jun. 10, 2010)	All In-Home Supportive Services consumers residing in Alameda, Calaveras, Contra Costa, Fresno, Marin, Mendocino, Monterey, Napa, Placer, Riverside, Sacramento, San Benito, San Francisco, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma and Yolo counties *Sub-class*: All In-Home Supportive Services consumers residing in Fresno County	Governor of California, Director of the California Department of Social Services, Director of the California Department of Health Care Services, California State Controller, Defendants-Appellants, Fresno County, Fresno County In-Home Supportive Services Public Authority	To enjoin the state from reducing its contribution to wages counties paid to IHSS providers
Dubois *et al*. v. Rhonda Medows *et al*., No. 03-CV-107 (N.D. Fla. March 1, 2004)	All individuals with traumatic brain or spinal cord injuries who are unnecessarily institutionalized or at risk of institutionalization who the state has already determined or will determine to be eligible to receive BSCI Waiver Program Services and have not received such services	Secretary of FL Agency for Health Care Administration; Secretary of FL Department of Health; Secretary of FL Agency for Health Care Administration; Secretary of Department of Health	Expansion of home and community based services to meet class needs

ADA Class Certification Cases

Case Name (Cite)	Certified Class	Defendants	Relief Sought
Dunakin v. Quigley, -- F. Supp. 3d -- , No. C14-0567JLR, 2015 WL 1619065 (W.D. Wash. Apr. 10, 2015), Pet. for Appeal under Fed. R. Civ. P. 23(f) denied, Dunakin v. Quigley, No. 15-80076 (9th Cir. Aug. 10, 2015)	"all individuals who: (a) are or will be residents of Medicaid-certified, privately-operated nursing facilities in the State of Washington; and (b) who [sic] are Medicaid recipients with an intellectual disability or related condition(s) such that they are eligible to be screened and assessed pursuant to 42 U.S.C. § 1396r(e)(7) and 42 C.F.R. § 483.122 *et seq.*"	State of Washington Department of Social and Health Services and the State of Washington's Developmental Disabilities Administration and agency officials.	PASRR screening and evaluations and special services for individuals with intellectual disabilities and/or related conditions who are in nursing facilities as well as community placement for such individuals.
Frederick L., et al. v. Department of Public Welfare et al., No. 00-4510 (E.D. Pa. Nov. 21, 2001)	Persons institutionalized at Norristown State Hospital at any time after September 5, 2000	Department of Public Welfare of PA; Secretary of Public Welfare of PA	Development of community placements and housing options in sufficient number to meet class needs
Fields v. Maram, No. 04 C 0174, 2004 WL 1879997 (N.D. Ill. Aug. 17, 2004)	All persons with disabilities who are or will be recipients of Illinois' Medicaid program, who reside in Medicaid-funded nursing homes and for whom motorized wheelchairs are medically necessary, but who have not been provided with such equipment	Director of the IL Department of Public Aid	Provide motorized wheelchairs

Case Name (Cite)	Certified Class	Defendants	Relief Sought
Gray v. Golden Gate Nat'l Recreational Area, 279 F.R.D. 501 (N.D. Cal. 2011)	All persons with mobility and/or vision disabilities who are being denied programmatic access under the Rehabilitation Act of 1973 due to barriers at park sites owned and/or maintained by Golden Gate National Recreation Area. For the purpose of class certification, persons with mobility disabilities are those who use wheelchairs, scooters, crutches, walkers, canes, or similar devices to assist their navigation. For the purpose of class certification, persons with vision disabilities are those who due to a vision impairment use canes or service animals for navigation	Golden Gate, National Recreational Area	The removal of access barriers for people with mobility and vision disabilities that violate the ADA and Section 504 of the Rehabilitation Act.
Hampe v. Hamos, No. 10-c-3121 (N.D. Ill. Nov. 22, 2010)	All persons who are enrolled or will be enrolled or were enrolled in the State of Illinois' Medically Fragile, Technology Dependent Medicaid Waiver Program (MF/TD) and when they obtain the age of 21 years are subjected to reduced Medicaid funding which reduces the medical level of care which they had been receiving prior to obtaining 21 years.	Director of the Illinois Department of Healthcare and Family Services.	The continuation of the funding and level of services received under the MF/TD program to individuals over the age of 21.

Case Name (Cite)	Certified Class	Defendants	Relief Sought
Henderson v. Thomas, 289 F.R.D. 506 (M.D. Ala. 2012)	Class of prisoners with HIV challenging prison's policy of segregating prisoners from general prison population in violation of Title II.	Commissioner, Alabama Department of Corrections; Warden of Limestone Correctional Facility; Warden of Julia Tutwiler Prison for Women; Warden of Decatur Work Release/Community Work Center; and Warden of Montgomery Women's Facility	Declaratory and injunctive relief including integration of prisoners with HIV into the general population and other relevant changes to policies.
Hernandez v. County of Monterey, Case No.: 5-13-cv-2354; 305 F.R.D. 132 (N.D. Ca., Jan. 29, 2015)	Current and recently released inmates from county jail.	Monterey, CA Sheriff, Monterey County, and Private Healthcare Company contracted by the county to provide jail health services	Provide adequate medical and mental health care and reasonable accommodation for disabilities.
Holmes v. Godinez, No. 11 C 2961, 2015 WL 5920750 (N.D. Ill. Oct. 10, 2015).	Prisoners who have a documented association with deafness or hearing loss	Director of the Illinois Department of Corrections	Accommodations for deaf and hearing disabled offenders
Hutchinson v. Patrick, 683 F. Supp. 2d 121 (D. Mass. 2010)	All Massachusetts residents who now, or at any time during the litigation: (1) are Medicaid eligible; (2) have suffered a brain injury after the age of 22; and (3) reside in a nursing or rehabilitation facility or are eligible for admission to such a facility.	Governor of Massachusetts; Secretary of the Massachusetts Executive Office of Health and Human Services; Secretary of the Massachusetts Executive Office of Administration and Finance; Acting Director of MassHealth; and Commissioner of Massachusetts Rehabilitation Commission.	Provide individuals with acquired brain injuries with the option of being placed in community settings with appropriate services and support rather than in nursing or rehabilitation facilities.

ADA Class Certification Cases

Case Name (Cite)	Certified Class	Defendants	Relief Sought
Jimmie v. Dept of Public Welfare, No. 09-cv-1112 (M.D. Pa. Sept. 8, 2009)	All individuals with mental retardation who are institutionalized in state psychiatric facilities and who are not subject to the jurisdiction of the criminal courts.	Department of Public Welfare of the Commonwealth of Pennsylvania; Secretary of Public Welfare of the Commonwealth of Pennsylvania	Community support and services for residents who are appropriate for discharge

ADA Class Certification Cases

Case Name (Cite)	Certified Class	Defendants	Relief Sought
Katie A. v. Bonta, No. Cv02-5662-AHM (C.D. Cal. June 18, 2003)	Children in California who (a) are in foster care or are at imminent risk of foster care placement; and (b) have a mental illness or condition that has been documented or, had an assessment already been conducted, would have been documented; and (c) who need individual mental health services, including but not limited to professionally acceptable assessments, behavioral support and case management services, therapeutic foster care and other necessary services in the home, or in a home-like setting, to treat or ameliorate their illness or condition.	Director of California Department of Health Services; Director of California Department of Social Services; Los Angeles County; Los Angeles County Department of Children and Family Services and its Acting Director.	Provision of coordinated home- and community-based behavioral health services to children with mental or behavioral health conditions who are in foster care or at risk of foster care placement

ADA Class Certification Cases

Case Name (Cite)	Certified Class	Defendants	Relief Sought
Kenneth R., ex rel. Tri-Cnty CAP, Inc./GS v. Hassan, 293 F.R.D. 254 (D.N.H. 2013)	Individuals with serious mental illness who had been institutionalized in a state facility, or who were at serious risk of being institutionalized.	Governor of New Hampshire; Commissioner of the NH Department of Health and Human Services; Associate Commissioner of the NH Department of Health and Human Services, Community Based Care Services; Deputy Commissioner, NH Department of Health and Human Services, Direct Programs/Operations; Administrator, NH Bureau of Behavioral Health, State of New Hampshire.	Provision of an adequate array of community based treatments.
Lane v. Kitzhaber, 283 F.R.D. 587 (D. Or. 2012)	Certifying a class of persons with intellectual and developmental disabilities in segregated employment workshops	Governor of the State of Oregon; Director of the Oregon Department of Human Services; Administrator of the Office of Developmental Disability Services; Administrator of Vocational Rehabilitation Services	Integrated supported employment for persons with intellectual and developmental disabilities
Long v. Benson, No. 08-cv-26, 2008 WL 4571904 (N.D. Fla. Oct. 14, 2008)	Any Florida-Medicaid-eligible adult, who at any time while this litigation has been pending, has resided in a nursing home that receives Medicaid funding, and how could and would reside in the community with appropriate community based services.	Secretary of the Florida Agency for Health Care Administration and Secretary of the Florida Department of Elder Affairs	Community placement and appropriate community-based services

Case Name (Cite)	Certified Class	Defendants	Relief Sought
Lovely H. v. Eggleston, 235 F.R.D. 248 (S.D.N.Y., April 19, 2006)	Certification of a main class consisting of "recipients of public assistance, food stamps and/or Medicaid who have received or will receive a notice from the New York City Human Resources Administration involuntarily transferring their case to one of three 'hub' centers in Manhattan, the Bronx or Brooklyn in connection with the WeCARE program." And certification of a subclass of "main class members who (a) have a physical or mental impairment that substantially limits one or more major life activities within the meaning of the Americans with Disabilities Act of 1990, (b) have a record of such an impairment, or (c) are regarded as having such an impairment."	City of New York and City of New York Department of Human Resources	Integrated benefits offices and reasonable modifications to the City of New York's public assistance, food stamps and other public benefits policies.

ADA Class Certification Cases

Case Name (Cite)	**Certified Class**	**Defendants**	**Relief Sought**
M.A.C. v. Betit, 284 F. Supp. 2d 1298 (D. Utah 2003)	Current and future Medicaid-eligible individuals residing in Utah who are at risk of institutionalization and who, because of their developmental disabilities or mental retardation, have or will be determined to be eligible for, and are or will be on the waiting list to receive, services under the HCBS waiver	The UT Department of Health and its Executive Director; Division of Health Care Financing of UT Department of Health and its Director; Division of Services for People with Disabilities of UT Department of Human Services and its Director.	Expansion of home and community based services to meet class needs

ADA Class Certification Cases

Case Name (Cite)	Certified Class	Defendants	Relief Sought
Makin ex rel. Russell v. Hawaii, 114 F. Supp. 2d 1017 (D. Haw. 1999)	Mentally retarded people living at home who are on a wait list for services from Hawaii's HCBS-MR program and seek but cannot obtain the services because of a lack of state funding for the services	State of HI; HI State Governor; Director of HI State Department of Human Services; Director of HI State Department of Health; Chief of Developmental Disabilities Division of HI State Department of Health; Med-Quest Division Administrator of HI State Department of Human Services; Deputy Director of Health Resources Administration of HI State Department of Health; Administrator of the Social Service Division of the HI State Department of Human Services	Expansion of home and community based services to meet class needs
Martin v. Voinovich, 840 F. Supp. 1175 (S.D. Ohio 1993)	More than 9,000 persons in Ohio with mental retardation or developmental disabilities who are institutionalized and are or will be in need of community housing and services which are normalized, home-like and integrated	Governor of State of OH; OH Department of Mental Retardation and Developmental Disabilities; Director of OH Department of Job and Family Services; Champaign Residential Services, Inc.	Development of community placements and housing options in sufficient number to meet class needs

ADA Class Certification Cases

Case Name (Cite)	Certified Class	Defendants	Relief Sought
Michelle P et al. v. Holsinger et al., No. 02-CV-00023 (E.D. Ky. Mar. 7, 2002)	All present and future Kentuckians with mental retardation and/or related conditions who live with caretakers who are eligible for, and have requested, but are not receiving Medical Assistance community residential and/or support services	Secretary of KY Cabinet for Health Services; Commissioner of KY Department for Mental Health and Mental Retardation; Commissioner for KY Department of Medicaid Services	Development of community placements and housing options in sufficient number to meet class needs
Miranda B. v. Kulongoski, No. 00-cv-01753 (D. Or. Dec. 13, 2004)	All civilly committed adults in Oregon state hospitals, as of December 1, 2003, who have not been discharged within 90 days of the ready-to-place determination of their Treatment Team and who consent to placement in the community	Governor of the State of Oregon; Oregon Department of Human Services; Director of the Oregon Department of Human Services	Community placement and services

ADA Class Certification Cases

Case Name (Cite)	Certified Class	Defendants	Relief Sought
Murray v. Auslander, No. 98-01066-CV, (S.D. Fla. March 10, 1999); Appeal: No. 00-11955, 244 F.3d 807 (11th Cir. 2001)	Participants in the Waiver Program who are not receiving needed services under the Waiver for which the state already has determined or will determine to be eligible and qualified to receive a medically necessary HCBW service	District Administrator of Department of Children and Families District XI; Highest ranking official of State of FL Agency for Health Care Administration; Highest ranking official of FL Department of Children and Family Services; Secretary of the Department of Children and Families; Director for Agency for Health Administration; Assistant Secretary for Developmental Services of the Department of Children and Families; The State of FL; Governor of FL	Provide all necessary home and community-based waiver services for participants of the Waiver Program whom Defendants already have deemed eligible to receive such services
N.B. v. Hamos, 26 F.Supp. 3d 756 (N.D. Ill. 2014)	All Medicaid-eligible children under the age of 21 in the State of Illinois: (1) who have been diagnosed with a mental health or behavioral disorder; and (2) for whom a licensed practitioner of the healing arts has recommended intensive home- and community-based services to correct or ameliorate their disorders.	Director of the Illinois Department of Healthcare and Family Services	Home and community-based children’s mental health services in the most integrated setting.

ADA Class Certification Cases

Case Name (Cite)	Certified Class	Defendants	Relief Sought
Oster v. Lightbourne, No. C 09-4668 CW, 2012 WL 685808 (N.D. Cal. Mar. 2, 2012)	Certifying two subclasses of persons whose services will be "limited, cut or terminated" under California's home-care prgrm"	Director of the California Department of Social Services; Director of the California Department of Health Care Services; California Department of Health Care Services; and California Department of Social Services	Injunctive and declaratory relief under the due process clause, the Medicaid Act, the ADA and Section 504, including restoration of reduced services.
O'Toole v. Cuomo, Order 13-cv-04166-NGG-MDG, slip op. (E.D.N.Y. Nov. 20, 2013)	All individuals with serious mental illness who reside in affected adult homes in New York City with a certified capacity of 120 or more beds and a mental health census of 25 percent or more of the resident population or 25 persons, whichever is less.	Governor of the State of New York; Commissioner of the New York State Department of Health; Acting Commissioner of the New York State Office of Mental Health; The New York State Department of Health; The New York State Office of Mental Health.	Expansion of supported housing and community services to enable class members to live in the most integrated setting appropriate.
Pashby v. Cansler, 279 F.R.D. 347 (E.D.N.C. 2011)	All current or future North Carolina Medicaid recipients age 21 or older who have, or will have, coverage of PCS denied, delayed, interrupted, terminated, or reduced by Defendant directly or through his agents or assigns as a result of the new eligibility requirements for in-home PCS and unlawful policies contained in ICHA Policy 3E.	Secretary of the North Carolina Department of Health and Human Services	To determine that the newly implemented In Home Care for Adults Clinical Policy 3E, which terminates eligibility for in-home care for Medicaid recipients who were eligible for such care prior to the new policy, is unlawful

ADA Class Certification Cases

Case Name (Cite)	Certified Class	Defendants	Relief Sought
Pitts v. Greenstein, No. 10-cv-635 (M.D. La. 2010 June 6 2011)	*Court ordered definition:* Louisiana residents with disabilities who have been receiving Medicaid-funded services through the LT-PCS program; who desire to reside in the community instead of a nursing facility; who require more than 32 hours of Medicaid-funded personal care services per week in order to avoid entering a nursing facility, and who not have available (including through family supports, shared living arrangement, or enrollment in the ADHS waiver) other means of receiving personal care services. *Redefinition as provided in the settlement agreement:* All persons who were approved to receive more than 32 hours of services through Louisiana's Long-Term Personal Care Services (LT-PCS) program as of September 5, 2010, and who are still approved to receive LT-PCS or who have a request for prior authorization pending or in process.	Louisiana Department of Health and Hospitals and the Secretary of the Department of Health and Hospitals	To stop the reduction of the maximum number of Medicaid Personal Care Services (PCS) hours available each week or risk the institutionalization of individuals with disabilities.

Case Name (Cite)	Certified Class	Defendants	Relief Sought
Stevens v. Harper, No. CIV-S-01-0675, 213 F.R.D. 358 (E.D. Cal. 2002)	All youths under the jurisdiction of the California Youth Authority ("CYA") who are at the time of the filing of the action, or will be during the pendency of the suit, confined at one of the CYA's eleven institutions	Program Director at Preston Youth Correctional Facility; Superintendent; Assistant Superintendent; Y.C.C; Director of CA Youth Authority; CA Youth Authority	Reform CYA's policies, practice and procedures regarding among others: (1) the physical safety of wards, (2) the confinement of wards in lock-up units, (3) administrative lockdown procedures, (4) the upkeep of the physical facilities, (5) discipline and segregation procedures, (6) health care
Staley v. Kitzhaber, No. 00-cv-78 (D. Or. 2000)	People throughout the State of Oregon with developmental disabilities who re on the waiting list to receive Medicaid services	Governor of Oregon, Director of the Oregon Department of Human Services, and the Oregon Department of Human Services	Medicaid services in the most integrated setting appropriate to their needs
Rolland v. Cellucci, No. 98-30208-KPN, 1999 WL 34815562 (D. Mass. Feb. 2, 1999)	Adults with mental retardation and other developmental disabilities in Massachusetts who resided in nursing facilities on or after October 29, 1998, or who are or should be screened for admission to nursing facilities pursuant to 42 U.S.C. § 1396r(e)(7) and 42 C.F.R. § 483.112 et seq.	Governor of MA; Secretary of the Executive Office of Administration and Finance; Secretary of the Executive Office of Health and Human Services; Commissioner of the Division of Medical Assistance; Commissioner of the Department of Mental Retardation; Commissioner of the MA Rehabilitation Commission; Commissioner of the Department of Public Health; Director of Region 1 for the Department of Mental Retardation.	Provision of and placement in integrated community living arrangements, and, while in nursing facilities, the provision of specialized services sufficient to constitute active treatment.

ADA Class Certification Cases

Case Name (Cite)	Certified Class	Defendants	Relief Sought
T.R. v. Dreyfus, No. 09-cv-1677 (W.D. Wash. Jul. 23, 2010)	All persons under the age of 21 who now or in the future: (1) meet or would meet the State of Washington's Title XIX Medicaid financial eligibility criteria; (2) are determined and documented by a licensed practitioner of the healing arts operating within the scope of their practice as defined by Washington state law, to have a mental illness or condition, or had a screen or an assessment been conducted by such practitioner, would have been determined and documented to have a mental illness or condition; (3) have a functional impairment, which substantially interferes with or substantially limits the ability to function in the family, school or community setting; and (4) for whom intensive home and community based services coverable under Title XIX Medicaid and eligible for Federal Financial Participation, have been, or would have been recommended by a licensed practitioner in order to correct or ameliorate a mental illness or condition.	Secretary of the Washington State Department of Social and Health Services.	The provision of home and community-based mental health services for Medicaid eligible children under 21 years with mental health needs.

Case Name (Cite)	Certified Class	Defendants	Relief Sought
Thorpe v. District of Columbia, 303 F.R.D. 120 (D.D.C. 2014), leave to appeal den., In re District of Columbia, 792 F.3d 96 (D.C. Cir. June 26, 2015)	Certifying class of individuals with physical disabilities in, or at risk of institutionalization in, nursing facilities.	District of Columbia	Declaratory and injunctive relief including transition for individuals with disabilities living in nursing facilities to integrated community-based settings
Toney-Dick v. Doar, No. 12 Civ.9162 (KBF); 2013 WL 5295221, *1 (S.D.N.Y. Sept. 16, 2013), slip op.	Certifying two subclasses: one subclass consisting of "disabled individuals who were eligible to apply for benefits from the Sandy D–SNAP Program" and the other subclass consisting of "individuals who may be eligible to apply for benefits from a future D–SNAP program and who will need reasonable accommodations because of a disability (or disabilities)."	Commissioner of the City of New Human Resources Administration; Acting Commissioner of the New York State Office of Temporary and Disability Assistance ("OTDA"); and OTDA , and Secretary of the United States Department of Agriculture ("USDA") and USDA.	Declaratory and injunctive relief to stop defendants from continuing to implement their emergency S-NAP benefits in a manner that discriminates against people with disabilities.

Case Name (Cite)	Certified Class	Defendants	Relief Sought
Van Meter v. Harvey, 272 F.R.D. 274 (D. Me. 2011)	The Named Plaintiffs . . . and all other Maine residents who currently are or in the future will be: (1) eligible for an enrolled in MaineCare, (2) age 21 or older, (3) have a related condition as defined at 42 C.F.R. § 435.1010, other than autism, and who do not have a diagnosis of Alzheimer's or dementia, and (4) who are or should be screened for admission to nursing facilities pursuant to 42 U.S.C. § 1396r(e)(7) and 42 C.F.R. § 483.112 et seq.	Commissioner of the Maine Department of Health and Human Services	Provision of and placement in integrated community living arrangements, and, while in nursing facilities, the provision of specialized services sufficient to constitute active treatment.
Williams v. Blagojevich, No. 05-C-4673, 2006 WL 3332844 (N.D. Ill. Nov. 13, 2006)	Illinois residents who: (a) have a mental illness; (b) are institutionalized in a privately-owned IMD ("Institutions for Mental Disease"); and, (c) with appropriate supports and services may be able to live in an integrated community setting	Governor of IL; Secretary of IL Department of Human Services; Director of the Division of Mental Health of IL Department of Human Services; Director of the IL Department of Public Health; Director of the IL Department of Healthcare and Family Services	An order that would require Illinois to offer and provide community services sufficient to permit IMD residents to reside in the most integrated community setting

Exhibit 2
Institutional Placement Class Actions

INSTITUTIONAL PLACEMENT CLASS ACTIONS

Case Name (Cite)	Plaintiff	Institution	Relief Sought
ABC of ND v Olson No. A1-80-141 561 F. Supp. 473 (D.N.D. 1982), *aff'd* 713 F.2d 1384 (8th Cir. 1983); 942 F.2d 1235 (8th Cir. 1991); 872 F. Supp. 689 (D.N.D. 1995)	Certified class of all persons who are or may become residents of Grafton or San Haven; ARC of ND	Grafton; San Haven	Community placement and institutional improvement.
A.M. v. Mattingly, No. 10-cv-02181 (E.D.N.Y.)	Certified class of children in the custody of New York City Administration for Children's Services who are currently in or will be admitted to acute psychiatric hospitals, deemed ready for discharge, and not moved to the least restrictive setting appropriate to their needs	Various psychiatric hospitals in New York	Prompt discharge, when appropriate, of children who are in the custody of ACS and New York City's foster care system from psychiatric hospitals to least restrictive settings
Baldridge v. Clinton No. LR C-83-1004 674 F. Supp. 665 (E.D. Ark. 1987); 139 F.R.D. 119 (E.D. Ark. 1991)	Certified class of institutionalized persons in the custody of DHS who are receiving inadequate treatment or inappropriate placement	Various institutions in Arkansas	Alternative placement and institutional improvement
Benjamin B. v. Cuomo No. 86-4248 (E.D.N.Y.)	Certified class of 70 persons with retardation institutionalized in psychiatric institution	Creedmoor Psychiatric Center	Provision of services required by professional judgment; additional staffing at institution pending placement in appropriate community facilities

INSTITUTIONAL PLACEMENT CLASS ACTIONS

Case Name (Cite)	Plaintiff	Institution	Relief Sought
Benjamin v. Dept. of Public Welfare, No. 09-cv-1182 (M.D. Pa.) Benjamin v. Dept. of Public Welfare, No. 11-3684, 11-3685, 701 F.3d 938 (3rd Cir. Dec. 12, 2012)	Certified class of individuals of developmental disabilities in state-run intermediate care facilities.	Five state-run intermediate care facilities	Institutional improvement, improved community based services, and alternative placement
Bogard v. Duffy No. 88-C-2414 (N.D. Ill.)	Certified class of persons with developmental disabilities who, on or before march 1986, resided in an Intermediate Care or Skilled Nursing Facility in Illinois For more than 120 days; The ARC, Illinois	Nursing facilities in Illinois	Appropriate developmental services in the least restrictive community setting appropriate to each class member's needs; development of community services
Bonnie S. v. Drew Altman No. 87-3709 1989 WL 71795 (D.N.J.)	N.J. developmental centers on behalf of class of approximately 1,500 persons	NJ mental retardation institutions	Community placement
Brewster v. Dukakis No. 76-4423 F 544 F. Supp. 1069 (D. Mass.1982)	Class of persons with mental illness hospitalized at Northampton	Northampton State Hospital	Creation and maintenance of appropriate community programs
CARC v. Thorne C.A. H-78-653 (D. Conn.)	Certified class of residents (now former residents) of Mansfield Training School and Connecticut Assoc. For Retarded Citizens	Mansfield Training School	Community placement and institutional improvement
Chambers v. S.F., No. 06-cv-06346, slip. op. at 1-4 (N.D. Cal. July 12, 2007)	Certified class of residents at the Laguna Honda Hospital and Rehabilitation Center	Laguna Honda Hospital and Rehabilitation Center	Community placements and appropriate community-based services

INSTITUTIONAL PLACEMENT CLASS ACTIONS

Case Name (Cite)	Plaintiff	Institution	Relief Sought
Chester Upland School District v. Pennsylvania, No. 12-132, 2012 WL 1473969 (E.D. Penn. Apr. 25, 2012)	Certified class of parents of students attending Chester Upland School District	Chester Upland School District	Adequate public funding for students with disabilities
Coffelt v. DDS No. 916401 (Ca. Super. San Francisco)	Californians with developmental disabilities who are or will be clients of four regional centers and are inappropriately placed in institutions or in need of appropriate community services; Assoc. For Retarded Citizens -- California; The Assoc. For Persons with Severe Handicaps, Calif. Chpt.;United Cerebral Palsy Assoc. Of Calif.,Inc.; Capitol People First; the Oaks Group	State Developmental Centers where class members were placed including Porterville, Stockton, Laterman, Agnew, Fairview, Sonoma and Camarillo	Development of an array of individualized quality community living arrangements to meet the needs of each class member
Consumer Advisory Board v. Glover No. 91-321-P-C 151 F.R.D. 490 (D. Ma. 1993)	Residents, outpatients, and advocates of Pineland Center	Pineland Center	Placement in least restrictive setting; physical safety of residents

INSTITUTIONAL PLACEMENT CLASS ACTIONS

Case Name (Cite)	Plaintiff	Institution	Relief Sought
Dunakin v. Quigley, -F. Supp. 3d-, No. C14-0567JLR, 2015 WL 1619065 (W.D. Wash. Apr. 10, 2015), Pet. for Appeal under Fed. R. Civ. P. 23(f) denied, Dunakin v. Quigley, No. 15-80076 (9th Cir. Aug. 10, 2015)	"all individuals who: (a) are or will be residents of Medicaid-certified, privately-operated nursing facilities in the State of Washington; and (b) who [sic] are Medicaid recipients with an intellectual disability or related condition(s) such that they are eligible to be screened and assessed pursuant to 42 U.S.C. § 1396r(e)(7) and 42 C.F.R. § 483.122 *et seq.*"	State of Washington Department of Social and Health Services and the State of Washington's Developmental Disabilities Administration and agency officials.	PASRR screening and evaluations and special services for individuals with intellectual disabilities and/or related conditions who are in nursing facilities as well as community placement for such individuals
Gieseking v. Schaler No. 86-4636 672 F. Supp. 1249 (W.D. Mo. 1987)	Developmentally disabled persons in Missouri for whom DMH has failed to develop plan or secure treatment	Various DMH operated institutions	Development of habilitation plans and comprehensive services

INSTITUTIONAL PLACEMENT CLASS ACTIONS

Case Name (Cite)	Plaintiff	Institution	Relief Sought
Halderman v. Pennhurst State School and Hospital No. 74-1345 446 F. Supp. 1295 (E.D. Pa. 1978) *aff'd in part; modified on appeal,* 612 F.2d 84 (3d Cir. 1979) *rev'd and remanded*, 451 U.S. 1 (1981), *aff'd on remand*, (3d Cir. 1982), *rev'd and remanded*, 465 U.S. 89 (1984) *consent degree* 610 F. Supp 1221	All persons with mental retardation at Pennhurst and those at risk of placement	Pennhurst	Creation of community living arrangements; institutional improvement; damages
Homeward Bound v. Hissom Memorial Center No. 85-C 437-E 1987 WI. 27104 (N.D. Ok. 1987)	Certified Class of residents and former residents of The Hissom Memorial Center	The Hissom Memorial Center	Institutional improvement and placement in integrated community setting
Horacek v. Fxon No. CV72-L-299 357 F. Supp. 71 (D. Neb. 1973)	Class of persons institutionalized at Beatrice State Home	Beatrice State Home	Placement in less restrictive community alternatives
Jackson v. Fort Stanton Hospital and Training School No. 87-839 757 F. Supp. 1243 (D.N.M. 1990), *appeal dismissed in part, rev'd in part*	Certified class of all persons who are or will reside at Fort Stanton or Los Lunas and all persons who have been transferred to nursing facilities and similar facilities funded by defendants	Fort Stanton and Los Lunas State School	Institutional improvements and placement in integrated community settings

INSTITUTIONAL PLACEMENT CLASS ACTIONS

Case Name (Cite)	Plaintiff	Institution	Relief Sought
Jimmie v. Dept of Public Welfare, No. 09-cv-1112 (M.D. Pa. Sept. 8, 2009)	All individuals with mental retardation who are institutionalized in state psychiatric facilities and who are not subject to the jurisdiction of the criminal courts.	Department of Public Welfare of the Commonwealth of Pennsylvania; Secretary of Public Welfare of the Commonwealth of Pennsylvania	Community support and services for residents who are appropriate for discharge
Kenneth R. v. Hassan, 293 F.R.D. 254 (D.N.H. 2013)	Individuals with serious mental illness who had been institutionalized in a state facility, or who were at serious risk of being institutionalized.	Governor of New Hampshire; Commissioner of the NH Department of Health and Human Services; Associate Commissioner of the NH Department of Health and Human Services, Community Based Care Services; Deputy Commissioner, NH Department of Health and Human Services, Direct Programs/Operations; Administrator, NH Bureau of Behavioral Health, State of New Hampshire.	Provision of an adequate array of community based treatments.
Kentucky ARC v. Conn No. 78-0157(A) 510 F. Supp. 1233 (W.D. Ky. 1980) 674 F.2d 582 (6th Cir. 1982)	Certified class of all persons who reside or may reside at Outwood; KY ARC	Outwood	Prevent new construction or purchase of new institutional facilities
Kope v. Watkins No. 88-61424 CZ (3rd Judicial Cir., Wayne Cty., Mich.)	Class of developmentally disabled residents who are or may be residents of specialized nursing homes for developmentally disabled persons	Greenbrook Manor, Kalamazoo Total Living Center, Mt. Pleasant Total Living Center, Taylor Total Living Center, and Wayne Total Living Center	Provision of developmental services, placement in community residential settings

INSTITUTIONAL PLACEMENT CLASS ACTIONS

Case Name (Cite)	Plaintiff	Institution	Relief Sought
K.W. v. Armstrong, 298 F.R.D. 479 (D. Idaho 2014)	Certified class of developmentally disabled adults who qualify for benefits under Medicaid, who are participants in or applicants to the DDS Waiver program administered by the IDHW as part of the Idaho Medicaid program, and who undergo the annual eligibility determination or reevaluation process.	Idaho Department of Health & Welfare	Injunction seeking to restrain IDHW from reducing benefits below certain levels.
Lane v. Kitzhaber, 283 F.R.D. 587 (D. Or. 2012)	Certified class of persons with intellectual and developmental disabilities in segregated employment workshops	Governor of the State of Oregon; Director of the Oregon Department of Human Services; Administrator of the Office of Developmental Disability Services; Administrator of Vocational Rehabilitation Services	Integrated supported employment for persons with intellectual and developmental disabilities
Lelsz v. Kavanaugh No. 3--8502462 673 F. Supp. 828 (N.D. Tex 1987); 783 F. Supp. 286 (N.D. Tex. 1991)	Certified class of 2,400 residents at Fort Worth State School representing class of mentally retarded residents treated at Texas facilities; 5,683 members total	Fort Worth State School; 13 institutions today	Community placement and institutional improvement
Long v. Benson, No. 08-cv-26, 2008 WL 4571904, (N.D. Fla. Oct. 14, 2008)	Certified class of at least 8,500 Medicaid beneficiaries in nursing homes in Florida	Any nursing home in Florida that receives Medicaid funding	Community placement with appropriate community-based services

INSTITUTIONAL PLACEMENT CLASS ACTIONS

Case Name (Cite)	Plaintiff	Institution	Relief Sought
L.S. v. Delia, No. 5:11-CV-354-FL, 2012 U.S. Dist. LEXIS 43822, (E.D.N.C. Mar. 29, 2012)	Certified class of current or future participants in the N.C. Innovations Waiver and whose Medicaid services have been or will be denied, reduced, or terminated by the Department of Health and Human Services	Secretary of the Department of Health and Human Services	Community placement with appropriate community-based services, including restoration of reduced services
Martin v. Voinovich No. C-2-89-362, 840 F. Supp. 1175 (S.D. Ohio 1993)	Class of more than 9,000 persons in Ohio with mental retardation or developmental disabilities who are or will be in need of community housing and services which are normalized, home-like and integrated	Various institutions in Ohio	Development of community placements and housing options in sufficient number to meet class needs
M.D. v. Perry 294 F.R.D. 7 (S.D. 2013)	Certified class of all children who were and all those who would be in the custody of the Permanent Managing Conservatorship of the Texas Department of Family and Protective Services	Texas Department of Family and Protective Services	Declaratory and injunctive relief for systemic deficiencies in Texas's administration of Permanent Managing Conservatorship
Medley v. Ginsberg No. 78-2099 492 F. Supp. 1294 (S.D.W.V. 1980)	Certified class of all persons under 23 with retardation who are or will be institutionalized because of defendants' failure to provide community homes	Shawnee Hills Community Mental Health Center	Provision of appropriate education, treatment, care and services in foster homes and other community based facilities in their home communities
Michigan ARC v. Smith No. 78-70384, 475 F. Supp. 990 (B.D.Mich. 1979)	Certified class of all residents of Plymouth Center	Plymouth Center for Human Development	Habilitation in appropriate, less restrictive residential alternative

INSTITUTIONAL PLACEMENT CLASS ACTIONS

Case Name (Cite)	Plaintiff	Institution	Relief Sought
Mihalcik v. Lensik No. H-89-529 732 F. Supp. 299 (D. Conn. 1990)	Class action on behalf of persons with mental retardation who are or will be patients at Conn. Valley Hospital, a state mental institution	Connecticut Valley Hospital	Implementation of professional recommendations for services and placement
Miranda B. v. Kulongoski, No. 00-cv-01753 (D. Or. Dec. 13, 2004)	All civilly committed adults in Oregon state hospitals, as of December 1, 2003, who have not been discharged within 90 days of the ready-to-place determination of their Treatment Team and who consent to placement in the community	Governor of the State of Oregon; Oregon Department of Human Services; Director of the Oregon Department of Human Services.	Community placement and services
N.B. v. Hamos, 26 F.Supp. 3d 756, (N.D. Ill. 2014)	All Medicaid-eligible children under the age of 21 in the State of Illinois: (1) who have been diagnosed with a mental health or behavioral disorder; and (2) for whom a licensed practitioner of the healing arts has recommended intensive home- and community-based services to correct or ameliorate their disorders.	Director of the Illinois Department of Healthcare and Family Services Department	Implementation of appropriate screening and treatment alternatives to the acute care provided in general and psychiatric hospitals.
Nelson v. Snider 160 F.R.D. 46 (E.D.Pa. 1994); 1994 WL 502352 (E.D.Pa.)	Certified class of residents and former residents of Embreeville Center; The Arc, Penna., and Penna. Protection & Advocacy	Embreeville Center	Community placement institutional improvement
New Jersey ARC v. New Jersey Dept of Human Services (89 NJ 234, 445 A.2d 704) (NJ 1982)	Class of mentally retarded citizens in public institutions in New Jersey	Hunterdon	Education and training; habilitation for adult residents; provision of services in the least restrictive setting feasible

INSTITUTIONAL PLACEMENT CLASS ACTIONS

Case Name (Cite)	Plaintiff	Institution	Relief Sought
Nicoletti v. Brown No. C87 1456 740 F. Supp. 1268 (N.D. Ohio 1987)	Class of involuntarily committed mentally retarded persons residing at Cleveland Developmental Center	Cleveland Developmental Center	Institutional improvement and opportunity for residents to choose placement in another appropriate Medicaid-certified facility; cease relocation to non-Medicaid certified facilities
NY State ARC v. Carey Nos.72 CIV 356, 357 393 F. Supp. 715 (E.D.N.Y. 1975); 706 F.2d 956 (2nd Cir. 1983)	Certified class of residents of Willowbrook State Developmental Center; New York State ARC	Willowbrook State Developmental Center	Consent judgment approved; development of community services for residents of Willowbrook
Oster v. Lightbourne, No. C 09-4668 CW, 2012 WL 685808 (N.D. Cal. Mar. 2, 2012)	Certifying two subclasses of persons whose services will be "limited, cut or terminated" under California's home-care program"	Director of the California Department of Social Services; Director of the California Department of Health Care Services; California Department of Health Care Services; and California Department of Social Services	Injunctive and declaratory relief under the due process clause, the Medicaid Act, the ADA and Section 504, including restoration of reduced services.
Parrent v. Angus No. 890907653CV (3rd Jud. Dist. Court, Salt Lake Cty., Utah)	Certified class of all residents of the Utah State Training School, Assoc. For Retarded Citizens of Utah	Utah State Training School	Individualized community placement determinations, planned development of community residential services

INSTITUTIONAL PLACEMENT CLASS ACTIONS

Case Name (Cite)	Plaintiff	Institution	Relief Sought
Pashby v. Cansler, 279 F.R.D. 347 (E.D.N.C. 2011) Pashby v. Delia, 11-2363, 709 F.3d 307 (4th Cir. Sept. 18, 2012)	All current or future North Carolina Medicaid recipients age 21 or older who have, or will have, coverage of PCS denied, delayed, interrupted, terminated, or reduced by Defendant directly or through his agents or assigns as a result of the new eligibility requirements for in-home PCS and unlawful policies contained in ICHA Policy 3E.	Secretary of the North Carolina Department of Health and Human Services	To determine that the newly implemented In Home Care for Adults Clinical Policy 3E, which terminates eligibility for in-home care for Medicaid recipients who were eligible for such care prior to the new policy, is unlawful
Price v. Medicaid Dir., No. 1:13-cv-74, 2015 U.S. Dist. LEXIS 116384 (S.D. Ohio Sept. 1, 2015)	Certified class of all Ohio individuals who meet the eligibility standards for the assisted living Medicaid waiver, but who are denied coverage under the assisted living Medicaid waiver	State officials with jurisdiction over Ohio's Medicaid assisted living waiver program	Prohibition on future denials of Medicaid assisted living waiver coverage to otherwise eligible plaintiffs for up to three months prior to month of application
Ricci v. Okin Nos. 72-469, 75-5210, 74-2768, 75-3910, and 75-5023 537 F. Supp. 817 (D. Mass. 1982); 97 F.R.D. 737 (D. Mass. 1983); 576 F. Supp. 415 (D. Mass. 1983); 781 F. Supp. 826 (D. Mass. 1992)	Class of mental retarded residents in five institutions; Mass. ARC	Belchertown, Fernald, Monson Wrentham, and Dever State Schools	Improve institutional conditions

INSTITUTIONAL PLACEMENT CLASS ACTIONS

Case Name (Cite)	Plaintiff	Institution	Relief Sought
Richard C. v. Snider 1993 WL 757634 (W.D. Pa.)	Certified class residents of Western Center, The Arc, Pennsylvania, The Arc, Allegheny County, and the Pennsylvania Protection and Advocacy Assoc.	Western Center	Community placement and institutional improvement
Rights, Equality Always at Letchworth, Inc. v. Cuomo No. 84 Civ. 4163 (CES) (S.D.N.Y.); 1985 WL 129 (S.D.N.Y.)	Certified class of residents of Letchworth Village Development Center and Rights, Equality Always at Letchworth, Inc. (REAL), a parents/representative organization	Letchworth Village Developmental Center, an institution for 1,400 to 1,700 persons with retardation	Complaint alleged violations of residents constitutional rights to care, habilitation, training, education and treatment, and alleged that the defendants have maintained plaintiffs in a setting where those services cannot properly be provided
Ruth L. v. White No. 90-5562 (E.D. Pa.)	All persons institutionalized in state hospitals in Pennsylvania for persons with mental illness contrary to professional judgment	Pennsylvania State Hospitals	Placement in appropriate community-based mental retardation settings
S.H. v. Edwards No. 87-8635 860 F.2d 1045 (11th Cir. 1988), *vacated*, 880 F.2d 1203 (1989), *judgment aff'd on reh'g en banc*, 886 F.2d 292 (1989)	Certified class of persons with retardation in state institutions denied individualized review of continued institutionalization	Gracewood and five other state institutions in Georgia	Review or hearings on plaintiffs' continued need for placement; release and treatment in community settings; damages

INSTITUTIONAL PLACEMENT CLASS ACTIONS

Case Name (Cite)	Plaintiff	Institution	Relief Sought
Society for Good Will to Retarded Children v. Cuomo No. 78 CV1847 (JBW) (E.D.N.Y.) 572 F. Supp. 1298; 572 F. Supp. 1300 (E.D.N.Y.) 1983), *vacate and remanded,* 737 F.2d 1239 (2d Cir. 1984); 103 F.R.D. 169 (E.D.N.Y. 1984); 1986 WL 13931	Certified class of more than 1,500 members; parents organization of Suffolk Developmental Center residents	Suffolk Developmental Center on Long Island, NY; renamed Long Island Developmental Center	Institutional improvement; expansion of community resources and support services; transfer of most clients to small community residences
Strouchler v. Shah, 286 F.R.D. 344 (S.D.N.Y. 2012)	Certified class of all New York City elderly or disabled recipients of continuous personal care services who have been threatened with unlawful reduction of discontinuance of these services or whose care has been unlawfully reduced to discontinued because the City Defendant has determined that they do not meet the medical criteria for these services.	The Commissioner of the New York State Department of Health and the Administrator of the New York City Human Resources Administration	Injunctive relief which would ensure the continuity of community care services
Thomas S. v. Flaherty No. C-82-418-M 699 F. Supp. 1178 (W.D.N.C. 1988), *aff'd* 902 F.2d 250 (4th Cir. 1990)	Certified class of adults with retardation who are inappropriately placed in public psychiatric institutions in NC	Public psychiatric institutions	Community placement and services in accordance with professional judgment

INSTITUTIONAL PLACEMENT CLASS ACTIONS

Case Name (Cite)	Plaintiff	Institution	Relief Sought
Thorpe v. D.C., 303 F.R.D. 120 (D.D.C. 2014), leave to appeal den., In re District of Columbia, 792 F.3d 96 (D.C. Cir. 2015).	Certified D.C. class members who have a physical disability, have been in a nursing facility for over 90 days, and need transition assistance from the D.C. in order to leave the nursing facility and obtain community-based long-term care services.	The District of Columbia	Broad and far-ranging institutional reform of the care and treatment of several thousand D.C. Medicated recipients who have physical disabilities and currently reside in nursing homes.
Van Meter v. Harvey, 272 F.R.D. 274 (D. Me. 2011)	Certified class of Maine residents eligible for MaineCare who reside in nursing facilities	Nursing homes in Maine and Massachusetts where Maine residents reside	Provision of and placement in integrated community living arrangements, and, while in nursing facilities, the provision of specialized services sufficient to constitute active treatment
Welsch v. Likins No. 4-72-CIV-451 373 F. Supp. 487 (D. Minn. 1974), *Aff'd* 550 F.2d 1122 (8th Cir. 1977); Welsch v. Gardebring 667 F. Supp. 1284 (D. Minn. 1987)	Class of all persons with retardation committed to Minnesota State institutions	Brainerd, Cambridge, Faribault, Fergus Falls, Hastings and Moose Lake	Individualized treatment and development of less restrictive community alternatives
Wuori v. Concannon No.75-80 551 F. Supp. 185 (D. Me. 1982)	Class of mentally retarded Maine citizens	Pineland Center	Institutional improvement and community services
Wyatt v. Stickney, No. 319-N 344 F.Supp. 387, *aff'd* 503 F.2d 1305 (5th Cir. 1974)	Certified class of institutionalized persons in Alabama with mental illness or mental retardations	Partlow State School and Hospital expanded to other Alabama retardation facilities	Promulgation and implementation of minimum standards

Exhibit 3
Declaration of Garth Corbett

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

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

Plaintiffs,

v.

GREG ABBOTT, Governor of the State of Texas, *et al.*,

Defendants.

THE UNITED STATES OF AMERICA,

Plaintiff-Intervenor,

v.

THE STATE OF TEXAS,

Defendant.

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

DECLARATION OF GARTH CORBETT REGARDING SUPPLEMENTAL EXHIBITS IN SUPPORT OF PLAINTIFFS' SECOND AMENDED MOTION FOR CLASS CERTIFICATION

I, GARTH CORBETT, hereby declare:

1. I am an attorney with Disability Rights Texas, and one of the attorneys of record for Plaintiffs in this case. I make this declaration in support of Plaintiffs' Second Amended Motion for Class Certification, Docket No.174. I am competent to testify to the matters stated herein and either have personal knowledge of the facts set forth below or they are from sources deemed reliable.

2. This declaration has been prepared to authenticate the attached exhibits pertinent to Plaintiffs' Second Amended Motion for Class Certification.

3. Attached hereto as Exhibit A is a true and correct copy of "REVIEW of INDIVIDUALS with POSITIVE PL1 and NEGATIVE PE" prepared by the Expert Reviewer, Kathryn du Pree (hereafter "ER"), pursuant to the terms of the Interim Settlement Agreement ("IA"), Docket No. 180, and provided by the ER to all counsel, including Disability Rights Texas, on or about September 25, 2015.

4. Attached hereto as Exhibit B is a true and correct copy of the May 29, 2015 "STATUS REPORT on IMPLEMENTATION of the QSR PASRR REVIEW PROCESS" prepared by the ER pursuant to the terms of the IA, and provided by the ER to all counsel, including Disability Rights Texas, on or about May 29, 2015.

5. Attached hereto as Exhibit C is a true and correct copy of the "STATUS REPORT on IMPLEMENTATION of the QSR PASRR REVIEW PROCESS – September 25, 2015" ("September 25, 2015 report") prepared by the ER, pursuant to the terms of the IA, and provided by the ER to all counsel, including Disability Rights Texas, on or about September 25, 2015.

6. According to the September 25, 2015 report at 1, the ER took a sample of 146 individuals from the total number of individuals with intellectual or developmental disabilities reviewed under the PASRR process during the first six months of 2015, including nursing facility residents and community members who were either being transitioned or diverted from nursing facilities. Based on the size of the sample, I have concluded that there are hundreds of individuals with intellectual or developmental disabilities reviewed under the PASRR process annually.

7. Attached hereto as Exhibit D is a true and correct copy of "Texas PASRR overview for Nursing Facilities" that is available at http://resources.simpleltc.com/slides/texas-pasrr.pdf (last visited on November 12, 2015).

8. Attached hereto as Exhibit E is a true and correct copy of the 2014 Promoting Independence Advisory Committee Stakeholder Report (2014 PI Stakeholder report) that is available at http://www.dads.state.tx.us/providers/pi/piac_reports/piac-2014-stakeholder.pdf (last visited November 12, 2015).

9. Attached hereto as Exhibit F is a true and correct copy of the December 1, 2014 Texas Biennial Disability Report, prepared by the Texas Council for Developmental Disabilities ("TCDD") that is available at:http://tcdd.texas.gov/wp-content/uploads/2014/12/2014_Tx_BDR.pdf (last visited November 12, 2015). This report discusses the state of services to individuals with disabilities in Texas. The report is mandated by legislation passed by the 76th Legislature (1999) and requires that the TCDD and the Texas Office for Prevention of Developmental Disabilities ("TOPDD") prepare such reports to the Legislature biennially.

10. Attached hereto as Exhibit G is a true and correct copy of "Administrator's Statement" from DADS' Legislative Appropriations Request (LAR) to the 84th Legislature in 2015 that is available at http://www.dads.state.tx.us/news_info/budget/docs/2016-17lar/AdministratorsStatement.pdf (last visited November 12, 2015).

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on this18th day of November, 2015 at Austin, Texas.

Garth Corbett

Declaration of Garth Corbett Exhibit A

REVIEW OF INDIVIDUALS WITH POSITIVE PL1 AND NEGATIVE PE

I. Introduction

As the Expert Reviewer I conducted a review and analysis of a number of PASRR Level II Evaluations (PE) completed by LIDDAs during the first five months of 2015 that resulted in a determination that the individual had no presence of an intellectual disability or a related condition. The purpose of this review was to determine the timeliness, the adequacy of these evaluations and to review the information the evaluators used to make the determinations. DADS submitted the names of the individuals that had a Positive PL1 and negative PE between January 1, 2015 and May 31, 2015. One hundred ninety eight (198) individuals were reviewed for this analysis.

II. Findings

- Number of Positive PL1 correlated with a Negative PE= 193
- Number of Positive PL1 correlated with Positive PE = 5
- Number of PE completed within 7 days of the PL1 screen = 85
- Number of 8578 forms completed which include a diagnosis of intellectual disability = 3
- ***Negative PE evaluations***: 67 of the 193 completed had sufficient information to verify the negative finding
- ***8578 Summaries of Disability***: 3 positive 8578's were completed and associated with individuals who had Positive PL 1's and Negative PE's
- ***Primary Diagnosis***: One hundred sixty-four (164) individuals had no primary diagnosis checked but the primary diagnosis could be determined with thorough review of the PE. Thirty (30) individuals had the primary diagnosis appropriately entered on the PE. For the

remaining individuals (4) a primary diagnosis could not be determined from the information available in the PE.

- ***Qualified Evaluators***: A Qualified Evaluator completed 85% of the evaluations. Of particular note however is that Harris County completed fifteen (15) PEs. All of these evaluations were performed by non-qualified personnel.

- ***Potential for a Co-Occurring Condition***: The number of individuals that may have been ignored for potentially having co-occurring conditions is sixty-eight (68). The methodology used for this conclusion is that the individuals had a positive PL1 for IDD and MI. Evidence of MI was checked in the PE and there was no finding of the presence of ID or DD but there was no supporting evidence for the determination.

III. SUMMARY OF PL1 and PE Completion by LIDDA

Below is a table that provides information by LIDDA. Only 6 LIDDAs had supporting evidence for all of the negative PEs the staff completed: Access, Andrews, Camino Real, Coastal, Helen Farabee, and Tropical. Most of the LIDDAs had all qualified evaluators. The following did not: Andrews, Burke, Harris, Metrocare, Tarrant and Tropical. Lifepath, Brazos and Tri-County did not have any individuals in the sample.

The LIDDAs that completed the 8578 forms and found the presence of a disability but submitted a negative PE for the individual were Border, and Texoma. Texoma did two of these evaluations.

Table Summarizing PE Completion by LIDDA

LIDDA	PE'S	QUALIFIED EVALUATORS	8578 ID YES	NEGATIVE PE W/SUPPORTING DOCUMENTATION	COC** POSSIBLE
Access	6	4 of 4	0	6	3
Alamo	12	4 of 4	0	5	6
Andre	1	0 of 1	0	1	0
Austin	3	2 of 2	0	1	0
Nueces	4	2 of 2	0	0	3
B. Hardwick	3	1 of 1	0	0	0
Blue-Bonnet	2	1 of 2	0	1	1
Border	2	1 of 1	0	1	1
Burke	2	0 of 2	0	1	1
Camino	1	1 of 1	0	1	0
Center for Life	6	1of 1	0	2	2
Cent Counties	7	4 of 4	0	3	3
Cent Plains	4	2 of 2	0	1	2
Coastal	1	1 of 1	0	1	1
Comm Health	10	5 of 5	0	0	3
Denton	6	2 of 2	0	4	4
Emergen	1	1 of 1	0	0	1
Gulf Bend	3	1 of 1	0	1	1
Heart TX	27	7 of 7	0	7	8
H. Farabee	3	1 of 1	0	1	1
Hill	2	1 of 1	0	0	0
Lakes	6	4 of 4	0	2	4
LifePath*					
Metro	11	2 of 3	0	5	6
Brazos*					
Harris	15	0 of 1	0	1	3

LIDDA	PE #	QUALIFIED EVALUATOR	8578 ID YES	NEGATIVE W/ SUPPORTING DOCUMENTATION	COC POSSIBLE
Tarrant	11	3 of 4	0	3	5
Concho	7	4 of 4	0	2	2
Pecan Valley	8	5 of 5	0	3	7
Permian*					
Spindle	10	3 of 3	0	3	7
Starcare	2	1 of 1	0	0	0
Texana	2	2 of 2	0	0	1
TX Pan-Handle	6	2 of 3	0	4	2
Texoma	4	2 of 2	2	1	2
Gulf Coast	6	2 of 2	0	4	3
Tri-County*					
Tropical	1	0 of 1	0	1	1
West TX	3	2 of 2	0	0	2

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* These LIDDAs did not have any PL1 and PE submissions in the sample
* COC = co-occurring conditions

IV. Other States Requirements to Complete PASRR Evaluations

I was asked by CPI staff to research how other states conduct the PASRR process. It seems that many states are contracting with external providers that have expertise in conducting this type of evaluation. Below are summaries of information about New York, Illinois, and New Hampshire.

New York

NYS contracts with IPRO to complete the PASRR Level II evaluation. The instructions to the reviewers are that if all of the documentation is not available the review is terminated. The lack of documentation is reported to the regulatory agency and pursued as an issue of regulatory compliance.

NYS requires 8 primary sources of information that include:

- A comprehensive history and physical examination including the medical history, review of all body systems, specific evaluation of the individual's neurological system in the areas of motor functioning, gait, deep tendon reflexes, cranial nerves and abnormal reflexes.
- A functional assessment of the individual's ability to engage in ADL's and IADL's. The assessment must address self-monitoring of health status, self-administering of medical treatment, including medical compliance, self-monitoring of nutritional status, handling of money, dressing appropriately, and grooming.
- Psychosocial evaluation, including current living arrangements, medical and systems support.
- A comprehensive psychiatric evaluation, including a complete psychiatric history, evaluation of intellectual functioning, memory functioning and orientation, description of current attitudes and overt behaviors, affect, suicidal or homicidal ideation, paranoia, and degree of reality testing and hallucination.
- PRI or H/C PRI
- SCREEN
- Physical request for RHCF placement
- Social Service discharge Panning documentation relevant to the PASRR request. This is to include a description of the individual's past successes and failures with previous community placements and relevant discharge planning notes; a description of the individual's specific needs related to nursing home placement and their desire for a NF placement; and the ADL and IADL needs of the individual.
- RCHF progress notes and psychiatric/applicable consults related to significant changes

Illinois

Illinois uses a contractor to complete the PEs. IL requires the evaluators review the following:

- Psychiatric evaluation not more than 1 year old including complete history, comprehensive mental status including an evaluation of intellectual functioning, memory functioning, orientation, description of current attitudes and overt behaviors, affect, response to reality testing, suicidal or homicidal ideation, and behaviors that place the person at risk; diagnostic information using DSM-IV with recommendations for treatment; risk recommendations; current medications
- Physical examination and medical history including neurological systems evaluation
- PAS MH level II Assessment

The reviewers must do a document review, face-to-face interviews, determinations and complete a disposition/referral process. They need hard copies of the assessment materials they reviewed and need to maintain them for 6 years. If any evaluations are older than 1 year new evaluations need to be completed. This includes purchasing medical and psychiatric evaluations.

New Hampshire

New Hampshire recently contracted with the University of Massachusetts Disability Service Center in Worcester, MA. UMASS conducts both the PL1 and PE. NH requires extensive information for the PL1 screening level. This includes: psychometric testing; a detailed social history; the ISP; two weeks of progress notes; a medical history; the most recent MDS; current medications and medication history; neurological evaluation; and a discharge summary.

V. Summary

Other states are using contractors to perform the PE including Connecticut. Detailed training and training manuals are provided to reviewers in all of the states I have mentioned

DADS has issued PL 2015-16: PASRR Facility requirements and a PE training manual. The training manual primarily describes each section and questions on the PE form to complete. There is no specificity provided for the documents that should be reviewed, other than to reference the reviewer looking at medical records. The information contained in the completed PEs reviewed, as part of this analysis does not indicate what medical and social records were reviewed. There is no summary of the information gathered from interviews with the individual and/or guardian. Very few reviewers use any of the comment boxes on the PE to summarize what led them to their conclusion that the individual does not have an intellectual disability or a related condition.

I recommend that DADS consider hiring an outside contractor to perform PASRR reviews to insure that the reviews are comprehensive and consistent. If DADS continues to require the LIDDAs to complete these reviews additional instruction, process requirements and training is needed to assure the reviews are being completed correctly and making the correct determination of the individual's disability. DADS also needs to establish an effective quality monitoring process to insure that PEs are completed on time and that includes an audit of a random sample of PEs with negative determinations to verify that the evaluators are qualified, have reviewed all relevant documents, and substantiated their determination that the individual does not have an ID or a related condition.

Submitted by: Kathryn du Pree
Expert Reviewer

Declaration of Garth Corbett Exhibit B

STATUS REPORT on IMPLEMENTATION of the QSR PASRR REVIEW PROCESS

The purpose of this status report is to provide an update of the implementation of the Quality Service Review (QSR) PASRR review process for Nursing Facility and Community Members as agreed to by the Parties. The Independent Review team began PASRR reviews for Calendar Year 2015 in late January after all reviewers were trained in the QSR process and the use of the PASRR Independent Review Monitoring (PIRM) tool. The first quarter sample was randomly selected by DADS staff in December 2014. This included individuals from all three target populations: diversion, transition (community members) and nursing facility members. The Independent Reviewer assigned the individuals to the three Review Teams. Each team is comprised of two reviewers. One reviewer is a generalist with experience in community transition planning, service coordination and individual service planning and the other reviewer is a clinician. The three clinicians working on this project include one RN and two OTRs. All reviewers have experience with the ID/DD population and with either or both nursing homes or community programs. On site reviews for the first sample were completed by April 30, 2015.

Local Authorities, community providers and nursing facility staff were very accommodating of the review process. Local Authorities made various documents available to the reviewers including the PASRR screening (PL1), PASRR evaluation (PE), the Individual Service Plan (ISP), the Community Living Option (CLO) form, the transition plan and the Service Coordinator progress notes. These were reviewed by the reviewers prior to the onsite visit. The facility and provider staff shared relevant assessment, planning and progress note data with the reviewers during the onsite visits. Staff, Service Coordinators and LARs made themselves available for interviews either during the site visit or by phone.

The following information is based on reviews that have been closed by May 28, 2015. A review is designated as closed when the review team has completed its full record review, onsite review, and interviews, and has rated the indicators using the PIRM tool, and the Independent Reviewer has reviewed and validated the ratings based on the findings of the reviewers. This report includes data for seventy six individuals including:

- 24 individuals who were diverted
- 21 individuals who were transitioned
- 31 individuals residing in a nursing facility

Nine of the individuals who were diverted had not been admitted to a nursing home but were supported to remain in the community. Only two of the thirty-one individuals who are NF Members had refused to participate in transition planning.

Five individuals returned to a NF after their transition to the community. None of them returned during the first 90 days. Two returned for rehabilitation subsequent to a fall. In both cases the group home planned for them to return to the community. One is scheduled to do so. The other individual chose to stay in the NF where her mother resides after multiple attempts by the SC to convince her to return to her community residence. One individual returned because of the

provider's inability to support him to manage his cancer. Two other individuals returned because of the provider's inability to fully support them. Of these two individuals one was transitioned to an assisted living facility (ALF) without sufficient supports and the other transitioned to a six person ICF/IDD. In the latter case the ICF/IDD program was willing to continue to serve the individual but the LAR was dissatisfied with the quality of the services. The woman that returned from the ALF hopes to transition back to the community in the future.

Eighteen of the thirty-nine Local Authorities were reviewed during this review period. Most of the individuals in the review period in the HCS program transitioned to either a Group Home or a Host Home. Many individuals with medical and physical care needs live in host homes with a significant number of these individuals supported by family members who have become host home providers.

There have been seventeen individuals selected for a QSR PASSR review so far that have not selected the HCS waiver. Five individuals have transitioned to ICF/IDDs and twelve individuals have selected the STAR+PLUS program. Two of the individuals were transitioned to a 116 bed ICF/IDD. In one situation the transfer to the 116 bed facility was made because the HCS program enrollment could not occur in the timeframe originally projected and the individual's behaviors escalated at the NF so an emergency placement was necessary. DADS was willing to re-offer the HCS waiver but the individual decided to stay in the ICF/IDD when this offer was extended.

The following table, ***Outcome Overall Compliance*** summarizes the level of compliance for the overall population for each of the six Outcomes. Compliance ranges from 36% for Outcome 6 (the role and responsibilities of the Service Planning Team) to 70% for Outcome 1 (the efforts to successfully divert individuals from long term placement in nursing facilities).

PASRR Individual Review Monitoring (PIRM)

Outcome Overall Compliance

Report Date:5/28/2015

This report displays:

- The percentage of **Overall Compliance** for each **Outcome** based on the findings recorded in PIRM (indicators only) for all closed Individual Review (IR) records that fall within the review period.

Review Year	Outcome	Overall Compliance *(without report metrics)*
2015 (Open Period)	OUTCOME 1. Individuals in the target population will be appropriately identified, evaluated and diverted from admission to nursing facilities.	70%
	OUTCOME 2. 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 their informed choice.	29%
	OUTCOME 3. Individuals in the Target Population in nursing facilities who are appropriate for and do not oppose transition to the community will receive transition planning, transition services, and placements in the most integrated setting necessary to meet their appropriately- identified needs, consistent with their informed choice.	47%
	OUTCOME 4. Community Members will receive services in the most integrated setting, with the frequency, intensity and duration necessary to meet their appropriately-identified needs, consistent with their informed choice.	53%
	OUTCOME 5. Individuals in the Target Population who do not refuse service coordination will receive coordination from trained service coordinators with the frequency necessary to meet the individual's appropriately-identified needs, consistent with their informed choice.	52%

Review Year	Outcome	Overall Compliance *(without report metrics)*
	OUTCOME 6. Individuals in the Target Population will have a service plan, developed by an interdisciplinary service planning team through a person-centered process that identifies the services and supports necessary to meet the individual's appropriately-identified needs, achieve the desired outcomes, and maximize the person's ability to live successfully in the most integrated setting consistent with their informed choice.	36%

The following table, ***PIRM Measure Overall Compliance*** provides information about the level of compliance that has been reached for each measure within each of the six outcomes. Many of the measures relate to more than one outcome and are captured under each outcome for which they are relevant. Some positive themes emerge as well as an indication of the many areas that need improvement.

The State is achieving a higher level of compliance for Outcome 1 than any other outcome. The Diversion target group is generally having the PL1 and PE completed, the Local Authorities and NFs are committing to the specialized services the PE recommends, diverting within 90 days of placement in a NF or without being admitted to a NF, and involving the Diversion Coordinator as appropriate. These individuals live in settings serving no more than four individuals. In all of these areas the compliance score is 85% or above. The Diversion target group is also generally receiving information about community services to assist them to select the providers and services they need.

Areas that are less than 70% compliant under Outcome 1 include: the PE appropriately assessing needs and recommending community supports; SPT involvement and planning; arranging for all services the individual needs while in the NF; and receiving specialized services while in the NF. Measure 1-14 measures the Local Authorities effort to inform the individual of rental and housing assistance. This is rated at 0% for both the Diversion and Transition target groups. Please be aware that this was only relevant to a few individuals because the vast majority of individuals entered the HCS waiver.

Outcome 2 does not include any Measures that are rated at a compliance level of 70% or greater. There is a significant lack of specialized services being provided to individuals while in the NFs and little discussion of opportunities for integrated day activities or community engagement of any kind.

There are four Measures that achieve a level of 85% or greater under Outcome 3. These are the measures that address the support the individual needs to transition; having the PE completed;

follow up on the MDS for individuals interested in community placement; and support to transition the individual within 180 days of confirming his/her interest in enrolling in a waiver.

The findings for both Outcomes 2 and 3 evidence that there are challenges convening the SPT and conducting quarterly meetings; having the required membership for SPTs; engaging individuals and LARs in a meaningful person-centered planning process; developing the ISP based on assessments of the full range of the individuals need areas; developing an ISP with all the supports and services the individual requires. There is also little evidence within this first sample of the coordination of the ISP and the nursing facility comprehensive plan of care (NFCPC). During this time period the vast majority of Local Authorities were not providing the quarterly educational opportunities to individuals and LARs. The development of transition plans needs to improve as well. There were very few cases in which a team was recommending an individual remain in a NF but in those situations there was not a comprehensive review of the reasons and barriers nor were the individual's needs assessed by professionals with community service experience.

The following Measures under Outcome 4 are rated above 70%: individuals having the opportunity to live with no more than three other individuals with a disability; the individuals having a choice of provider; service coordination continues after 180 days; and a review of critical incidents.

The following issues are related to Measures under Outcome 4 and are rated lower than 70%. The SPT role and the ISP planning process are not in place for most individuals. ISPs are not designed based on assessments of all need areas and do not include all services the individual needs. Goals and objectives are not fully developed to address the individual's needs or maximize his or her potential. Not everyone who needs a crisis plan has one. Very few individuals participate in integrated day activities although we were encouraged to find a few individuals referred to DARS the vocational support agency.

Measures that are related to Outcomes 5 and 6 are included under one of the first four Outcomes with rare exception so the themes have already been addressed. In general the Service Coordinators understand their responsibility to meet with the individual on a monthly basis and do well continuing this responsibility after 180 days. The rating for the monthly review is only 69% because many SCs fail to use this monthly meeting to actually review progress toward implementing the ISP or there are not goals and objectives in the ISP to monitor. Local Authorities are starting to implement the quarterly review process involving the SPTs but there was little evidence of this occurring during the first review period.

PASRR Individual Review Monitoring (PIRM)

Measure Overall Compliance

Report Date:5/29/2015

This report displays:

- The percentage of **Overall Compliance** (without report metrics) for each **Measure** based on *just* the findings recorded in PIRM (indicators only) for all closed Individual Review (IR) records that fall within the review period.
- The Measures that are not scored below are either rated solely by a report or were rated Not Applicable for the individuals in this sample. As an example 1-5 is blank because it will be rated based on an annual report. Measure 1-17 is blank because it was Not Applicable for anyone in this sample.

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
2015 (Open Period)	Outcome Measure 1-1. A PASRR Level I screening is completed for individuals seeking admission to nursing facilities. DADS tracks and shares the results with the Local Authority (LA) and the Diversion Coordinator if the individual needs a PASRR Level II evaluation.	95%
	Outcome Measure 1-2. An individual in the TP seeking admission to a NF who is determined by a PASRR Level I to be in need of a PASRR Level II will receive a PASRR Level II evaluation completed by the LA or other qualified entity with experience working with community based services for individuals with ID/DD, within the timeframes set out in V.B.	90%
	Outcome Measure 1-3. The PASRR Level II evaluation confirms whether the individual has ID or DD and if so, appropriately assesses whether the needs of the individual can be met in the community and accurately identifies, based on the information available, the specialized services the person needs if s/he is admitted to a NF. A report of the reviewer's decision is shared with the individual and his/her LAR.	56%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 1-4. Individuals in the TP who need specialized services will only be admitted to a NF if the individual's needs for specialized services can be met by the NF, the LA, or both.	92%
	Outcome Measure 1-5. Each LA has a Diversion Coordinator who is responsible for identifying community services. The Diversion Coordinator is a professional who is experienced in coordinating and/or providing community services to people with I/DD, including people with complex medical needs.	
	Outcome Measure 1-6. The Diversion Coordinator identifies available community living options, supports, and services to assist individuals in the TP to successfully live in the community, and provides information and assistance to SCs and other LA staff who facilitate diversion for these individuals.	
	Outcome Measure 1-7. The Diversion Coordinator coordinates education for SCs and other LA staff to learn about available community services and strategies to avoid NF placement for the TP.	
	Outcome Measure 1-8. Nursing Facility Members have access to information from DADS that describes the community services available to support them to live in the community.	82%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 1-9. For members of the Target Population living in the community or in a NF for 90 days or less who can be diverted from NF admission, the SC or other LA staff identify, arrange and coordinate all community options, services, and supports, for which the individual may be eligible and that are necessary to enable the individual to remain in the community and avoid admission to a NF or return to the community within 90 days of admission to a NF. Services and supports will be consistent with an individual's or LAR's informed choice.	61%
	Outcome Measure 1-10. All individuals seeking admission to a NF or who have lived in a NF for fewer than 90 days, who were identified through a PASRR Level II evaluation as having ID/DD and who do not oppose living in the community, will receive support, consistent with their individual choice, to participate with their Service Planning Team (SPT) in a planning process that identifies the community supports they need to remain in or move to the community. The planning process includes assessments of medical, nursing, nutritional management, psychiatric, behavioral, therapy, independent living, community participation and integrated day activity needs, and a review of health related incidents. The individual and the LAR are informed of community options that will meet the individual's needs.	60%
	Outcome Measure 1-11. For individuals who are diverted from a NF placement, supports and services are made available to remain in the community, or to move to the community after a stay in a NF of fewer than 90 days. These supports and services recognize the needs and choices of the individual.	96%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 1-12. Individuals who are in the NF for up to 90 days prior to diversion will have an ISP, including a discharge plan that describes the necessary supports for the individual to move to the community, which is coordinated with the NFCPC by the SC. The ISP includes all specialized services the individual needs, including strategies for the individual to learn about community options, such as opportunities to visit community programs, and transition activities.	43%
	Outcome Measure 1-13. Individuals who are placed in a NF for fewer than 90 days receive all specialized services that are needed, as specified in the ISP and the NFCPC. These services are based upon the PASRR Level II and the SPT assessments and reflect the individual's choices and preferences.	51%
	Outcome Measure 1-14. In order to provide opportunities for individuals to live in the most integrated setting that meets their needs and that is reflective of their choices, the State provides information about all existing sources of housing options and rental assistance programs to individuals who are being diverted from NF placement or who are in a NF for fewer than 90 days, and makes appropriate referrals to these sources for these individuals.	0%
	Outcome Measure 1-15. Within 45-75 days after an individual is admitted to a NF, the DC reviews whether community living options, services, and supports that provide an alternative to the NF placement have been explored. If alternatives have not been explored, the Diversion Coordinator ensures that the individual's SC coordinates this exploration.	88%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 1-16. No Community Member is served in a residential setting that serves more than 4 individuals with I/DD unless the SPT and Diversion Coordinator tried but could not address the barriers to such a placement and the individual or LAR made an informed decision to accept the placement.	100%
	Outcome Measure 1-17. Any NF Member expressing an interest through the MDS Section Q process in speaking to someone about moving to the community is reported to the LA, which contacts the individual within 30 days of this notification to discuss community options.	
	Outcome Measure 1-18. Using data, including the information reported in V.F.5 and V.F.6, DADS identifies frequent reasons for admission to NFs of individuals in the Target Population and takes steps to reduce such admissions and to remove barriers to diversion and transition for such individuals.	
	Outcome Measure 2-1. All individuals in the Target Population (TP) have a Service Planning Team (SPT), convened and facilitated by the Service Coordinator (SC). The SPT meets with the individual at least quarterly to develop, review, and revise the Individual Service Plan (ISP) as indicated by the individual's changing needs and the SPT's assessment of the adequacy of the services and supports provided to the person to meet his/her needs. The SC facilitates the coordination of services and supports the individual receives.	26%
	Outcome Measure 2-2. SPTs for individuals in NFs include the LA Service Coordinator, the individual and the LAR, nursing facility staff familiar with the individual's needs, providers of specialized services, and a community provider if a community placement is planned.	29%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 2-3. The NF Member is supported through a person-centered ISP process to identify his/her needs, preferences, strengths and goals, and to develop annual objectives to assist the individual to achieve these goals. The individual or LAR approves the content of the plan.	29%
	Outcome Measure 2-4. The ISP is based on assessments of the person's needs that appropriately identify these needs and recommend services and supports to address them. These assessments are completed by licensed and qualified staff within the timeframes established by the SPT. They include assessments of the medical, nursing, nutritional management, psychiatric, behavioral, therapy, independent living, community participation and the integrated day activity needs of the individual.	13%
	Outcome Measure 2-5. The individual has an ISP that includes all of the services and supports, including integrated day activities, s/he needs to achieve his/her goals, maximize his/her potential, and participate in community activities. The NF Member receives all of the specialized services identified in the ISP, including transition services and opportunities to learn about community options such as opportunities to visit community programs, in the frequency, intensity, and duration specified in the ISP. The SPT monitors the provision of specialized services.	13%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 2-6. At least quarterly, individuals who are in the NFs and their LARs receive education and information about community options that explain the benefits of community living, address their concerns about community living, and that assist them to make informed choices about whether to move to the community. This information is provided by people knowledgeable about community supports and services and may include opportunities for individuals to visit community programs and talk to individuals with I/DD living in the community and their families.	14%
	Outcome Measure 2-7. Upon admission to a NF and at least semi-annually, the SC will provide each individual and LAR information about community services and supports. The SC will discuss this information with the individual and the LAR to better enable them to make an informed decision about moving to the community. The SC discusses a range of community options and alternatives, facilitates visits to community programs, and addresses concerns about community living. The SC will use the CLO process designed by the State to provide this community educational material.	48%
	Outcome Measure 2-8. Each individual in the NF has an ISP and a NFCPC. The ISP includes all the needed specialized services and responsibilities of all the specialized service providers. The NFCPC includes those needed specialized services and supports that are the responsibilities of the NF. The SC facilitates and ensures the coordination of specialized services in the ISP and the NFCPC and makes the ISP available to the NF staff on the SPT for sharing with key NF staff who work with the individual. The SPT ensures that the services in the ISP, including specialized services, are provided to the individual and are delivered in a consistent and coordinated manner reflective of the ISP.	21%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 2-9. Any individual whose SPT recommends continued placement in a NF has a plan that documents the reasons for this decision and describes the steps the team will take to address the identified barriers to placement in the most integrated setting. The plan is implemented as designed by the SPT and in the timeframes the team established.	18%
	Outcome Measure 2-10. LAs have caseloads for Service Coordinators based on a methodology that reflects the amount of time involved in the person-centered planning process; the transition process; and the coordination and monitoring responsibilities of service coordinators related to the provisions of the agreement.	
	Outcome Measure 2-11. Each NF Member meets with his/her SC at least monthly to review his/her plan and its implementation.	35%
	Outcome Measure 2-12. No NF Member may be moved to another NF unless the SPT and Diversion Coordinator could not address barriers to placement in a more integrated setting and the individual and LAR made an informed decision to accept the placement.	33%
	Outcome Measure 2-13. Individuals in the TP who need specialized services will only be admitted to a NF if the individual's needs for specialized services can be met by the NF, the LA, or both.	66%
	Outcome Measure 3-1. For individuals who have lived in a NF for more than 90 days and who are moving or who have moved to the community, supports and services are made available to move to the community and to remain in the community. These supports and services recognize the needs and choices of the individual.	87%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 3-2. Any individual in a NF who should have been identified through a Level I screening to need a PASRR Level II evaluation but was not evaluated will receive a PASRR Level II completed by the LA.	100%
	Outcome Measure 3-3. 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.	36%
	Outcome Measure 3-4. Any NF Member expressing an interest through the MDS Section Q process in speaking to someone about moving to the community is reported to the LA, which contacts the individual within 30 days of this notification to discuss community options.	100%
	Outcome Measure 3-5. All individuals in the TP have a SPT, convened and facilitated by the Service Coordinator. The SPT meets with the individual at least quarterly to develop, review, and revise the Individual Service Plan (ISP) as indicated by the individual's changing needs and the SPT's assessment of the adequacy of the services and supports provided to the person to meet his/her individual needs. The SC facilitates the coordination of services and supports the individual receives.	22%
	Outcome Measure 3-6. The NF Member is supported through a person-centered ISP process to identify his/her needs, preferences, strengths and goals, and to develop annual objectives to assist the individual to achieve these goals. The individual or LAR approves the plan.	28%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 3-7. The ISP is based on assessments of the person's needs that appropriately identify these needs and recommend services and supports to address them. These assessments are completed by licensed and qualified staff within the timeframes established by the SPT. They include assessments of the medical, nursing, nutritional management, psychiatric, behavioral, therapy, independent living, community participation, and integrated day activity needs of the individual.	11%
	Outcome Measure 3-8. The individual has an ISP that includes all of the services and supports, including integrated day activities, s/he needs to achieve his/her goals, maximize his/her potential, and participate in community activities. The NF member receives all of the specialized services identified in the ISP, including transition services and opportunities to learn about community options such as opportunities to visit community programs, in the frequency, intensity, and duration specified in the ISP. The SPT monitors the provision of all specialized services.	12%
	Outcome Measure 3-9. The individual will move to the community within 180 days of the individual accepting the waiver slot, unless DADS grants an extension. DADS maintains data about the reasons for extensions and analyzes the data to identify relevant trends and patterns.	98%
	Outcome Measure 3-10. The SPT ensures that the ISP, including the CLDP, is coordinated with the NFCPC and monitors the implementation of the CLDP.	34%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 3-11. The individual has a Community Living Discharge Plan (CLDP), developed and implemented by the SPT, which includes all of the activities necessary to assist the person to move to the community. The CLDP specifies the activities, timetable, responsibilities, services and supports the person needs to live in the most integrated setting. The CLDP is shared with the NF staff and providers of specialized services, and any responsibilities such staff and providers have to support its implementation are included in the NFCPC. The services and supports in the individual's CLDP are in place before the individual moves to the community. The SPT monitors and revises the CLDP as necessary.	47%
	Outcome Measure 3-12. Any individual whose SPT recommends continued placement in a NF has a plan that documents the reasons for this decision and describes the steps the team will take to address the identified barriers to placement in the most integrated setting. The plan is implemented as designed by the SPT and in the timeframes the team established.	13%
	Outcome Measure 3-13. The State monitors all individuals who have been discharged from the NF with the frequency specified in the CLDP to determine if all supports and services specified in the CLDP are adequately provided to the individual and addresses any gaps in services to prevent crises, re-admissions, or other negative outcomes. The individual will receive at least 3 monitoring visits during the first 90 days following the individual's move to the community, including one within the first 7 days.	69%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 3-14. In order to provide opportunities for individuals to live in the most integrated setting that meets their needs and is reflective of their choices, the State provides information about all existing sources of housing options and rental assistance programs to individuals who are moving to the community, and makes appropriate referrals to these sources for these individuals.	0%
	Outcome Measure 4-1. All individuals in the TP have a Service Planning Team (SPT) convened and facilitated by the Service Coordinator (SC). The SPT meets with the individual at least quarterly to develop, review, and revise the Individual Service Plan (ISP) as indicated by the individual's changing needs and the SPT's assessments of the adequacy of the services and supports provided to the person to meet his/her individual's needs. The SC facilitates the coordination of services and supports the individual receives.	43%
	Outcome Measure 4-2. The community member is supported through a person-centered ISP process to identify his/her needs, preferences, strengths and goals, and to develop annual objectives to assist the individual to achieve these goals. The individual and the LAR approve the content of the plan.	56%
	Outcome Measure 4-3. The ISP is based on assessments of the person's needs that appropriately identify these needs and recommend services and supports to address them. These assessments are completed by licensed and qualified staff within the timeframes established by the SPT. They include assessments of the medical, nursing, nutritional management, psychiatric, behavioral, therapy, independent living, community participation, and integrated day activity needs of the individual.	31%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 4-4. The individual has an ISP that includes all of the services and supports, including integrated day activities, s/he needs to achieve his/her goals, maximize his/her potential, and participate in community activities. The plan identifies the frequency, intensity, and duration of all services the Community Member receives. All services in the plan are implemented. The SPT monitors the provision of services.	50%
	Outcome Measure 4-5. Each Community Member meets with his/her SC at least monthly to review his/her ISP and its implementation for the first 180 days after moving to a community program.	69%
	Outcome Measure 4-6. After the individual has been in his/her community placement for 180 days, the SC meets with him/her at the frequency required by the program. The SPT determines if more frequent face-to-face contact is needed based on an assessment of the individual's risk factors.	74%
	Outcome Measure 4-7. For all community members, the SC inquires about recent Critical Incidents, increased physician visits, changes in the individual's health status, and medical crises and, if the person has experienced critical incidents or medical concerns, convenes the SPT to identify all necessary modifications to the ISP. The SC notifies the provider if changes in the individual's health status have not been recorded in the record and ensures that this information is recorded in the record. The SC ensures the individual receives timely and ongoing medical, nursing, and nutritional management assessments. The SC works with the SPT to arrange for any additional services and supports that are needed by the individual.	73%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 4-8. The State annually uses available outcome data and other information about the delivery of medical, nursing and nutritional management services and supports to determine if these services are available in the community to all Community Members, including those with complex medical needs, and to identify any gaps in providing these services to Community Members in the most integrated settings.	
	Outcome Measure 4-9. In collaboration with LAs and stakeholders, the State develops a plan to address gaps in medical, nursing and nutritional management services, including the capacity of small residential settings to meet the needs of Community Members with complex medical needs. Within available authority and resources, the State implements the plan within the timeframes set out in the plan.	
	Outcome Measure 4-10. Residential and other providers have access to training, technical assistance, and support from a qualified registered nurse, advanced practice nurse, and/or medical doctor from each LA to assist them to meet the needs of Community Members who have complex medical needs.	
	Outcome Measure 4-11. The State develops collaborative relationships with healthcare providers to promote timely access to routine, preventive, and emergency clinical services in the most integrated setting for all Community Members, including those with complex medical needs.	

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 4-12. The State will ensure that Community Members have access to the existing array of day activities in the most integrated settings appropriate to their needs and desires. Integrated day activities include supported and competitive employment, community volunteer activities, community learning and recreational activities, and other integrated day activities.	22%
	Outcome Measure 4-13. In order to provide opportunities for individuals to live in the most integrated setting that meets their needs and that is reflective of their choices, the State provides information about all existing sources of housing options and rental assistance programs to community members and makes appropriate referrals to these sources for these individuals.	0%
	Outcome Measure 4-14. No Community Member is served in a residential setting that serves more than 4 individuals with I/DD unless the SPT and Diversion Coordinator tried but could not address barriers to such a placement and the individual or LAR made an informed decision to accept the placement.	96%
	Outcome Measure 4-15. The State monitors all individuals who have been discharged from a NF with the frequency specified in the CLDP to determine if all supports and services specified in the CLDP are adequately provided to the individual, and addresses any gaps in services to prevent crises, re-admissions, or other negative outcomes. The individual will receive at least 3 monitoring visits during the first 90 days following the individual's move to the community, including one within the first 7 days.	61%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 4-16. Community members are given a choice of providers that have the capacity to meet their needs and can change service providers if they are dissatisfied with their services and supports, or their provider cannot meet their needs.	80%
	Outcome Measure 4-17. The State annually collects and analyzes data regarding Community Members' change in providers, including information about the known reasons for the change.	
	Outcome Measure 4-18. The State annually collects and analyzes data regarding Community Members' relocation within a provider's residential settings, including known reasons for the relocation.	
	Outcome Measure 4-19. An individual who has an identified risk of behavioral or medical crisis has a crisis plan in his/her ISP that focuses on crisis prevention.	35%
	Outcome Measure 5-1. All individuals in the Target Population (TP) who do not refuse service coordination will have a Service Coordinator who is employed by the Local Authority (LA) or an entity other than a NF.	100%
	Outcome Measure 5-2. All individuals in the TP have a Service Planning Team (SPT), convened and facilitated by the SC. The SPT meets at least quarterly to develop, review, and revise the Individual Service Plan (ISP) as indicated by the individual's changing needs and the SPT's assessment of the adequacy of the services and supports provided to the person to meet his/her individual needs. The SC facilitates the coordination of supports and services for the individual.	35%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 5-3. Each individual in the NF has an ISP and a NFCPC. The ISP includes all the needed specialized services and responsibilities of the special service providers. The NFCPC includes those needed specialized services and supports that are the responsibility of the NF. The SC facilitates and ensures the coordination between the ISP and the NFCPC and makes the ISP available to the NF staff on the SPT for sharing with key NF staff who work with the individual.	21%
	Outcome Measure 5-4. Each individual in the TP meets with his/her SC at least monthly to review his/her plan and its implementation while in the NF and/or for the first 180 days after moving to a community program.	51%
	Outcome Measure 5-5. After an individual has been in his/her community placement for 180 days the SC meets with him/her at the frequency specified by the program. The SPT determines if more frequent face-to-face contact is needed based on an assessment of the individual's risk factors.	92%
	Outcome Measure 5-6. At least quarterly individuals who are in the NF's and their LARs receive education and information about community options that explain the benefits of community living, address their concerns about community living, and that assist them to make informed choices about whether to move to the community. This information is provided by people knowledgeable about community services and supports and may include opportunities for individuals to visit community programs and talk to individuals with ID living in the community and with their families.	14%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 5-7. Upon admission to a NF and at least semi-annually the SC will provide each individual and LAR information about community services and supports. The SC will discuss this information to better enable the individual and LAR to make an informed decision about moving to the community. The SC discusses a range of community options and alternatives, facilitates visits to community programs, and addresses concerns about community living. The SC will use the CLO process designed by the State to provide the community educational material.	48%
	Outcome Measure 5-8. The individual has a Community Living Discharge Plan (CLDP), developed and implemented by the SPT, which includes all of the activities necessary to assist the person to move to the community. The CLDP specifies the activities, timetable, responsibilities, services and supports the person needs to live in the most integrated setting. The CLDP is shared with the NF staff and providers of specialized services, and any responsibilities such staff and providers have to support its implementation are included in the NFCPC. The services and supports in the individual's CLDP are in place before the individual moves to the community. The SPT monitors and revises the CLDP as necessary.	47%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 5-9. For all community members the SC inquires about recent Critical Incidents, increased physician visits, changes in the health status, and medical crises, and, if the person has experienced critical incidents or medical concerns, convenes the SPT to identify all necessary modifications to the ISP. The SC notifies the provider if changes in the individual's record have not been recorded in the record and ensures that this information is recorded in the record. The SC ensures the individual receives timely and ongoing medical, nursing, and nutritional management assessments. The SC works with the SPT to arrange for any additional services and supports that are needed by the individual.	57%
	Outcome Measure 5-10. LAs have caseloads for Service Coordinators based on a methodology that reflects the amount of time involved in the person-centered planning process; the transition process; and the coordination and monitoring responsibilities of service coordinators related to the provisions of the agreement.	
	Outcome Measure 6-1. All individuals in the Target Population have a Service Planning Team (SPT) convened and facilitated by the Service Coordinator (SC). The SPT meets at least quarterly to develop, review and revise the Individual Service Plan (ISP) as indicated by the individual's changing needs and the SPT's assessment of the adequacy of the services and supports provided to the person to meet his/her individual needs. The SC facilitates the coordination of services and supports the individual receives.	35%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 6-2. The individual is supported through a person-centered ISP process to identify his/her needs, preferences, strengths and goals, and to develop the annual objectives to assist the individual to achieve these goals. The individual or LAR approves the content of the plan.	41%
	Outcome Measure 6-3.The ISP is based on assessments of the person's needs that appropriately identify these needs and recommend services and supports to address them. These assessments are completed by licensed and qualified staff within the timeframes established by the SPT. They include assessments of the medical, nursing, nutritional management, psychiatric, behavioral, therapy, independent living, community participation, and integrated day activity needs of the individual.	23%
	Outcome Measure 6-4. SPT's for individuals in NFs include the LA Service Coordinator, the individual and the LAR, nursing facility staff familiar with the individual's needs, providers of specialized services, and a community provider if a community placement is planned.	29%
	Outcome Measure 6-5. The individual has an ISP that includes all of the services and supports including, integrated day activities, s/he needs to achieve his/her goals, maximize his/her potential, and participate in community activities. The NF Member receives all of the specialized services identified in the ISP, including transition services and opportunities to learn about community options such as opportunities to visit community programs, in the frequency, intensity, and duration specified in the ISP. The SPT monitors the provision of specialized services.	19%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 6-6. Each individual in the NF has an ISP and a NFCPC. The ISP includes all the needed specialized services and responsibilities of all the specialized service providers. The NFCPC includes those specialized services that are the responsibilities of the NF. The SC facilitates and ensures the coordination of specialized services in the ISP and the NFCPC and makes the ISP available to the NF staff on the SPT for sharing with key NF staff who work with the individual. The SPT ensures that the services in the ISP, including specialized services, are provided to the individual in a consistent and coordinated manner reflective of the ISP.	21%
	Outcome Measure 6-7. Individuals in the TP who live in the community have a SPT whose members include those people who are specified in the program rules. The SPT is responsible to develop the ISP, ensure the ISP is implemented, and monitor that all services and supports in the plan are provided to the individual.	33%
	Outcome Measure 6-8. Each individual in the TP meets with his/her SC at least monthly to review his/her plan and its implementation while in the NF or for the first 180 days of community placement.	51%
	Outcome Measure 6-9. After the individual has been in his/her community placement for 180 days, the SC meets with him/her at the frequency specified by the program. The SPT determines if more frequent face- to- face contact is needed based on an assessment of the individual's risk factors.	90%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 6-10. Any individual whose SPT recommends continued placement in a NF has a plan that documents the reasons for this decision and describes the steps the team will take to address the identified barriers to placement in the most integrated setting. The plan is implemented as designed by the SPT and in the timeframes the team established.	18%

The use of the QSR and the PIRM application as the foundation to complete the reviews has proven to be effective. The Reviewers have achieved a level of consistency in their interpretations of the indicators and the interpretive guidelines. The review process as designed has continued for the second sample. The second sample was pulled in March 2015 and these reviews began May 1, 2015.

Submitted by: Kathryn du Pree, Expert Reviewer

May 29, 2015

Declaration of Garth Corbett Exhibit C

STATUS REPORT on IMPLEMENTATION of the QSR PASRR REVIEW PROCESS

September 25, 2015

The purpose of this status report is to provide an update of the implementation of the Quality Service Review (QSR) PASRR review process for Nursing Facility and Community Members as agreed to by the Parties. The Independent Review team began PASRR reviews for Calendar Year 2015 in late January after all reviewers were trained in the QSR process and the use of the PASRR Independent Review Monitoring (PIRM) tool. The first quarter sample was randomly selected by DADS staff in December 2014. The second quarter sample was randomly selected by DADS staff in February 2014. Both samples followed the sampling methodology approved by the Parties. The samples included individuals from all three target populations: diversion, transition (community members) and nursing facility members. The Expert Reviewer assigned the individuals to the three Review Teams. Each team is comprised of two reviewers. One reviewer is a generalist with experience in community transition planning, service coordination and individual service planning and the other reviewer is a clinician. The three clinicians working on this project include one RN and two OTRs. All reviewers have experience with the ID/DD population and with either or both nursing homes or community programs. On site reviews for the second sample were completed by July 31, 2015.

Local Authorities, community providers and nursing facility staff were very accommodating of the review process. Local Authorities made various documents available to the reviewers including the PASRR screening (PL1), PASRR evaluation (PE), the Individual Service Plan (ISP), the Community Living Option (CLO) form, the transition plan and the Service Coordinator progress notes. These were reviewed by the reviewers prior to the onsite visit. The facility and provider staff shared relevant assessment, planning and progress note data with the reviewers during the onsite visits. Staff, Service Coordinators and LARs made themselves available for interviews either during the site visit or by phone.

The following information is based on reviews that have been closed by September 24, 2015. A review is designated as closed when the review team has completed its full record review, onsite review, and interviews, and has rated the indicators using the PIRM tool, and the Expert Reviewer has reviewed and validated the ratings based on the findings of the reviewers. This report includes data for one hundred forty-six (146) individuals reviewed between January and July 2015 including:

- 39 individuals who were diverted
- 40 individuals who were transitioned
- 67 individuals residing in a nursing facility

The vast majority if individuals that were diverted did not enter a Nursing Facility. Approximately twelve of the sixty-seven individuals who are NF Members had refused to participate in transition planning. Many of them reside at Marbridge Villa in Austin. This is a

facility that specializes in serving individuals with ID and DD. Many of the individuals are over 60 and have diagnoses of dementia or Alzheimer's disease.

Five individuals returned to a NF after their transition to the community. None of them returned during the first 90 days. Two returned for rehabilitation subsequent to a fall. In both cases the group home planned for them to return to the community. One is scheduled to do so. The other individual chose to stay in the NF where her mother resides after multiple attempts by the SC to convince her to return to her community residence. One individual returned because of the provider's inability to support him to manage his cancer. Two other individuals returned because of the provider's inability to fully support them. Of these two individuals one was transitioned to an assisted living facility (ALF) without sufficient supports and the other transitioned to a six person ICF/IDD. In the latter case the ICF/IDD program was willing to continue to serve the individual but the LAR was dissatisfied with the quality of the services. The woman who returned from the ALF hopes to transition back to the community in the future. These five individuals were part of the first sample.

Thirty one of the thirty-nine Local Authorities were reviewed during this review period. Reviews are underway involving four more of the LIDDAs. Most of the individuals in the review period enrolled in the HCS program transitioned to either a Group Home or a Host Home. Many individuals with medical and physical care needs live in host homes with a significant number of these individuals supported by family members who have become host home providers.

There have been twenty individuals reviewed so far that have not selected the HCS waiver. Five individuals have transitioned to ICF/IDDs and fifteen individuals have selected the STAR+PLUS program. Two of the individuals were transitioned to a 116 bed ICF/IDD. In one situation the transfer to the 116 bed facility was made because the HCS program enrollment could not occur in the timeframe originally projected and the individual's behaviors escalated at the NF so an emergency placement was necessary. DADS was willing to re-offer the HCS waiver but the individual decided to stay in the ICF/IDD when this offer was extended. No additional individuals during the second quarter transitioned to an ICF/IID. DADS has changed its expectations of the LIDDAs regarding service coordination for individuals that transition to an ICF/IID. Effective July 2015 the LIDDAs will provide service coordination to PASRR Community Members in ICF/IIDs for twelve months. The Service Coordinator will follow up on all transition activities; meet with the individual/LAR monthly for six months; and meet with the individual/LAR quarterly for the second six months following the placement. This guidance is issued in IL 2015-39.

The Service Coordinators are beginning to understand their responsibilities to conduct quarterly review meetings at the NFs, and to a lesser extent with the community providers. To date the LIDDAs have not provided community educational opportunities on a quarterly basis. The Reviewers continue to find a lack of specialized services identified during the PASRR Level II evaluation or by the SPT. Nursing Facility staff remain confused about the differences between short term rehabilitative therapy and habilitative therapy. DADS has recently issued new guidance on this distinction and clarified authorization procedures. DADS has also issued an expanded list of specialized service definitions to include behavioral supports, day habilitation, employment assistance, independent living skills training, and supported employment.

Service Planning Teams need a better understanding of the design of goals and objectives as part of the person-centered planning process. Reviewers do not usually find that plans include meaningful goals and objectives that reflect the assessments, needs, preferences and choices of the individual.

I offered a webinar for LIDDA I/DD Directors; Diversion Coordinators; PASRR SC Supervisors; and Service Coordinators in July 2015. The focus of the webinar was to explain the Outcomes and Measures of the QSR as well as the review process. It was attended by over 200 LIDDA staff.

The following table, ***Outcome Overall Compliance*** summarizes the level of compliance for the overall population for each of the six Outcomes. Compliance ranges from 31% for Outcome 2 (the provision of specialized services) to 73% for Outcome 1 (the efforts to successfully divert individuals from long term placement in nursing facilities).

PASRR Individual Review Monitoring (PIRM)

Outcome Overall Compliance

Report Date:9/24/2015

This report displays:

- **Column 1**-The percentage of **Overall Compliance** (without report metrics) for each **Outcome** based on *just* the findings recorded in PIRM (indicators only) for all closed Individual Review (IR) records that fall within the review period.
- **Column 2**-The percentage of **Overall Compliance** (without report metrics) for each **Outcome** base on *just* the findings recorded in PIRM (indicators only) for all closed Individual Review Records (IR) completed by April 30,2015 and reported in the first Status Report

Review Year	Outcome	Overall Compliance *(without report metrics)* *Through the 2nd quarter*	Overall Compliance *(without indicator metrics)* *Through the 1st quarter*
2015 (Open Period)	OUTCOME 1. Individuals in the target population will be appropriately identified, evaluated and diverted from admission to nursing facilities.	73%	70%
	OUTCOME 2. 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 their informed choice.	31%	29%
	OUTCOME 3. Individuals in the Target Population in nursing facilities who are appropriate for and do not oppose transition to the community will receive transition planning, transition services, and placements in the most integrated setting necessary to meet their appropriately- identified needs, consistent with their informed choice.	43%	47%
	OUTCOME 4. Community Members will receive services in the most integrated setting, with the frequency, intensity and duration necessary to meet their appropriately-identified needs, consistent with their informed choice.	55%	53%
	OUTCOME 5. Individuals in the Target Population who do not refuse service coordination will receive coordination from trained service coordinators with the frequency necessary to meet the individual's appropriately-identified needs, consistent with their informed choice.	53%	52%
	OUTCOME 6. Individuals in the Target Population will have a service plan, developed by an interdisciplinary service planning team through a person-centered process that identifies the services and supports necessary to meet the individual's appropriately-identified needs, achieve the desired outcomes, and maximize the person's ability to live successfully in the most integrated setting consistent with their informed choice.	39%	36%

The following is a report of the levels of compliance by Measure for the overall population.

PASRR Individual Review Monitoring (PIRM)

Measure Overall Compliance

Report Date:9/24/2015

This report displays:

- The percentage of **Overall Compliance** (without report metrics) for each **Measure** based on *just* the findings recorded in PIRM (indicators only) for all closed Individual Review (IR) records that fall within the review period.
- This report includes a summary of overall compliance for each Measure through Quarter 2
- Measures with blanks are not rated because they depend on reports to be produced annually by the LIDDAs or DADS
- Measures 1-14, 3-14 and 4-13 are 0% compliance. This is because housing and rental information is only offered to individuals that are not in the HCS waiver or an ICF/IID and that want to live on their own. This Measure was only relevant to two individuals in the sample.

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
2015 (Open Period)	Outcome Measure 1-1. A PASRR Level I screening is completed for individuals seeking admission to nursing facilities. DADS tracks and shares the results with the Local Authority (LA) and the Diversion Coordinator if the individual needs a PASRR Level II evaluation.	97%
	Outcome Measure 1-2. An individual in the TP seeking admission to a NF who is determined by a PASRR Level I to be in need of a PASRR Level II will receive a PASRR Level II evaluation completed by the LA or other qualified entity with experience working with community based services for individuals with ID/DD, within the timeframes set out in V.B.	94%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 1-3. The PASRR Level II evaluation confirms whether the individual has ID or DD and if so, appropriately assesses whether the needs of the individual can be met in the community and accurately identifies, based on the information available, the specialized services the person needs if s/he is admitted to a NF. A report of the reviewer's decision is shared with the individual and his/her LAR.	52%
	Outcome Measure 1-4. Individuals in the TP who need specialized services will only be admitted to a NF if the individual's needs for specialized services can be met by the NF, the LA, or both.	93%
	Outcome Measure 1-5. Each LA has a Diversion Coordinator who is responsible for identifying community services. The Diversion Coordinator is a professional who is experienced in coordinating and/or providing community services to people with I/DD, including people with complex medical needs.	
	Outcome Measure 1-6. The Diversion Coordinator identifies available community living options, supports, and services to assist individuals in the TP to successfully live in the community, and provides information and assistance to SCs and other LA staff who facilitate diversion for these individuals.	
	Outcome Measure 1-7. The Diversion Coordinator coordinates education for SCs and other LA staff to learn about available community services and strategies to avoid NF placement for the TP.	

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 1-8. Nursing Facility Members have access to information from DADS that describes the community services available to support them to live in the community.	89%
	Outcome Measure 1-9. For members of the Target Population living in the community or in a NF for 90 days or less who can be diverted from NF admission, the SC or other LA staff identify, arrange and coordinate all community options, services, and supports, for which the individual may be eligible and that are necessary to enable the individual to remain in the community and avoid admission to a NF or return to the community within 90 days of admission to a NF. Services and supports will be consistent with an individual's or LAR's informed choice.	62%
	Outcome Measure 1-10. All individuals seeking admission to a NF or who have lived in a NF for fewer than 90 days, who were identified through a PASRR Level II evaluation as having ID/DD and who do not oppose living in the community, will receive support, consistent with their individual choice, to participate with their Service Planning Team (SPT) in a planning process that identifies the community supports they need to remain in or move to the community. The planning process includes assessments of medical, nursing, nutritional management, psychiatric, behavioral, therapy, independent living, community participation and integrated day activity needs, and a review of health related incidents. The individual and the LAR are informed of community options that will meet the individual's needs.	63%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 1-11. For individuals who are diverted from a NF placement, supports and services are made available to remain in the community, or to move to the community after a stay in a NF of fewer than 90 days. These supports and services recognize the needs and choices of the individual.	97%
	Outcome Measure 1-12. Individuals who are in the NF for up to 90 days prior to diversion will have an ISP, including a discharge plan that describes the necessary supports for the individual to move to the community, which is coordinated with the NFCPC by the SC. The ISP includes all specialized services the individual needs, including strategies for the individual to learn about community options, such as opportunities to visit community programs, and transition activities.	41%
	Outcome Measure 1-13. Individuals who are placed in a NF for fewer than 90 days receive all specialized services that are needed, as specified in the ISP and the NFCPC. These services are based upon the PASRR Level II and the SPT assessments and reflect the individual's choices and preferences.	49%
	Outcome Measure 1-14. In order to provide opportunities for individuals to live in the most integrated setting that meets their needs and that is reflective of their choices, the State provides information about all existing sources of housing options and rental assistance programs to individuals who are being diverted from NF placement or who are in a NF for fewer than 90 days, and makes appropriate referrals to these sources for these individuals.	0%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 1-15. Within 45-75 days after an individual is admitted to a NF, the DC reviews whether community living options, services, and supports that provide an alternative to the NF placement have been explored. If alternatives have not been explored, the Diversion Coordinator ensures that the individual's SC coordinates this exploration.	82%
	Outcome Measure 1-16. No Community Member is served in a residential setting that serves more than 4 individuals with I/DD unless the SPT and Diversion Coordinator tried but could not address the barriers to such a placement and the individual or LAR made an informed decision to accept the placement.	100%
	Outcome Measure 1-17. Any NF Member expressing an interest through the MDS Section Q process in speaking to someone about moving to the community is reported to the LA, which contacts the individual within 30 days of this notification to discuss community options.	100%
	Outcome Measure 1-18. Using data, including the information reported in V.F.5 and V.F.6, DADS identifies frequent reasons for admission to NFs of individuals in the Target Population and takes steps to reduce such admissions and to remove barriers to diversion and transition for such individuals.	

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 2-1. All individuals in the Target Population (TP) have a Service Planning Team (SPT), convened and facilitated by the Service Coordinator (SC). The SPT meets with the individual at least quarterly to develop, review, and revise the Individual Service Plan (ISP) as indicated by the individual's changing needs and the SPT's assessment of the adequacy of the services and supports provided to the person to meet his/her needs. The SC facilitates the coordination of services and supports the individual receives.	32%
	Outcome Measure 2-2. SPTs for individuals in NFs include the LA Service Coordinator, the individual and the LAR, nursing facility staff familiar with the individual's needs, providers of specialized services, and a community provider if a community placement is planned.	28%
	Outcome Measure 2-3. The NF Member is supported through a person-centered ISP process to identify his/her needs, preferences, strengths and goals, and to develop annual objectives to assist the individual to achieve these goals. The individual or LAR approves the content of the plan.	36%
	Outcome Measure 2-4. The ISP is based on assessments of the person's needs that appropriately identify these needs and recommend services and supports to address them. These assessments are completed by licensed and qualified staff within the timeframes established by the SPT. They include assessments of the medical, nursing, nutritional management, psychiatric, behavioral, therapy, independent living, community participation and the integrated day activity needs of the individual.	23%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 2-5. The individual has an ISP that includes all of the services and supports, including integrated day activities, s/he needs to achieve his/her goals, maximize his/her potential, and participate in community activities. The NF Member receives all of the specialized services identified in the ISP, including transition services and opportunities to learn about community options such as opportunities to visit community programs, in the frequency, intensity, and duration specified in the ISP. The SPT monitors the provision of specialized services.	15%
	Outcome Measure 2-6. At least quarterly, individuals who are in the NFs and their LARs receive education and information about community options that explain the benefits of community living, address their concerns about community living, and that assist them to make informed choices about whether to move to the community. This information is provided by people knowledgeable about community supports and services and may include opportunities for individuals to visit community programs and talk to individuals with I/DD living in the community and their families.	7%
	Outcome Measure 2-7. Upon admission to a NF and at least semi-annually, the SC will provide each individual and LAR information about community services and supports. The SC will discuss this information with the individual and the LAR to better enable them to make an informed decision about moving to the community. The SC discusses a range of community options and alternatives, facilitates visits to community programs, and addresses concerns about community living. The SC will use the CLO process designed by the State to provide this community educational material.	46%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 2-8. Each individual in the NF has an ISP and a NFCPC. The ISP includes all the needed specialized services and responsibilities of all the specialized service providers. The NFCPC includes those needed specialized services and supports that are the responsibilities of the NF. The SC facilitates and ensures the coordination of specialized services in the ISP and the NFCPC and makes the ISP available to the NF staff on the SPT for sharing with key NF staff who work with the individual. The SPT ensures that the services in the ISP, including specialized services, are provided to the individual and are delivered in a consistent and coordinated manner reflective of the ISP.	24%
	Outcome Measure 2-9. Any individual whose SPT recommends continued placement in a NF has a plan that documents the reasons for this decision and describes the steps the team will take to address the identified barriers to placement in the most integrated setting. The plan is implemented as designed by the SPT and in the timeframes the team established.	12%
	Outcome Measure 2-10. LAs have caseloads for Service Coordinators based on a methodology that reflects the amount of time involved in the person-centered planning process; the transition process; and the coordination and monitoring responsibilities of service coordinators related to the provisions of the agreement.	
	Outcome Measure 2-11. Each NF Member meets with his/her SC at least monthly to review his/her plan and its implementation.	44%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 2-12. No NF Member may be moved to another NF unless the SPT and Diversion Coordinator could not address barriers to placement in a more integrated setting and the individual and LAR made an informed decision to accept the placement.	30%
	Outcome Measure 2-13. Individuals in the TP who need specialized services will only be admitted to a NF if the individual's needs for specialized services can be met by the NF, the LA, or both.	74%
	Outcome Measure 3-1. For individuals who have lived in a NF for more than 90 days and who are moving or who have moved to the community, supports and services are made available to move to the community and to remain in the community. These supports and services recognize the needs and choices of the individual.	88%
	Outcome Measure 3-2. Any individual in a NF who should have been identified through a Level I screening to need a PASRR Level II evaluation but was not evaluated will receive a PASRR Level II completed by the LA.	100%
	Outcome Measure 3-3. 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.	36%
	Outcome Measure 3-4. Any NF Member expressing an interest through the MDS Section Q process in speaking to someone about moving to the community is reported to the LA, which contacts the individual within 30 days of this notification to discuss community options.	50%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 3-5. All individuals in the TP have a SPT, convened and facilitated by the Service Coordinator. The SPT meets with the individual at least quarterly to develop, review, and revise the Individual Service Plan (ISP) as indicated by the individual's changing needs and the SPT's assessment of the adequacy of the services and supports provided to the person to meet his/her individual needs. The SC facilitates the coordination of services and supports the individual receives.	29%
	Outcome Measure 3-6. The NF Member is supported through a person-centered ISP process to identify his/her needs, preferences, strengths and goals, and to develop annual objectives to assist the individual to achieve these goals. The individual or LAR approves the plan.	34%
	Outcome Measure 3-7. The ISP is based on assessments of the person's needs that appropriately identify these needs and recommend services and supports to address them. These assessments are completed by licensed and qualified staff within the timeframes established by the SPT. They include assessments of the medical, nursing, nutritional management, psychiatric, behavioral, therapy, independent living, community participation, and integrated day activity needs of the individual.	20%

Review Year	Outcome Measure	**Overall Compliance** *(without report metrics)*
	Outcome Measure 3-8. The individual has an ISP that includes all of the services and supports, including integrated day activities, s/he needs to achieve his/her goals, maximize his/her potential, and participate in community activities. The NF member receives all of the specialized services identified in the ISP, including transition services and opportunities to learn about community options such as opportunities to visit community programs, in the frequency, intensity, and duration specified in the ISP. The SPT monitors the provision of all specialized services.	15%
	Outcome Measure 3-9. The individual will move to the community within 180 days of the individual accepting the waiver slot, unless DADS grants an extension. DADS maintains data about the reasons for extensions and analyzes the data to identify relevant trends and patterns.	96%
	Outcome Measure 3-10. The SPT ensures that the ISP, including the CLDP, is coordinated with the NFCPC and monitors the implementation of the CLDP.	28%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 3-11. The individual has a Community Living Discharge Plan (CLDP), developed and implemented by the SPT, which includes all of the activities necessary to assist the person to move to the community. The CLDP specifies the activities, timetable, responsibilities, services and supports the person needs to live in the most integrated setting. The CLDP is shared with the NF staff and providers of specialized services, and any responsibilities such staff and providers have to support its implementation are included in the NFCPC. The services and supports in the individual's CLDP are in place before the individual moves to the community. The SPT monitors and revises the CLDP as necessary.	42%
	Outcome Measure 3-12. Any individual whose SPT recommends continued placement in a NF has a plan that documents the reasons for this decision and describes the steps the team will take to address the identified barriers to placement in the most integrated setting. The plan is implemented as designed by the SPT and in the timeframes the team established.	10%
	Outcome Measure 3-13. The State monitors all individuals who have been discharged from the NF with the frequency specified in the CLDP to determine if all supports and services specified in the CLDP are adequately provided to the individual and addresses any gaps in services to prevent crises, re-admissions, or other negative outcomes. The individual will receive at least 3 monitoring visits during the first 90 days following the individual's move to the community, including one within the first 7 days.	60%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 3-14. In order to provide opportunities for individuals to live in the most integrated setting that meets their needs and is reflective of their choices, the State provides information about all existing sources of housing options and rental assistance programs to individuals who are moving to the community, and makes appropriate referrals to these sources for these individuals.	0%
	Outcome Measure 4-1. All individuals in the TP have a Service Planning Team (SPT) convened and facilitated by the Service Coordinator (SC). The SPT meets with the individual at least quarterly to develop, review, and revise the Individual Service Plan (ISP) as indicated by the individual's changing needs and the SPT's assessments of the adequacy of the services and supports provided to the person to meet his/her individual's needs. The SC facilitates the coordination of services and supports the individual receives.	46%
	Outcome Measure 4-2. The community member is supported through a person-centered ISP process to identify his/her needs, preferences, strengths and goals, and to develop annual objectives to assist the individual to achieve these goals. The individual and the LAR approve the content of the plan.	61%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 4-3. The ISP is based on assessments of the person's needs that appropriately identify these needs and recommend services and supports to address them. These assessments are completed by licensed and qualified staff within the timeframes established by the SPT. They include assessments of the medical, nursing, nutritional management, psychiatric, behavioral, therapy, independent living, community participation, and integrated day activity needs of the individual.	35%
	Outcome Measure 4-4. The individual has an ISP that includes all of the services and supports, including integrated day activities, s/he needs to achieve his/her goals, maximize his/her potential, and participate in community activities. The plan identifies the frequency, intensity, and duration of all services the Community Member receives. All services in the plan are implemented. The SPT monitors the provision of services.	55%
	Outcome Measure 4-5. Each Community Member meets with his/her SC at least monthly to review his/her ISP and its implementation for the first 180 days after moving to a community program.	72%
	Outcome Measure 4-6. After the individual has been in his/her community placement for 180 days, the SC meets with him/her at the frequency required by the program. The SPT determines if more frequent face-to-face contact is needed based on an assessment of the individual's risk factors.	72%

Review Year	Outcome Measure	**Overall Compliance** *(without report metrics)*
	Outcome Measure 4-7. For all community members, the SC inquires about recent Critical Incidents, increased physician visits, changes in the individual's health status, and medical crises and, if the person has experienced critical incidents or medical concerns, convenes the SPT to identify all necessary modifications to the ISP. The SC notifies the provider if changes in the individual's health status have not been recorded in the record and ensures that this information is recorded in the record. The SC ensures the individual receives timely and ongoing medical, nursing, and nutritional management assessments. The SC works with the SPT to arrange for any additional services and supports that are needed by the individual.	75%
	Outcome Measure 4-8. The State annually uses available outcome data and other information about the delivery of medical, nursing and nutritional management services and supports to determine if these services are available in the community to all Community Members, including those with complex medical needs, and to identify any gaps in providing these services to Community Members in the most integrated settings.	
	Outcome Measure 4-9. In collaboration with LAs and stakeholders, the State develops a plan to address gaps in medical, nursing and nutritional management services, including the capacity of small residential settings to meet the needs of Community Members with complex medical needs. Within available authority and resources, the State implements the plan within the timeframes set out in the plan.	

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 4-10. Residential and other providers have access to training, technical assistance, and support from a qualified registered nurse, advanced practice nurse, and/or medical doctor from each LA to assist them to meet the needs of Community Members who have complex medical needs.	
	Outcome Measure 4-11. The State develops collaborative relationships with healthcare providers to promote timely access to routine, preventive, and emergency clinical services in the most integrated setting for all Community Members, including those with complex medical needs.	
	Outcome Measure 4-12. The State will ensure that Community Members have access to the existing array of day activities in the most integrated settings appropriate to their needs and desires. Integrated day activities include supported and competitive employment, community volunteer activities, community learning and recreational activities, and other integrated day activities.	32%
	Outcome Measure 4-13. In order to provide opportunities for individuals to live in the most integrated setting that meets their needs and that is reflective of their choices, the State provides information about all existing sources of housing options and rental assistance programs to community members and makes appropriate referrals to these sources for these individuals.	0%
	Outcome Measure 4-14. No Community Member is served in a residential setting that serves more than 4 individuals with I/DD unless the SPT and Diversion Coordinator tried but could not address barriers to such a placement and the individual or LAR made an informed decision to accept the placement.	95%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 4-15. The State monitors all individuals who have been discharged from a NF with the frequency specified in the CLDP to determine if all supports and services specified in the CLDP are adequately provided to the individual, and addresses any gaps in services to prevent crises, re-admissions, or other negative outcomes. The individual will receive at least 3 monitoring visits during the first 90 days following the individual's move to the community, including one within the first 7 days.	61%
	Outcome Measure 4-16. Community members are given a choice of providers that have the capacity to meet their needs and can change service providers if they are dissatisfied with their services and supports, or their provider cannot meet their needs.	81%
	Outcome Measure 4-17. The State annually collects and analyzes data regarding Community Members' change in providers, including information about the known reasons for the change.	
	Outcome Measure 4-18. The State annually collects and analyzes data regarding Community Members' relocation within a provider's residential settings, including known reasons for the relocation.	
	Outcome Measure 4-19. An individual who has an identified risk of behavioral or medical crisis has a crisis plan in his/her ISP that focuses on crisis prevention.	27%
	Outcome Measure 5-1. All individuals in the Target Population (TP) who do not refuse service coordination will have a Service Coordinator who is employed by the Local Authority (LA) or an entity other than a NF.	98%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 5-2. All individuals in the TP have a Service Planning Team (SPT), convened and facilitated by the SC. The SPT meets at least quarterly to develop, review, and revise the Individual Service Plan (ISP) as indicated by the individual's changing needs and the SPT's assessment of the adequacy of the services and supports provided to the person to meet his/her individual needs. The SC facilitates the coordination of supports and services for the individual.	39%
	Outcome Measure 5-3. Each individual in the NF has an ISP and a NFCPC. The ISP includes all the needed specialized services and responsibilities of the special service providers. The NFCPC includes those needed specialized services and supports that are the responsibility of the NF. The SC facilitates and ensures the coordination between the ISP and the NFCPC and makes the ISP available to the NF staff on the SPT for sharing with key NF staff who work with the individual.	24%
	Outcome Measure 5-4. Each individual in the TP meets with his/her SC at least monthly to review his/her plan and its implementation while in the NF and/or for the first 180 days after moving to a community program.	55%
	Outcome Measure 5-5. After an individual has been in his/her community placement for 180 days the SC meets with him/her at the frequency specified by the program. The SPT determines if more frequent face-to-face contact is needed based on an assessment of the individual's risk factors.	94%

Review Year	Outcome Measure	**Overall Compliance** *(without report metrics)*
	Outcome Measure 5-6. At least quarterly individuals who are in the NF's and their LARs receive education and information about community options that explain the benefits of community living, address their concerns about community living, and that assist them to make informed choices about whether to move to the community. This information is provided by people knowledgeable about community services and supports and may include opportunities for individuals to visit community programs and talk to individuals with ID living in the community and with their families.	7%
	Outcome Measure 5-7. Upon admission to a NF and at least semi-annually the SC will provide each individual and LAR information about community services and supports. The SC will discuss this information to better enable the individual and LAR to make an informed decision about moving to the community. The SC discusses a range of community options and alternatives, facilitates visits to community programs, and addresses concerns about community living. The SC will use the CLO process designed by the State to provide the community educational material.	46%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 5-8. The individual has a Community Living Discharge Plan (CLDP), developed and implemented by the SPT, which includes all of the activities necessary to assist the person to move to the community. The CLDP specifies the activities, timetable, responsibilities, services and supports the person needs to live in the most integrated setting. The CLDP is shared with the NF staff and providers of specialized services, and any responsibilities such staff and providers have to support its implementation are included in the NFCPC. The services and supports in the individual's CLDP are in place before the individual moves to the community. The SPT monitors and revises the CLDP as necessary.	42%
	Outcome Measure 5-9. For all community members the SC inquires about recent Critical Incidents, increased physician visits, changes in the health status, and medical crises, and, if the person has experienced critical incidents or medical concerns, convenes the SPT to identify all necessary modifications to the ISP. The SC notifies the provider if changes in the individual's record have not been recorded in the record and ensures that this information is recorded in the record. The SC ensures the individual receives timely and ongoing medical, nursing, and nutritional management assessments. The SC works with the SPT to arrange for any additional services and supports that are needed by the individual.	71%
	Outcome Measure 5-10. LAs have caseloads for Service Coordinators based on a methodology that reflects the amount of time involved in the person-centered planning process; the transition process; and the coordination and monitoring responsibilities of service coordinators related to the provisions of the agreement.	

Review Year	Outcome Measure	**Overall Compliance** *(without report metrics)*
	Outcome Measure 6-1. All individuals in the Target Population have a Service Planning Team (SPT) convened and facilitated by the Service Coordinator (SC). The SPT meets at least quarterly to develop, review and revise the Individual Service Plan (ISP) as indicated by the individual's changing needs and the SPT's assessment of the adequacy of the services and supports provided to the person to meet his/her individual needs. The SC facilitates the coordination of services and supports the individual receives.	39%
	Outcome Measure 6-2. The individual is supported through a person-centered ISP process to identify his/her needs, preferences, strengths and goals, and to develop the annual objectives to assist the individual to achieve these goals. The individual or LAR approves the content of the plan.	47%
	Outcome Measure 6-3.The ISP is based on assessments of the person's needs that appropriately identify these needs and recommend services and supports to address them. These assessments are completed by licensed and qualified staff within the timeframes established by the SPT. They include assessments of the medical, nursing, nutritional management, psychiatric, behavioral, therapy, independent living, community participation, and integrated day activity needs of the individual.	29%
	Outcome Measure 6-4. SPT's for individuals in NFs include the LA Service Coordinator, the individual and the LAR, nursing facility staff familiar with the individual's needs, providers of specialized services, and a community provider if a community placement is planned.	28%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 6-5. The individual has an ISP that includes all of the services and supports including, integrated day activities, s/he needs to achieve his/her goals, maximize his/her potential, and participate in community activities. The NF Member receives all of the specialized services identified in the ISP, including transition services and opportunities to learn about community options such as opportunities to visit community programs, in the frequency, intensity, and duration specified in the ISP. The SPT monitors the provision of specialized services.	19%
	Outcome Measure 6-6. Each individual in the NF has an ISP and a NFCPC. The ISP includes all the needed specialized services and responsibilities of all the specialized service providers. The NFCPC includes those specialized services that are the responsibilities of the NF. The SC facilitates and ensures the coordination of specialized services in the ISP and the NFCPC and makes the ISP available to the NF staff on the SPT for sharing with key NF staff who work with the individual. The SPT ensures that the services in the ISP, including specialized services, are provided to the individual in a consistent and coordinated manner reflective of the ISP.	24%
	Outcome Measure 6-7. Individuals in the TP who live in the community have a SPT whose members include those people who are specified in the program rules. The SPT is responsible to develop the ISP, ensure the ISP is implemented, and monitor that all services and supports in the plan are provided to the individual.	48%

Review Year	Outcome Measure	Overall Compliance *(without report metrics)*
	Outcome Measure 6-8. Each individual in the TP meets with his/her SC at least monthly to review his/her plan and its implementation while in the NF or for the first 180 days of community placement.	55%
	Outcome Measure 6-9. After the individual has been in his/her community placement for 180 days, the SC meets with him/her at the frequency specified by the program. The SPT determines if more frequent face- to- face contact is needed based on an assessment of the individual's risk factors.	88%
	Outcome Measure 6-10. Any individual whose SPT recommends continued placement in a NF has a plan that documents the reasons for this decision and describes the steps the team will take to address the identified barriers to placement in the most integrated setting. The plan is implemented as designed by the SPT and in the timeframes the team established.	12%

PASRR Individual Review Monitoring (PIRM)

Target Population Compliance

Report Date:9/24/2015

This report displays:

- The percentage of compliance for each **Target Population** (Diversion, Nursing Facility, and Transition) based only on the findings recorded in PIRM (indicators only) for all closed Individual Review (IR) records that fall within the review period.
- The original Target Population segment that an individual is in when the sample file is pulled.
- A summary of everyone reviewed through July 31. 2015

Review Year	Target Population	Outcome	Compliance *(without report metrics)*
2015 (Open Period)	Diversion	OUTCOME 1. Individuals in the target population will be appropriately identified, evaluated and diverted from admission to nursing facilities.	73%
		OUTCOME 2. 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 their informed choice.	N/A for Diversion
		OUTCOME 3. Individuals in the Target Population in nursing facilities who are appropriate for and do not oppose transition to the community will receive transition planning, transition services, and placements in the most integrated setting necessary to meet their appropriately- identified needs, consistent with their informed choice.	N/A for Diversion
		OUTCOME 4. Community Members will receive services in the most integrated setting, with the frequency, intensity and duration necessary to meet their appropriately-identified needs, consistent with their informed choice.	59%

Review Year	Target Population	Outcome	Compliance *(without report metrics)*
		OUTCOME 5. Individuals in the Target Population who do not refuse service coordination will receive coordination from trained service coordinators with the frequency necessary to meet the individual's appropriately-identified needs, consistent with their informed choice.	78%
		OUTCOME 6. Individuals in the Target Population will have a service plan, developed by an interdisciplinary service planning team through a person-centered process that identifies the services and supports necessary to meet the individual's appropriately-identified needs, achieve the desired outcomes, and maximize the person's ability to live successfully in the most integrated setting consistent with their informed choice.	57%
	Nursing Facility	OUTCOME 1. Individuals in the target population will be appropriately identified, evaluated and diverted from admission to nursing facilities.	N/A for NF
		OUTCOME 2. 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 their informed choice.	31%
		OUTCOME 3. Individuals in the Target Population in nursing facilities who are appropriate for and do not oppose transition to the community will receive transition planning, transition services, and placements in the most integrated setting necessary to meet their appropriately- identified needs, consistent with their informed choice.	42%
		OUTCOME 4. Community Members will receive services in the most integrated setting, with the frequency, intensity and duration necessary to meet their appropriately-identified needs, consistent with their informed choice.	N/A for NF
		OUTCOME 5. Individuals in the Target Population who do not refuse service coordination will receive coordination from trained service coordinators with the frequency necessary to meet the individual's appropriately-identified needs, consistent with their informed choice.	44%

Review Year	Target Population	Outcome	Compliance *(without report metrics)*
		OUTCOME 6. Individuals in the Target Population will have a service plan, developed by an interdisciplinary service planning team through a person-centered process that identifies the services and supports necessary to meet the individual's appropriately-identified needs, achieve the desired outcomes, and maximize the person's ability to live successfully in the most integrated setting consistent with their informed choice.	37%
	Transition	OUTCOME 1. Individuals in the target population will be appropriately identified, evaluated and diverted from admission to nursing facilities.	N/A for Transition
		OUTCOME 2. 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 their informed choice.	34%
		OUTCOME 3. Individuals in the Target Population in nursing facilities who are appropriate for and do not oppose transition to the community will receive transition planning, transition services, and placements in the most integrated setting necessary to meet their appropriately- identified needs, consistent with their informed choice.	38%
		OUTCOME 4. Community Members will receive services in the most integrated setting, with the frequency, intensity and duration necessary to meet their appropriately-identified needs, consistent with their informed choice.	51%
		OUTCOME 5. Individuals in the Target Population who do not refuse service coordination will receive coordination from trained service coordinators with the frequency necessary to meet the individual's appropriately-identified needs, consistent with their informed choice.	50%
		OUTCOME 6. Individuals in the Target Population will have a service plan, developed by an interdisciplinary service planning team through a person-centered process that identifies the services and supports necessary to meet the individual's appropriately-identified needs, achieve the desired outcomes, and maximize the person's ability to live successfully in the most integrated setting consistent with their informed choice.	36%

Declaration of Garth Corbett Exhibit D

Texas PASRR Overview for Nursing Facilities

Updated June 2014

Background

- SimpleLTC software simplifies healthcare information for long-term care
- In Texas, many know us as the makers of SimpleCFS™ the leading alternative for managing Medicaid forms and MESAV data
- For more information about SimpleLTC, visit http://www.simpleltc.com

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What Is PASRR?

PASRR is required part of each state's Medicaid program to ensure that those with MI/IDD are cared for properly

- **P**re-
- **A**dmission
- **S**creening and
- **R**esident
- **R**eview

Three Core Parts

- **Level I Screening (TX: PL1)**
  - Is there a chance the individual might have MI/IDD?
- **Level II Evaluation (TX: PE)**
  - Do they have MI/IDD?
  - What specialized services do they need?
  - What is the right setting for that care?
- **Resident Review**
  - When does a resident need to be reevaluated?

What is MI?

Federal regulations define three criteria for disorder to be MI

1. It must be a major mental-disorder listed in DSM-III-R (1987); and
2. It has resulted in functional impairments in major life activities in the last 3-6 months, including interpersonal functioning, concentration, and adaptation to change; and
3. The individual must have a recent (in the last two years) history of treatment including:
   - Inpatient hospitalization; or
   - An episode of "significant disruption" to normal life requiring supportive services or law enforcement intervention

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What is IDD?

Federal regulations say an individual has an intellectual disability under PASRR if they have:

- A level of intellectual disability as described in the AAMR Manual on Classification in Mental Retardation (1983); or
- A related condition as defined by 42 CFR 435.1009
  - DADS has created a list of related conditions on their website

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Definitions

- **Nursing Facility (NF)**
  - A Medicaid-certified nursing facility
- **Referring Entity (RE)**
  - The entity that refers an individual to a NF (hospital, doctor, LAR, family member, law enforcement)
- **Local Authority (LA)**
  - Agencies contracted by the state to serve as the point of entry for publicly funded MI & IDD programs.

  - Each county has one LA assigned for MI and another assigned for IDD.
  - DSHS regulates LA for MI; DADS regulates LA for IDD

Texas PASRR Redesign

A brief history

- **1987**: Congress institutes PASRR so that residents with MI/IDD receive proper care in the proper setting
- **Dec 2009**: CMS informs TX HHSC of Federal compliance issues with the TX PASRR program
- **May 2013**: TX HHSC launches Phase I of PASRR redesign
- **Jun 2014**: TX HHSC launches Phase II of PASRR redesign

CMS Identified Three Main Problems

1. Level II evaluation needs to recommend specialized services prior to admission
2. NF staff should not perform the Level II evaluation
3. State needs to describe resident review process better

Redesign Phase I

- Rolled out May 2013
- PL1 must be completed for every individual being admitted to a Medicaid NF
  - Preadmission: RE completes PL1. If positive, LA submits. Otherwise, NF submits.
  - Expedited Admission: RE completes and NF submits PL1
  - Exempt Hospital Discharge: RE completes and NF submits PL1

Redesign Phase I

- Electronic message sent to LA to come and perform the PE (typically within 7 days)
  - Exception: Coma, Exempt Hospital Discharge, Respite (14 days)
- After PE, NF must certify ability to provide specialized services from PE
- LA coordinates placement in NF or alternate setting and participates in NF IDT

Redesign Phase II

- Rolled out June 2014
- **LTCMI rejections and Medical Necessity**
  - If a PL1 is not on file for the resident, the LTCMI will be rejected
  - In other words, **No PL1 = No LTCMI = No Payment**
  - For preadmission PL1-positive individuals:
    - The LA will need to submit the PL1
    - MN will be determined for the first LTCMI based on the PE. Therefore, the LTCMI will not be accepted until the PE has been submitted by the LA.

Redesign Phase II

- **New Alerts**
  - On LTCMI submission, if a matching PE is found but the PL1 has not been certified (D0100N), the NF receives an electronic alert telling them that they need to review the PE and certify their ability to serve.
    - Alerts can be viewed through SimpleLTC (for SimpleLTC customers) or the TMHP LTC Online Portal
  - On MDS, LA will automatically be notified to perform a PE if MDS coding shows potential PASRR eligibility
  - On MDS SCSA, if resident is no longer comatose, LA will automatically be notified to perform a PE

Redesign Phase II

- **Validation Changes**
- TMHP will now allow NFs to 'Update Form' on "data convert" PL1s
- TMHP will now allow NFs to submit a PL1 after an individual has been admitted
  - D0100P NF Date of Entry can now be prior to the date the PL1 is submitted
  - D0100P NF Date of Entry can be prior to A1200B (Referring Entity Signature Date)
  - D0100P NF Date of Entry can be prior to A0600 (Date of Assessment)

Redesign Phase II

- **Change of Ownership (CHOW) Process**
  - Notify DADS PASRR Unit via e-mail (pasrr@dads.state.tx.us) that a CHOW is happening:
    1. Include Former NF Name, Address, Vendor/Contract, New NF Name, Date CHOW initiated, # of residents
    2. Keep a list of all residents admitted after the CHOW was started
    3. Once the new Contract # is active, a PL1 must be submitted for *every* resident within 90 days

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Redesign Phase II

- **Change of Ownership (CHOW) Process (continued)**
  - DADS PASRR unit will contact the NF weekly to get a list of all newly admitted residents
  - After 90 days, DADS PASRR will verify a PL1 has been introduced for every resident pre- and post-CHOW

Regulatory Notes

- **Noncompliant REs**
- If an RE (hospital or doctor) refuses to complete the PL1, contact the Dept. of State Health Services (DSHS)
  - E-mail: pasrr@dshs.state.tx.us
  - The state recognizes that the relationship between NFs and hospitals is important to NFs.
  - The identity of the NF will be kept confidential.
  - DSHS will follow-up on complaints with targeted outreach to ensure REs understand their responsibilities under PASRR

Regulatory Notes

- **Noncompliant LAs**
- LAs are paid based on their completion of the PE so it is in their best interest to complete the PE expediently
- State office staff review reports based on PL1 submission and will provide timely follow-up with the LA for completion of the PE.

Regulatory Notes

- **IDT/Care Plan Coordination**
  - NFs are responsible for coordinating with the LA to schedule the IDT / care plan meeting
    - Must be held within the first 14 days after admission
    - NF must inform the LA of the date and time of the meeting
    - Can be conducted over the phone
- **Delivery of Specialized Services**
  - Specialized services (by NF or LA) must be included the comprehensive care plan
  - All specialized services must be started within 30 days after being added to the care plan

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Regulatory Notes

- **Survey Tag F285**
  - If sampled residents have MI or ID, did the state determine:
    - Whether the residents needed the services of an NF?
    - Whether the residents need specialized services for their ID or MI?
  - This is fulfilled by the completion of the PE
    - Performed by the LA on behalf of the state
  - Facilities will have an issue during surveys if a resident has MI/ID but does not have a positive PE

What is SimpleLTC doing to help?

- **Alerts**
  - Alerts from TMHP will be available within SimpleLTC
- **"Medicaid Residents Missing PL1" Report**
  - We've introduced a new report that identifies active residents (based on form history) who do not have a PL1 on file
- **Admission LTCMI Warning**
  - LTCMIs submitted through SimpleLTC will display a warning if the resident does not have a PL1 on file

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That's it!

If you need more help...

- SimpleLTC PASRR Resources
  - http://www.simpleltc.com/pasrr
- SimpleLTC Customer Support

  (469) 916-2803, support@simpleltc.com
- DADS PASRR Unit

  (855) 435-7180, pasrr@dads.state.tx.us

Federal References

- Federal Regulations - PASRR Program Requirements
  - 42 CFR 483.100-138
- Federal Regulations - Resident Assessment (PASRR)
  - 42 CFR 483.20(m)
- CMS State Operations Manual (100-07) - Appendix PP
  - Guidance to Surveyors for LTC Facilities
  - Federal Tag F285
- PTAC - PASRR Definition of Mental Illness (MI)
- PTAC - PASRR Definition of Intellectual Disability (IDD)

Texas References

- Texas Administrative Code - PASRR
  - 40 TAC §17
- List of Related Conditions for IDD
- DADS PASRR Website

Declaration of Garth Corbett Exhibit E

Promoting Independence

Advisory Committee Stakeholder Report 2014

Submitted to
Kyle L. Janek, Executive Commissioner,
Texas Health and Human Services Commission

by the
Promoting Independence Advisory Committee

September 2014

DISCLAIMER

This *2014 Promoting Independence Advisory Committee (Committee) Stakeholder Report* reflects the views and opinions of a majority of the Committee's membership.[1] The Committee for purposes of this report refers only to those members named to the Committee by the Health and Human Services Commission's (HHSC) Executive Commissioner and does not include agency representatives. Unless otherwise noted, the views and opinions expressed in these recommendations do not necessarily reflect the policy of HHSC, the Department of Aging and Disability Services (DADS), or any state agency represented on the Committee.

This report and the Committee's recommendations for the *2014 Promoting Independence Plan* and agency legislative appropriations request (LAR) exceptional items, reflect the positions of a majority of Committee members. Committee membership represents a number of different perspectives and policy interests and not all statements in this report reflect each member's official position. The Committee discussed the contents of this report and all members voted on each recommendation independently.

Recommendations were passed by a simple majority and each vote is illustrated in the report in order of members who voted yay, members who voted nay and members who abstained.

[1] See Appendix A for a detailed listing of the Committee membership.

INTRODUCTION

The non-agency stakeholders of the Promoting Independence Advisory Committee (Committee) respectfully submit the following recommendations to HHSC Executive Commissioner, as required by Section 531.02441, Subchapter B, Chapter 531, Government Code, to be considered for inclusion in the 2014 Promoting Independence Plan.

Texas has made significant strides and investments to ensure that individuals have the ability and right to live in the most integrated setting as required by the Americans with Disabilities Act and upheld by the U.S. Supreme Court's Olmstead decision in June 1999. Through Executive Orders GWB 99-2 and RP-13, Texas made a strong commitment to provide community-based services to individuals and ordered the development of a Texas Olmstead plan. Since the development of the Texas Promoting Independence Plan in 2001, over 41,000 Texans with disabilities, both old and young, have moved from institutions to the community, where services on average cost significantly less than in institutions.

While Texas has achieved remarkable progress implementing the Texas Promoting Independence Plan and rebalancing the long-term service and supports (LTSS) system, significant challenges persist for those remaining in facilities and those at risk of institutionalization who wish to remain in the community. Legislative appropriations have consistently provided resources for expansion of home and community-based services; however, extensive interest lists remain for these programs.

The Committee understands that significant promising opportunities exist for Texas to continue to rebalance the LTSS system and assist people to move into the community. Texas was awarded a Balancing Incentive Program grant from the Centers for Medicare and Medicaid Services that is assisting the state in developing the structural changes necessary to support people to live in the community. The grant allows the state to receive a two percent increase in the Federal Medical Assistance Percentage (FMAP) on community services through 2015. Texas also continues to participate in the Money Follows the Person Demonstration awarded in 2008 that provides enhanced match for eligible populations transitioned from nursing facilities (NF) and large and medium sized intermediate care facilities for individuals with an intellectual disability or related conditions (ICFs/IID). In addition, Texas is developing the Community First Choice option in the Medicaid State Plan and will receive a six percent increase in FMAP for services that support people in their homes once the option is implemented.

This report includes 27 recommendations organized into 9 categories with no specific order of priority. The categories include:

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

RECOMMENDATIONS

SECTION I: COMMUNITY-BASED SERVICES

Recommendation 1: Increase funding to reduce waiver interest lists by ten percent annually.

Waiver interest lists mean that individuals who need community services are not receiving them. Waiting for services can result in ongoing deterioration of medical and functional well-being and being institutionalized. Community services, on average, are significantly less expensive than institutional services. While there is progress in reducing interest lists for individuals who would otherwise enter nursing facilities any wait time is not acceptable. Individuals with intellectual and developmental disabilities (IDD) continue to wait as long as 12 years for services.

Vote: 11-0-2 *(Kevin Warren, Texas Health Care Association, and Susan Payne, PART, Inc., abstaining)*

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

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

Vote: 11-0-2 *(Kevin Warren, Texas Health Care Association, and Susan Payne, PART, Inc., abstaining)*

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

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

Vote 11-0-2 *(Kevin Warren, Texas Health Care Association, and Susan Payne, PART, Inc., abstaining)*

Recommendation 4: Implement Community First Choice (CFC) and officially name the Promoting Independence Advisory Committee as the CFC Development and Implementation Council. HHSC must implement CFC as soon as possible.

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

Vote 11-0-2 *(Kevin Warren, Texas Health Care Association, and Susan Payne, PART, Inc., abstaining)*

SECTION II: CHILDREN'S INITIATIVES

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

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

Vote: 11-0-2 *(Kevin Warren, Texas Health Care Association, and Susan Payne, PART, Inc., abstaining)*

SECTION III: MANAGED CARE INITIATIVES

Recommendation 6: Invest in community care ombudsman.

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

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

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

Vote: 9-0-4 *(Kevin Warren, Texas Health Care Association, Susan Payne, PART, Inc., Carole Smith, Private Providers Association of Texas, and Danette Castle, Texas Council of Community Centers, abstaining)*

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

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

Vote: 10-0-3 *(Kevin Warren, Texas Health Care Association, Susan Payne, PART, Inc., and Cindy Adams, Superior HealthPlan, abstaining)*

SECTION IV: MENTAL AND BEHAVIORAL HEALTH

Recommendation 8: HHSC and DADS will develop and implement strategies to improve the mental health and wellness of people with IDD receiving publicly funded physical health, mental health and/or long-term services and supports.

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

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

Vote: 11-0-2 *(Kevin Warren, Texas Health Care Association, and Susan Payne, PART, Inc., abstaining)*

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

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

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

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

Vote: 11-0-2 *(Kevin Warren, Texas Health Care Association, and Susan Payne, PART, Inc., abstaining)*

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

In order to increase opportunities for recovery, DSHS must develop and implement a program to provide relocation and transition for individuals leaving state psychiatric facilities and those with frequent hospital readmissions services (similar to those available to individuals leaving other institutions including nursing facilities and state supported living centers). DSHS needs to look at the lessons learned from other relocation/transition services programs as well as the unique needs of individuals experiencing serious mental illness when developing the design of the program.

Vote: 11-0-2 *(Kevin Warren, Texas Health Care Association, and Susan Payne, PART, Inc., abstaining)*

SECTION V: RELOCATION SERVICES

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

In order to increase the number of relocations back into the community and decrease admissions to institutional settings, the state of Texas should increase the number of relocation specialists. Additionally, relocation specialists should focus on diverting individuals from institutional settings.

Vote: 7-1-5 *(Danette Castle opposing. Kevin Warren, Texas Health Care Association, Susan Payne, PART, Inc., Carole Smith, Private Providers Association of Texas, and Doni Green, Texas Association of Area Agencies on Aging, abstaining)*

Recommendation 12: Establish metrics to determine the degree of success that relocation/diversion specialists are having with relocation/diversion activities. The state needs to establish a public dashboard in order to be transparent and share this data.

Vote: 10-0-3 *(Susan Payne, PART, Inc., Carole Smith, Private Providers Association of Texas, and Danette Castle, Texas Council of Community Centers, abstaining)*

Recommendation 13: DADS needs to develop benchmarks/metrics for its state supported living center (SSLC) relocation specialists.

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

Vote: 12-0-1 *(Susan Payne, PART, Inc., abstaining)*

SECTION VI: HOUSING

Recommendation 14: Increase targeting in all housing programs for individuals with disabilities at the SSI level of income administered/funded through the Texas Department of Housing and Community Affairs (TDHCA).

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

Vote: 11-0-2 *(Kevin Warren, Texas Health Care Association, and Susan Payne, PART, Inc., abstaining)*

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

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

Vote: 11-0-2 *(Kevin Warren, Texas Health Care Association, and Susan Payne, PART, Inc., abstaining)*

Recommendation 16: Increase funding for DSHS housing voucher program to serve more individuals in the community to provide stable housing options for individuals experiencing mental illness. The current funding allocated by the 83rd legislative session will not address the number of individuals with mental illness who require housing assistance.

Vote: 11-0-2 *(Kevin Warren, Texas Health Care Association, and Susan Payne, PART, Inc., abstaining)*

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

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

Vote: 11-0-2 *(Kevin Warren, Texas Health Care Association, and Susan Payne, PART, Inc., abstaining)*

Recommendation 18: Reclassify TDHCA's Amy Young Barrier Removal Program as a separate category of 'home modification' program that would be exempt from the Single Family Umbrella Rules rather than its current status as a 'rehabilitation' activity.

The current classification results in a refocus of the program away from barrier removal and has eliminated manufactured housing as a type of housing that can have barriers removed. Affordable and accessible housing has been identified as an obstacle to living in the community and individuals with disabilities need home modifications to allow them to remain in their homes instead of institutions. The state of Texas has indicated a commitment to providing services to individuals with disabilities to remain in the community. The Amy Young Barrier Removal Program has been modified to require non-barrier removal items to be addressed focusing more of the funds away from the critical modifications needed and raising the funds available for each home. These changes have resulted in less households being assisted so many more individuals with disabilities are waiting for much needed assistance to live more independently. In addition, many low income individuals with disabilities reside in one of the approximately 750,000 manufactured homes in Texas that are now excluded from assistance leaving more facing barriers to living independently.

Vote: 11-0-2 *(Kevin Warren, Texas Health Care Association, and Susan Payne, PART, Inc., abstaining)*

SECTION VII: EMPLOYMENT

Recommendation 19: HHSC should develop specific guidance for service coordinators / case managers as to how to provide information on employment that includes information about how Employment First information is provided, when the information is provided and the frequency with which it is repeated.

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

Vote: 11-0-2 *(Kevin Warren, Texas Health Care Association, and Susan Payne, PART, Inc., abstaining)*

Recommendation 20: Texas should provide payments for customized or supported employment services on an individualized budget that reflects the needs of the person and where they are in the process of employment. The current rate setting codes and methodology do not provide the flexibility that is needed to implement sound employment services with sustainability. Incentives for obtaining quality outcomes in employment should be built into contracts for both MCOs and the direct support providers.

Vote: 11-0-2 *(Kevin Warren, Texas Health Care Association, and Susan Payne, PART, Inc., abstaining)*

SECTION VIII: WORKFORCE AND PROVIDER STABILIZATION

Recommendation 21: HHSC, DADS and DSHS should seek an increase in legislative appropriations in an amount necessary to raise the base wage for entry-level direct-support workers (DSWs) in home and community-based services (HCBS) programs.

Initial efforts should focus on programs with the lowest paid DSWs. Additional requests should fund increased wages to DSWs on a graduated scale based on scope of work. The PIAC subcommittee on DSWs continues to find that the state faces serious challenges meeting current and future needs for a stable and adequate direct-support workforce. The demand for DSWs in Texas is expected to increase substantially over the next decade due to numerous factors, including the aging baby boom generation, aging family caregivers, and the increasing prevalence of disabilities. Meanwhile, retaining DSWs has long been a challenge and job turnover rates are high statewide. Low pay is a significant factor in recruitment and retention. Evidence indicates that increased wages positively influence recruitment and retention. DSWs are the foundation of the community-based long-term services and supports system. Higher wages contribute to a more stable workforce and improved service quality. A significant decline in recruitment and retention will likely lead to a shortage of available community services, resulting in increased hospitalization and institutionalization. The 83rd Legislature did increase wages to establish a floor for DSWs at $7.86/hour. This amount is barely above minimum wage and significantly below the standard for a living wage.

Vote: 11-0-2 *(Kevin Warren, Texas Health Care Association, and Susan Payne, PART, Inc., abstaining)*

Recommendation 22: Increase provider and managed care reimbursement in order to attract and sustain provider capacity and network readiness.

Increasingly, the state is losing providers of direct services, direct service workers, physicians, licensed nurses and other professional who provide long-terms services and supports to all individuals regardless of disability or age. Serving individuals with complex needs including co-occurring and multiple occurring needs is becoming very challenging as the state does not have sufficient contracts with specialists and providers who can serve these individuals. It is critical for the provider base and managed care systems to have an adequate direct service worker and network system in place to serve all in individuals in a community-based setting.

Vote: 10-0-3*(Kevin Warren, Texas Health Care Association, Susan Payne, PART, Inc., and Danette Castle, Texas Council of Community Centers, abstaining)*

Recommendation 23: Require Community Living Options and Information Process (CLOIP) for all individuals residing in private ICFs/IID.

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

Vote: 9-0-4 *(Kevin Warren, Texas Health Care Association, Susan Payne, PART, Inc., Carole Smith, Private Providers Association of Texas, and Rachel Hammon, Texas Association for Home Care, Inc., abstaining)*

Recommendation 24: Decrease the amount of time an individual in a private nine or more bed ICF/IID has to wait for an HCS slot. Currently, individuals residing in a nine or more bed private ICF/IID may have to wait up to twelve months for an HCS Promoting Independence Priority slot.

Vote: 9-0-4 *(Kevin Warren, Texas Health Care Association, Susan Payne, PART, Inc., Carole Smith, Private Providers Association of Texas, and Rachel Hammon, Texas Association for Home Care, Inc., abstaining)*

Recommendation 25: Implement recommendations developed as a result of developing the SSLC Long-Term Plan as required by the 2014-15 General Appropriations Act (Article II, Department of Aging and Disability Services, Rider 39, Senate Bill 1, 83rd Legislature, Regular Session, 2013). Rider 39 requires a ten-year SSLC Long-Term Plan.

Vote: 9-0-4 *(Kevin Warren, Texas Health Care Association, Susan Payne, PART, Inc., Danette Castle, Texas Council of Community Centers, and Rachel Hammon, Texas Association for Home Care, Inc., abstaining)*

SECTION IX: MISCELLANEOUS

Recommendation 26: The State of Texas should tie employment opportunities for individuals with disabilities to its economic development programs, including businesses that receive incentives.

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

Vote: 11-0-2 *(Kevin Warren, Texas Health Care Association, and Susan Payne, PART, Inc., abstaining)*

Recommendation 27: Create reciprocity of paratransit approvals among Texas communities. Remove the 21 day cap for use of paratransit in community visited. Make a paratransit approval valid statewide and remove limit on the use in the visited community. Encourage the use of mainline transportations systems when possible and the development of mainline systems everywhere. Individuals with disabilities require pre-approval to use paratransit in their home community.

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

Vote: 11-0-2 *(Kevin Warren, Texas Health Care Association, and Susan Payne, PART, Inc., abstaining)*

Appendix A

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Declaration of Garth Corbett Exhibit F

December 1

2014

Texas Biennial Disability Report

Prepared by the
Texas Council for Developmental Disabilities
in collaboration with the
Texas Office for Prevention of Developmental Disabilities

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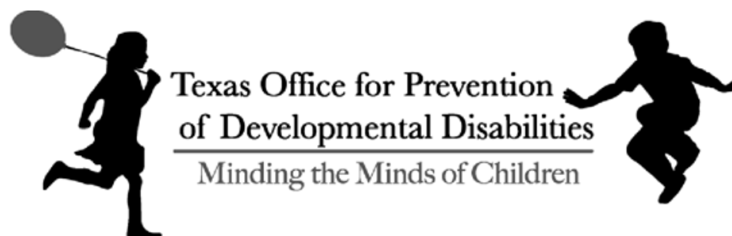

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Table of Contents

About the Texas Biennial Disability Report……………………………………………………………………………1

Executive Summary……………………………………………………………………………………………………2

About Developmental Disabilities……………………………………………………………………………………4

About Preventable Developmental Disabilities…………………………………………………………………5

About the Texas Council for Developmental Disabilities……………………………………………………6

About the Texas Office for Prevention of Developmental Disabilities…………………………………..8

Report Methodology…………………………………………………………………………………………………12

State of the State for Developmental Disabilities……………………………………………………………13

Disability Rates in Texas……………………………………………………………………13

Trends in Service Demand…………………………………………………………………15

Texas' Rank in Nation………………………………………………………………………20

Consumer Satisfaction………………………………………………………………………24

Future Demand………………………………………………………………………………27

Role of Preventive Services…………………………………………………………………33

Benchmarks for Service Delivery System Performance………………………………………………..36

Federal Policy: Impact on Persons with Developmental Disabilities…………………………………...37

Texas State Policy: Impact on Persons with Developmental Disabilities……………………………….48

State Budget…………………………………………………………………………………48

Co-occurrence of Developmental Disabilities and Mental Illness……………..53

State Supported Living Centers……………………………………………………………54

Medicaid Managed Care……………………………………………………………………60

Employment First……………………………………………………………………………65

Guardianship…………………………………………………………………………………70

Individuals with Complex Needs…………………………………………………………74

Summary……76

Appendix A: Government Code: Texas Biennial Disability Report…………………………………………77

Appendix B: Sunset Advisory Commission Recommendations for TCDD and TOPDD…………....78

About the Texas Biennial Disability Report

The Texas Biennial Disability Report is mandated by Senate Bill 374, which was passed by the 76th Texas Legislature (1999) (R). This legislation requires the Texas Council for Developmental Disabilities (TCDD) and the Texas Office for Prevention of Developmental Disabilities (TOPDD) to prepare a biennial report to the legislature on the state of services to persons with disabilities in Texas; to outline present and future needs for consumer-friendly, appropriate, and individualized services and supports; and to make recommendations related to those services. Specifically, SB 374 directs TCDD and TOPDD to address the following:

- Fiscal and Programmatic Barriers to Consumer Friendly Services
- Progress Toward Individualized Service Delivery Based on Functional Needs
- Progress in Development of Local Cross-Disability Access Structures
- Projection of Future Long-term Care Service Needs
- Consumer Satisfaction and Consumer Preferences

As directed by state law, this report is focused on health and human services and does not address in detail the broader array of policy issues that impact the lives of persons with developmental disabilities.

In each *Texas Biennial Disability Report*, TCDD and TOPDD have elected to provide additional detail on current state level policy discussions related to services for persons with developmental disabilities. This includes recently enacted state and/or federal legislation, or policy discussions with state agency partners about the delivery of health and human services.

The 2014 Report summarizes the key federal and state legislative actions that are changing the landscape of long-term services and supports in Texas. These include implementation of the Affordable Care Act, workforce innovation and employment, and new rules for Medicaid home and community based settings. At the state level, the system of services and supports for people with disabilities is impacted by the statewide expansion of managed care, implementation of Employment First policies, and the Sunset Commission review and recommendations for health and human service agencies, including TCDD and TOPDD.

The *Texas Biennial Disability Report* is submitted to the Governor, Lieutenant Governor, Speaker of the House of Representatives, and Executive Commissioner of the Health and Human Services Commission, no later than December 1st of each even-numbered year.

Executive Summary

Texas statute (Title IV, Chapter 531, Section 531.0235) requires that every two years, the Texas Council for Developmental Disabilities (TCDD), in collaboration with the Texas Office for Prevention of Developmental Disabilities (TOPDD), prepare the *Texas Biennial Disability Report*. The report provides an overview and "State of the State" related to reducing the occurrence of preventable disabilities and the strengths and weaknesses in the state service delivery system. TCDD and TOPDD are also asked to make specific recommendations for improving how Texas supports individuals with developmental disabilities and their families.

TCDD and TOPDD evaluate the long-term services and supports (LTSS) system in Texas against national benchmarks to ensure that: 1) people with disabilities have access to and receipt of necessary publically funded services and supports with reasonable promptness, 2) services and supports are provided in the most integrated setting appropriate to the needs of the individual, and 3) the funding and delivery of services and supports is economic and efficient.

Unfortunately, Texas is not meeting these standards and benchmarks for service delivery. The demand for long term services and supports continues to rise as our state population grows and individuals with intellectual and developmental disabilities (I/DD) are living longer. The number of requests for home-and-community based services currently exceeds the state's capacity leaving many individuals to wait years for needed support. While Texas has made improvements over the years to address these benchmarks, state contributions to institutions remain high and the investments in home and community based services have been too small to effectively rebalance the system.

Federal and state policies passed over this last biennium will ultimately strengthen the ability of individuals with developmental disabilities to live, work, be healthy, and participate in their community. The anticipated impact of federal policy related to affordable health care, workforce innovation, and home and community based settings will require Texas to change the way it does the business of long term services and supports. Similarly, Texas legislative action related to state supported living centers, expansion of Medicaid managed care, and employment first policies are shifting the types and manner in which individuals access needed supports. Those who need guardianship, individuals with complex needs, and individuals with both developmental disabilities and mental illness are particularly vulnerable and costly if not strategically addressed.

However, the current policy environment offers multiple opportunities for Texas to be proactive and lead with innovation. System recommendations include, but are not limited to:

- Rebalance the system that serves persons with I/DD by expanding cost-effective policies that honor the choices of individuals to live in the most integrated setting to meet their needs, identifying and providing supports and services to meet the needs of persons when and where they need them, and transferring the inevitable savings so that more persons with disabilities have the opportunity to be included in their communities.
- Define an overall vision and commitment to the prevention of developmental disabilities and develop an integrated plan across multiple disciplines to strengthen assessment and early intervention.
- Develop and implement strategies that address the needs of families in crisis to prevent the unnecessary placement of children in any institutional setting.
- Address the current and looming direct support workforce shortage by collecting and analyzing trends regarding workforce demographics and wages, developing and promoting a peer support workforce, expanding consumer direction, and restructuring payment methodologies to ensure that the Texas Legislature has the ability to set direct service wages at levels commensurate with the value and scope of the service.
- Support the expansion of Medicaid under the federal Affordable Care Act. The expansion would have covered an additional 1.2 million Texans by 2016.
- Empower self-advocates and their families to fully benefit from the new federal home and community based settings guidelines in areas of individual privacy, control over one's schedule and activities, money management, visitors, and community involvement.
- Explore less restrictive alternatives to guardianship, such as supported decision-making, and direct the courts to determine whether alternatives could meet the needs of the person rather than guardianship.
- Jointly adopt and implement the Employment-First policy by the Health and Human Services Commission, Texas Education Agency, and the Texas Workforce Commission.
- Establish goals to increase the number of individuals in integrated, competitive employment and to decrease the number of individuals in workshops earning sub-minimum wage.

The *2014 Texas Biennial Disability Report* outlines the details of current policies and the opportunities Texas has to strengthen the continuum of support for individuals with developmental disabilities and their families. TCDD and TOPDD look forward to engaging policy makers in a meaningful, informed discussion over the next biennium about what is needed to move the Texas long-term services and supports system forward to serve individuals and families with efficiency and promptness.

About Developmental Disabilities

The Developmental Disabilities Assistance and Bill of Rights Act (DD Act) of 2000 (P.L. 106-402) defines a developmental disability as a severe chronic disability of an individual five years of age or older that:

- is attributable to a mental or physical impairment or combination of mental and physical impairments;
- is manifested before the individual attains age 22*
- is likely to continue indefinitely;
- results in substantial functional limitations in three or more of the following areas of major life activity:
    - self-care
    - receptive and expressive language
    - learning
    - mobility
    - self-direction
    - capacity for independent living
    - economic self-sufficiency
- Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

*An individual from birth to age 9, inclusive, who has a substantial developmental delay or specific congenital or acquired condition, may be considered to have a developmental disability without meeting 3 or more of the criteria described in clauses (i) through (v) of subparagraph (A) if the individual, without services and supports, has a high probability of meeting those criteria later in life.

About Preventable Developmental Disabilities

Huge strides have been made in the prevention of intellectual and developmental disabilities (I/DD). Each year, our nation prevents thousands of developmental disabilities through increased screenings, dietary supplements, vaccines, preventative safety measures and early interventions. In an ever-changing society, these successes have established a solid foundation to build on and advance the charge of prevention. Texas is well positioned to focus on the future and strategically expand prevention efforts, thus improving outcomes for Texas children.
The integration of prevention into the full range of existing health and human services is critical because it is cost effective, simple and provides opportunities to reach large populations with consistent messaging. Secondary disabilities, including mental illness, are those that are connected with a primary disability but were preventable. For instance, a child who has a speech/language disorder and receives appropriate and timely intervention could avoid serious reading problems in the future.

Research indicates that 95% of individuals with a primary developmental disability also experience secondary disabilities. Mental illness, disrupted school experiences, trouble with the law, confinement, inappropriate sexual behavior and alcohol/drug problems are all experiences and challenges commonly facing individuals with a developmental disability. Secondary disabilities can reasonably be avoided or mitigated through improved interventions and support for the individual and family. The needs of people with I/DD must be addressed holistically and integrated in the many areas of service available.

Research on epigenetics is revealing that genetics related to I/DD is far more complex than it was once considered. The good news in this research is it is demonstrating that genes can be "turned on" and "turned off," providing increased opportunities for prevention. This research is in its infancy but it promises to revolutionize prevention. As systems apply the new knowledge of protective and risk factors, they can mitigate risk. For instance, the research on the impact of stress and nutrition on a fetus, infant or child is demonstrating both the power of prevention and the consequences of missing prevention opportunities. Texas is working with national experts who can bring the latest research to guide the system in building a healthier future for the children of Texas.

About the Texas Council for Developmental Disabilities

The Texas Council for Developmental Disabilities (TCDD) is governed by a 27-member board appointed by the Governor. At least 60 percent of the members of the board are individuals with developmental disabilities, parents of young children with developmental disabilities, or family members of people with developmental disabilities who are unable to represent themselves.

Members also include Texas state agency representatives from agencies that provide key services and supports to individuals with developmental disabilities: the Department of Aging and Disability Services, the Department of Assistive and Rehabilitative Services, the Department of State Health Services, the Health and Human Services Commission, and the Texas Education Agency. Disability Rights Texas (the state's legal protection and advocacy agency), the Texas Center for Disability Studies at The University of Texas, and the Center on Disability and Development at Texas A&M University are also agency members.

TCDD is guided by the federal Developmental Disabilities Act (DD Act) that says that individuals with developmental disabilities and their families should participate in the design of, and have access to, needed community services, individualized supports, and assistance that promote self-determination, independence, productivity, and integration and inclusion in all areas of community life, through culturally competent programs. Specifically, the federal Developmental Disabilities Act (DD Act) directs TCDD to engage in:

- systems change (example: the way agencies and other organizations do business to improve outcomes for individuals with developmental disabilities (DD) and families),
- advocacy (example: educating policy makers about unmet needs), and
- capacity building (example: helping communities grow their resources).

TCDD is established as a state agency by state and federal law to support and promote community inclusion and integration of people with developmental disabilities. The Council uses information about the system of service provision, disability-related issues, and consumer needs to develop projects and activities that address gaps and barriers in services and supports in order to help the estimated 489,500 Texans with developmental disabilities live, work, and contribute to their communities.

Texas Council for Developmental Disabilities Members

Member	City
Mary Durheim (Chair)	Spring
Andrew Crim (Vice-Chair)	Fort Worth
Hunter Rebecca Adkins	Lakeway
Kimberly Blackmon	Fort Worth
Kristine Clark	San Antonio
Gladys Cortez	McAllen
Kristen Cox	El Paso
Mateo Delgado	El Paso
Stephen Gersuk	Plano
Diana Kern	Cedar Creek
Ruth Mason	Houston
Scott McAvoy	Cedar Park
Michael Peace	Poteet
Dana Perry	Brownwood
Brandon Pharris	Beaumont
David Taylor	El Paso
Lora Taylor	Houston
John Thomas	Abilene
Richard Tisch	Spring
Member (Alternate)	**Agency**
Mary Faithful (Patty Anderson)	Disability Rights Texas
Penny Seay	Texas Center for Disability Studies (UT Austin)
Michael Benz (Amy Sharp)	Center on Disability and Development (Texas A&M)
Nancy Walker (April Young)	Health and Human Services Commission
Penny Larkin	Texas Department of Aging and Disability Services
Sara Kendall	Texas Department of Assistive and Rehabilitative Services
Manda Hall, MD (Ivy Goldstein)	Texas Department of State Health Services
Cindy Swain (Barbara Kaatz)	Texas Education Agency

About the Texas Office for Prevention of Developmental Disabilities

The Texas Office for Prevention of Developmental Disabilities (TOPDD) is administratively attached to the Health and Human Services Commission. TOPDD is a public-private partnership overseen by an executive committee with members appointed by the Governor, Lieutenant Governor, and the Speaker of the House.

Importance of the Structure of the Office:

- It is instrumental in the fundraising efforts of the Office.
- Since the Office began, the state has only paid for approximately 20% of TOPDD's budget, while the Office has raised 80%.
- It facilitates the active involvement and leadership of organizations in the state.
- Over 100 leaders representing diverse entities plan and organize the work of TOPDD.
- It allows TOPDD to facilitate the development of public policy to prevent developmental disabilities, which would not be possible without its independence.
- Public policy development is a core function of TOPDD.

Major Areas of Focus:

The majority of the Office's work focuses on fetal alcohol spectrum disorders, brain injury and co-occurring developmental disabilities with mental illness. TOPDD also assesses the full range of preventable developmental disabilities to better position the state to implement targeted prevention strategies. The Office develops reports and updates on these issues:

- Spearheading state planning
- Developing resources
- Educating and engaging stakeholders
- Convening leaders to facilitate collaboration
- Integrating prevention across systems
- Improving public policy

TOPDD is the only state entity building a coordinated and focused prevention approach that uses the latest research to minimize the incidence and severity of preventable developmental disabilities.

Texas Office for Prevention of Developmental Disabilities Members

TOPDD Executive Committee Members:
Richard Garnett, Ph.D, Chair
Marian Sokol, Ph.D, MPH, Vice-Chair
Ashley Givens
Valerie Kiper, DNP, MSN, RN, NEA-BC
State Representative Elliott Naishtat
State Representative Ron Simmons
Mary Tijerina, PhD, MSSW
Joan Roberts-Scott

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The Honorable Ernie Glenn, Bexar County Felony Drug Court Judge

Don Hall, LCDC, Counselor, SEARCH Homeless Services

Stevie Hansen, Chief of Addiction Services, MHMR Tarrant County

Lisa Harrison-Ramirez, Coordinator, Women's Substance Abuse Services , Mental Health & Substance Abuse, Texas Department of State Health Services

The Honorable Bonnie Hellums, 247th District Court Judge

Susan Homan, M.D., FAAP, Physician, Developmental/Behavioral Pediatrics

Carole Hurley, J.D., Attorney at Law

Linda Kagey, LCDC, Counselor, Linda Kagey Counseling

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Mimi Martinez McKay, Information Services, Texas Department of State Health Services
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Gloria Moore, Community Advocate
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Report Methodology

This *2014 Texas Biennial Disability Report* is a collaborative report prepared by the Texas Council for Developmental Disabilities (TCDD) and the Texas Office for Prevention of Developmental Disabilities (TOPDD).

This report updates the Texas specific data contained in the *2012 Texas Biennial Disability Report* as directed by Texas Government Code Title V, Chapter 531 (See Appendix A) that asks for a summary of the state of developmental disability services in Texas. In responding to the state request for projections of future demand, TCDD and TOPDD reviewed national data comparing Texas and national spending on Medicaid residential facilities, intermediate care facilities, and home and community based services. The most recent national data was compiled in 2012 and is provided here.

TCDD and TOPDD reviewed and synthesized information from a variety of sources including peer-reviewed academic articles, state and national research reports, and demographic data and projections. Data were obtained from the Texas State Data Center, and Texas health and human service agencies including the Health and Human Services Commission, the Department of Aging and Disability Services, the Department of Assistive and Rehabilitative Services, the Department of State Health Services, and the Department of Family and Protective Services.

A detailed analysis is provided of the policy actions taken by the United States Congress, as well as the 83rd Texas Legislature that impact persons with developmental disabilities. The anticipated federal policy impact of federal health care, workforce innovation, and Medicaid home and community based settings are included. Texas policy related to state supported living centers, Medicaid managed care, employment first, guardianship, services for individuals with complex needs, and the co-occurrence of developmental disabilities and mental health are discussed.

This report summarizes information from the Sunset Advisory Commission, which conducted its review of health and human service agencies this year and made recommendations for each agency. The Sunset recommendations, if approved by the Legislature, will significantly change the way Texas provides long-term services and supports in our state moving forward.

State of the State for Developmental Disabilities

Demand for publicly funded developmental disabilities services is growing nationwide and has been increasing at a rate slightly greater than population growth alone. Increased demand is the product of several factors including a reduction in large congregate and institutional options, the increased utilization and capacity of community services and supports that better meet the needs of individuals and families, and the increased longevity of people with developmental disabilities. The following sections discuss these current and future trends in service demand and how Texas compares with other states providing services to those with intellectual and developmental disabilities (I/DD.)

Disability Rates in Texas

The term "developmental disabilities" refers to a group of conditions or disabilities that occur prior to or at birth, or during childhood (before age 22), and result in substantial functional limitations in three or more life activity areas (self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency) and reflect the individual's need for individualized supports and assistance.[1] Individuals with such functional limitations may have various diagnoses such as intellectual and developmental disabilities, cerebral palsy, epilepsy, autism, severe learning disabilities, brain injuries, and others that may impact intellectual or physical function. People with developmental disabilities may need assistance throughout life in self-care, housing, employment, and social interaction. It is estimated that the rate of developmental disabilities is 1.5-2.5% of the population.[2] In Texas with a population of 26.4 million, this translates to approximately 489,500 or more state residents with developmental disabilities.

Rates of Select Preventable Developmental Disabilities

Fetal Alcohol Spectrum Disorders

The Behavioral Risk Factor Surveillance System (BRFSS, 2011) found that 43.8% of women ages 18-44 in Texas drink, with 11.4% engaging in binge drinking (4 or more drinks in one sitting). Additionally, the Pregnant Risk Assessment and Monitoring (PRAMS, 2011) report found that 44.3% of women in Texas reported drinking three months before they were pregnant. These figures are similar to national figures for women. National studies indicate that one in eight

[1]The Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Public Law 106 – 402106th Congress)
[2] *Intellectual Disability: Definition, Classification, and Systems of Supports*, 11th Edition. (2011). Washington, DC: American Association on Intellectual & Developmental Disabilities.

women continue to drink during pregnancy. The prevalence of Fetal Alcohol Spectrum Disorder (FASD) may be as high as one to five percent in the United States. This is higher than the prevalence of autism spectrum disorders. Given that the drinking rates in Texas are similar to national rates, it is a reasonable to assume that the national rates of FASD are reflected in Texas.

Brain Injury Prevention

According to the Texas Traumatic Brain Injury Advisory Council Report from 2007, approximately 3,500 children ages 0-19 suffer a brain injury each year, with about one third of those injuries resulting in a lifelong disability. Common causes of brain injury in children include transportation and bicycle accidents, along with sports related injuries, falls, and physical abuse/neglect. Leaders in Texas working on injury prevention could benefit from sharing and collaborating but they often do not know of each other's work. Texas needs to connect and recognize the outstanding leaders in child safety and is doing so
through TOPDD.

Co-occurring Developmental Disabilities and Mental Illness

The prevalence of mental illness among individuals with developmental disabilities ranges from 30 to 40% (Quintero & Flick, 2010). Few systems are designed to identify and meet the needs of people with developmental disabilities and mental health disorders. Health and human services systems are not designed to identify or treat co-occurring developmental disabilities and mental illness. Consequently, individuals with these co-occurring disorders often are viewed as willfully non-compliant and "fail.” This creates the revolving door and escalation of needs and services, along with further decline of the individuals. This leads to incredible costs for our systems and devastating results for the people being treated inappropriately. TOPDD recently launched a new, intensive study of this issue in Texas and is currently working on recommendations.

Trends in Service Demand

The movement toward community living for all persons with developmental disabilities has been gaining momentum. Being part of the community and living as independently as possible are among the most important values and goals shared by people with disabilities and their families. Individuals with disabilities continue to express a desire for access to services in a timely manner without having to wait for services; to receive services in the most integrated setting; and to have choice in deciding how services are delivered. Surveys indicate individuals with disabilities have the same goals as their neighbors — they want to have access to quality health care, have meaningful relationships, and be able to work and build assets needed to be independent and productive members of the community.

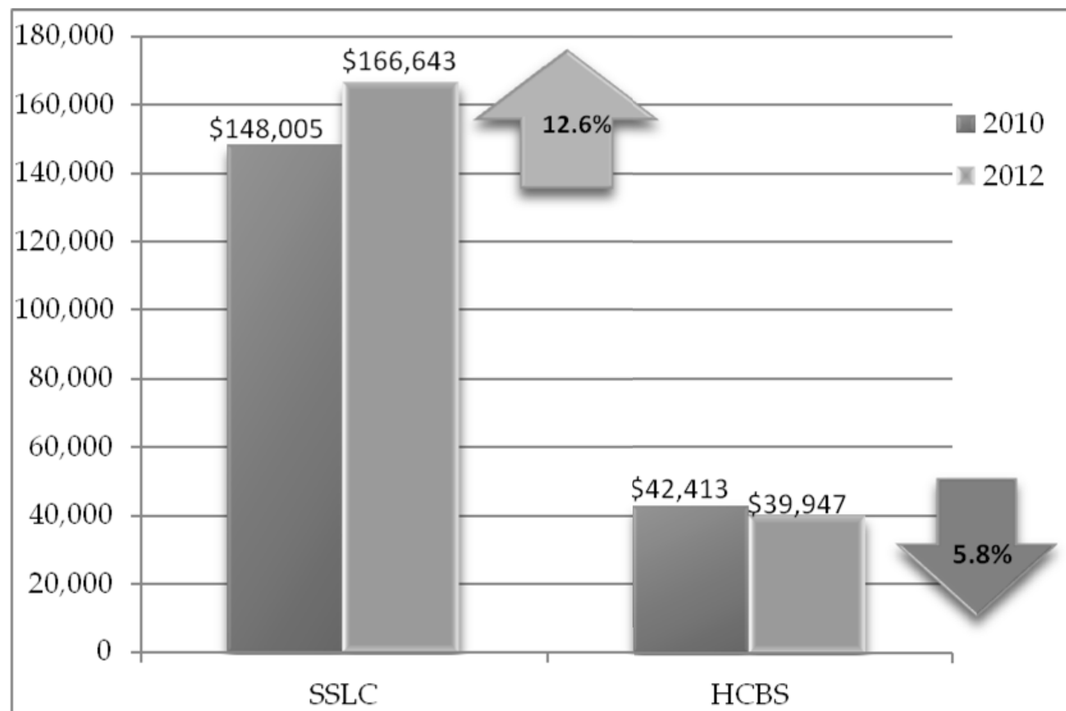
Despite this movement, Texas is one of the few remaining states that maintain a large system of public residential institutions for this population. Texas developed this system of centers over many years, housing as many as 13,700 residents when placing people with I/DD in institutions was the norm. Today, the vast majority of people with I/DD live in the community, and the 13 centers house only about 3,362 people. Yet maintaining this large system of state-run facilities is costly, involving a budget of $661.9 million a year.[3] Despite transitioning many residents into the community, Texas has not closed a facility since the 1990s.

Although the service delivery system for people with I/DD has shifted to the community, Texas has chosen not to eliminate, but to only downsize the State Supported Living Centers (SSLCs), maintaining this costly infrastructure. Delivering services to a person for a year in an SSLC costs approximately $113,000 more than serving people with similar levels of need in a community based program. In fiscal year 2013, DADS employed about 16,000 staff, 80 percent of whom worked in state supported living centers around the state.[4]

[3] Sunset Advisory Commission Staff Report, Department of Aging and Disability Services, May 2014.
[4] Ibid

Texas annual expenditures per resident in an SSLC were $148,005 in 2010 and $166,643 in 2012, a 12.6% increase.[5] Expenditures for home and community based services participants were $42,413 in 2010 and $39,947 in 2012, a 5.8% decrease.[6]

Total Annual Expenditures Per Resident in a State Supported Living Center and Home andCommunity Based Service Recipient



The situation is exacerbated by the fact that Texas, for several decades, has been one of the fastest growing states. Between 2000 and 2010, the Texas population grew by 21%, from 20.8 million to 25.1 million[7], while the U.S. population increased by 10%.[8] Data from the Texas State Data Center suggest that the population of Texas could grow from 26.4 million in 2014 to 54.3 million by 2040.[9]

[5] "3.A. Strategy Request: 82nd Regular Session, Agency Submission, Version 1 Automated Budget and Evaluation System of Texas (ABEST), Goal 1.8.1." *Budget & Data Management*. Department of Aging and Disability Services. 2010:1.
[6] Ibid
[7] 2014 Preliminary Population Projections by Migration Scenario for Texas – Report Texas State Data Center Projections Report (0.5 migration rate)
[8] *U.S. and State Decennial Census Population Counts, 1990-2010*. Bureau of Business & Economic Research. 22 Dec. 2010. Web. 10 Sept. 2012. http://bber.unm.edu/census/2010States.htm.
[9] 2014 Preliminary Population Projections by Migration Scenario for Texas – Report; Texas State Data Center Projections Report (0.5 migration rate)

Given such growth, it will be an extraordinary challenge to address the current backlog of unmet needs for long-term services while simultaneously keeping pace with population-driven growth in demand.

Trends in Home and Community Based Services

Nationally, the number of people with I/DD known to the state I/DD agencies or receiving residential services through a state I/DD agency increased from 693,691 in 1998 to 1,138,121 in 2012 (an average increase of 31,745 people per year). The number of people with I/DD living in a home they own or rent nearly doubled from 62,669 in 1989 to 122,664 in 2012. Similarly, the number of people living in the home of a family member also nearly doubled, increasing from 325,650 in 1998 to 634,988 in 2012.[10]

These trends have forced many states to reexamine how services are provided to people with developmental disabilities. Public policies increasingly support consumer choice and the rights of people with developmental disabilities to live with their families or in communities of their choice.[11] These policies are the result of research, advocacy, and federal actions such as the Americans with Disabilities Act, the Individuals with Disabilities Education Act, and the U.S. Supreme Court decision in Olmstead v. L.C. 527 U.S. 581 (1999). Initiatives in Texas have been consistent with these trends that promote the provision of services in the least restrictive manner possible and the philosophy that individuals should be supported to make decisions concerning their own lives.

To further reduce unnecessary institutionalization, Congress authorized the Money Follows the Person (MFP) program (2005) to help states decrease the number of people with disabilities living in Medicaid institutions. The legislation provided a system of flexible and supplemented financing for long-term services and supports to assist states in moving people to smaller more integrated, appropriate and preferred settings. Texas has been active in promoting independence and transition from institutional settings to the community for almost 15 years.

[10] Larson, S.A., Hallas-Muchow, L., Aiken, F., Hewitt, A., Pettingell, S., Anderson, L.L., Moseley, C., Sowers, M., Fay, M.L., Smith, D., & Kardell, Y. (2014). *In-Home and Residential Long-Term Supports and Services for Persons with Intellectual or Developmental Disabilities: Status and trends through 2012*. Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration.
[11] Heller, T., Stafford, P., Davis, L.A., Sedlezky, L., and Gaylord, V. (Eds.). "Impact: Feature Issue on Aging and People with Intellectual and Developmental Disabilities. Volume *23* (1)." Minneapolis: University of Minnesota, Institute on Community Integration and Research and Training Center on Community Living. 2010:2.

In response, the Medicaid program today includes multiple community-based mechanisms through which states can request funds. Medicaid long term services and supports are increasingly provided to people with I/DD living in the home of a family member, a host home or the person's own home, as well as various sizes and types of community group home settings. Medicaid community based long-term services and supports include but are not limited to service coordination/case management, homemaker, home health aide, personal care, adult day services, day and residential habilitation, and respite care.

Trends in Capitated Service Delivery and Managed Care

A most notable trend has been the growth in the delivery of long-term services and supports through capitated Medicaid managed care programs. Specifically, Medicaid (CMS) Section 1115 Research and Demonstration Projects allowed states the flexibility to test new or existing approaches to financing and delivering Medicaid services including the option to provide home and community based services through a Managed Care Organization (MCO). Similarly, states could amend their Medicaid State Plan under the 1932(a) federal authority to implement a managed care delivery system. Finally, Section 1915(a) and (b) Managed care waivers allow states to use managed care delivery systems. A joint program (between 1915(c) and 1915 (b) waivers – also referred to as 1915b/c waivers) allows states to implement two types of waivers at the same time as long as all federal requirements were met for both programs. As of 2014, 26 states have contracts with MCOs to deliver long-term care for seniors and individuals with disabilities.[12]

More states are now turning to Medicaid managed care to control long term services and supports (LTSS) costs. Although managed care organizations can make budgeting more predictable, there is little definitive evidence about whether they actually save money or improve outcomes for individuals with disabilities. Further, states must contend with rising expenses for those individuals who are "dual-eligible" — those who are covered by both Medicare and Medicaid.[13] Poor coordination between the two programs has led to inefficient delivery of services and confusion among program recipients and providers. A detailed summary of Medicaid Managed Care Reform in Texas is provided later in this report.

[12] "States Turn to Managed Care To Constrain Medicaid Long-Term Care Costs". Agency for Healthcare Research and Quality. 2014-04-09. Retrieved 2014-04-14

[13] Managed Care for People with Disabilities: Policy and Implementation Considerations for State and Federal Policymakers. National Council on Disability. March 18, 2013.

Trends in the Aging of Individuals with Disabilities and Their Caregivers

There are an estimated 641,000 adults age 60 and older with I/DD in the United States and the numbers are expected to double in the next two decades. The average life expectancy of people with I/DD was just 22 years in 1931 but is now 63 years for males and 69 years for females.[14] The causes of death for all individuals with developmental disabilities are similar to those of the general population (i.e., coronary heart disease, type 2 diabetes, respiratory illnesses, and cancer). At these rates, the number of American adults with I/DD aged 60 years and older is projected to reach 1.2 million by 2030.[15]

As they age, people with I/DD seek the same outcomes as people without disabilities, such as maintaining their physical and mental health and the ability to function as independently as possible, actively engaging with life through friendships, contributing to society, and meaningfully participating in community life. However, older adults with I/DD are often more vulnerable to conditions that will make their old age potentially more difficult. In comparison with adults without long-term disabilities, adults with I/DD are more likely to experience earlier age-related health changes, limited access to quality health care, and fewer financial resources. In addition, they are more likely to be living with parents into adulthood and have more limited social supports outside the family.

Although most adults with I/DD live with their families, just 7.1% of funding for I/DD services is for state-provided, community-based services for individuals living in the family home.[16] Without a mandate for support to adults with I/DD and their families, most will receive few support services and face long residential services waiting lists.[17] An urgent need exists for aging adults with I/DD and their families to have access to quality supports that address their age-related health and social changes in the face of aging family caregivers who may no longer be available for care. Already, more than 25% of family care providers are over the age of 60 years and

[14] Centers for Disease Control and Prevention: Faststats: Life Expectancy, 2014. Accessed http://www.cdc.gov/nchs/fastats/life-expectancy.htm

[15] Janicki, M.P., Dalton, A.J., Henderson, C.M., and Davidson, P.W. "Mortality and Morbidity Among Older Adults With Intellectual Disability: Health Services Considerations." *Disability and Rehabilitation, 21*. 1999:284–294.

[16] Ibid

[17] Lakin, K.C., Larson, S., Salmi, P. & Scott, N. (2009). Residential services for persons with developmental disabilities: Status and trends through 2008. Minneapolis: Research and Training Center on Community Living, Institute on Community Integration, University of Minnesota.

another 38% are between 41-59 years[18]. With the growing life expectancy of the individual and the aging of the informal caregiver, the system will be stretched further to absorb the new demand.

Texas' Rank in the Nation

Among the more than 60 million citizens who rely on Medicaid are about 9 million nonelderly people with disabilities, including 1.4 million children. While people with disabilities constituted 16.5% of Medicaid enrollees in fiscal year (FY) 2008, expenditures on their behalf represented 44 percent of total Medicaid spending.[19] The proportion of total Medicaid expenditures spent on long-term supports for people with I/DD declined from 12.0% to 9.0%. It has remained below 10.3% since 1992.[20] Nationally, there has been a fundamental rebalancing of spending on individuals with disabilities in institutions as compared to spending on HCBS in the years since the *Olmstead* decision.

Further, the population of individuals with disabilities under 65 in nursing homes actually increased between 2008 and 2012. This is true even though 38 studies over the past seven years have clearly demonstrated that providing HCBS is more cost-effective than providing services in an institution[21] – it costs less money to provide needed services in a community setting than an institution.

Since the Texas Council for Developmental Disabilities (TCDD) detailed the gaps in the Texas service system in 2008[22], TCDD has advocated for more investment in home and community based services and less emphasis on large congregate facilities. In 2009, the 81st Texas Legislature increased funding for community services, but simultaneously increased funds for SSLCs, which maintained significant expenditures for institutional care. Similarly, in 2011, the 82nd Texas

[18] Braddock, D., Hemp, R., & Rizzolo, M.C. (2008). The state of the states in developmental disabilities: 2008. Boulder, CO: University of Colorado, Coleman Institute for Cognitive Disabilities and Department of Psychiatry.
[19] Medicaid and CHIP Payment and Access Commission, "MACStats, Table 9," in Report to Congress: The Evolution of Managed Care in Medicaid (Washington, DC: Medicaid and CHIP Payment and Access Commission, June 2011).
[20] Larson, S.A., et.al (2014). In-Home and Residential Long-Term Supports and Services for Persons with Intellectual or Developmental Disabilities: Status and trends through 2012. Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration.
[21] US Senate HEALTH, EDUCATION, LABOR, AND PENSIONS COMMITTEE, Tom Harkin, Chairman "Separate And Unequal: States Fail To Fulfill The Community Living Promise Of The Americans With Disabilities Act." July 18, 2013
[22] Agosta, John, Jon Fortune, Drew Smith, Kerri Melda, Robert Gettings, and Valerie Bradley. *Closing the Gaps in Texas: Improving Services for People with Intellectual and Developmental Disabilities*. Texas Council for Developmental Disabilities. Oct. 2008:7.

Legislature maintained funding for SSLCs and actually decreased funding for community ICF facilities and Medicaid waiver programs. Thus, the imbalance in the Texas system that favors institutional care remains strong, despite some relative increases in community services.

Children Living in Institutions

The stated policy of Texas is that all children should grow up in families whenever possible and that all institutional placements of children are to be considered temporary.[23] Texas has been successful in moving more than 2,100 children from institutions to families since 2003 and a similar number have moved to less restrictive environments.[24]

Despite these successes, approximately 1,259 children and young adults with developmental disabilities still resided in long-term care institutions as of August 2013.[25] In SSLCs, there were 203 children (6% of total SSLC census). Of the 116 new admissions (September 2013 to August 2014), 42 were children (36%). This is down from 50% in 2009 (88 children of 177 new admissions). These numbers represent the efforts Texas is making to expand community supports. (See Table 1)

Table 1: Number of Children Residing in Institutions (2013)

Nursing Facilities	Small ICF	Medium ICF	Large ICF	SSLC	HCS	DFPS Licensed Facility	TOTAL
70	233	48	16	203	640	49	1,259

*Data reflect the number of children residing in an institution as of August 31, 2013.
**Of the 1,259 children in institutions, 842 are ages 18-21

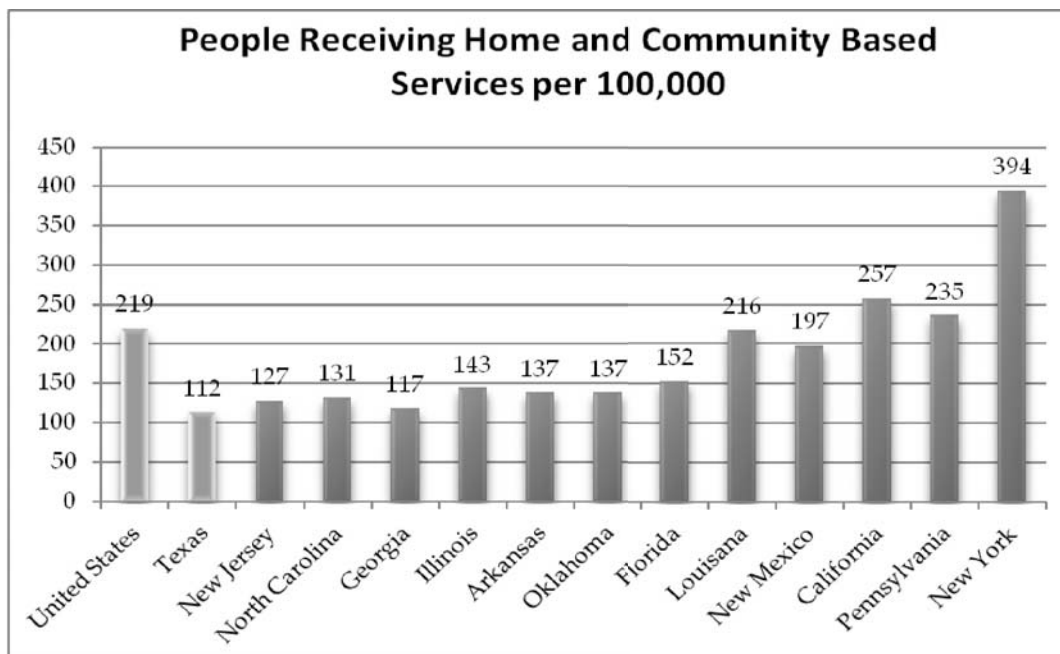
The Department of Aging and Disability Services (DADS) received federal approval last fall to create a new target group in the Home and Community-based Services waiver for children who live in General Residential Operations or group homes for children with I/DD in Child Protective Services. Thus, children living in congregate foster care settings will now have the opportunity to grow up in a family environment with the use of Home and Community-based Services Host Homes.

[23] *Senate Bill 368 77 (R) Bill Analysis.* Texas Legislature Online. Web. 2 October. 2014 http://capitol.state.tx.us/tlodocs/77R/analysis/html/SB00368F.htm.
[24] Permanency Planning and Family-Based Alternatives Report, Texas Department of Aging and Disability Services, January 2013 www.hhsc.state.tx.us/reports/2014/SB368-Permanency-Planning.pdf Jan 14
[25] Ibid.

Home and Community Based Spending

Texas overall has a relatively low utilization rate for Medicaid home and community based services of 112 people per 100,000 of the state population.[26] This compares to the national average of 219 people per 100,000 (as shown in Chart 1). Only two states have lower home- and community-based services utilization rates than Texas – Mississippi and Nevada.[27]

Chart 1. Home and Community Based Service Utilization



[26] I Larson, S.A., Hallas-Muchow, L., Aiken, F., Hewitt, A., Pettingell, S., Anderson, L.L., Moseley, C., Sowers, M., Fay, M.L., Smith, D., & Kardell, Y. (2014). *In-Home and Residential Long-Term Supports and Services for Persons with Intellectual or Developmental Disabilities: Status and trends through 2012*. Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration.
[27] Ibid

In FY 2012, Texas provided services and supports for 29,193 individuals with I/DD through the Medicaid home and community based service waiver programs and spent a total of $1.05 billion on home and community based service waiver programs for persons with I/DD.[28]

Table 2. Monthly Expenditures for Home and Community Based Waivers

Medicaid Waiver	Population Served	Average Number Persons Served/Month	Monthly Cost Per Person	Annual Expenditures
Community Based Alternatives	Age 21 and over with need for nursing home level of care	9,553	$1,265	$146,496,512
Community Living Assistance and Support Services	All ages with related condition such as cerebral palsy or epilepsy and eligibility for ICF/IID admission	4,671	$3,610	$202,977,068
Deaf Blind with Multiple Disabilities	All ages with deaf-blindness and eligibility for ICF/IID admission	150	$4,257	$7,728,434
Home and Community-based Services	All ages with intellectual disability or related condition with IQ of 75 or below, and eligibility for ICF/IID admission	20,159	$3,489	$846,609,878
Medically Dependent Children Program	Under age 21 with need for nursing home level of care	2,291	$1,444	$39,818,738
Texas Home Living	All ages with intellectual disability or related condition with IQ of 75 or below, and eligibility for ICF/IID admission	4,611	$870	$48,308,518

[28] Larson, S.A., Hallas-Muchow, L., Aiken, F., Hewitt, A., Pettingell, S., Anderson, L.L., Moseley, C., Sowers, M., Fay, M.L., Smith, D., & Kardell, Y. (2014). In-Home and Residential Long-Term Supports and Services for Persons with Intellectual or Developmental Disabilities: Status and trends through 2012. Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration.

Texas has a higher proportion of Medicaid long-term care recipients in ICF programs compared to the national rate.

- Of all Medicaid long-term care recipients nationally, 88.9% received home and community based services and 11.1% received services in an ICF[29]
- In Texas, 75.5% of Medicaid long-term care recipients received services from home and community based programs and 24.5% received services from ICF.[30]

Texas also spends a greater proportion of its Medicaid dollars on institutional care than almost all other states. Texas ranks second highest in the nation (after New York) with ICF expenditures now exceeding $1.03 billion.[31]

Evidence Based Practices

Research advancements have changed the way that we understand the human brain. However, the majority of state systems and approaches were developed long before this critical research occurred. Today's research has tremendous implications for policy makers and many of the best researchers are located in Texas. Brain research has pinpointed where problems exist in the brain and behavior research has demonstrated what interventions are effective. The Infant and Toddler Courts in Texas are a great example of demonstrating how using more science-based approaches can boost success. Science based policies would reduce waste and improve outcomes to better meet the needs of the citizens of Texas.

Consumer Satisfaction

Section §2114.002 of the Texas Government Code, requires that Texas state agencies biennially submit to the Governor's Office of Budget, Planning, and Policy and the Legislative Budget Board information gathered from customers about the quality of agency services. The state compiles the results of over 119,000 individual survey responses from 34 surveys conducted by health and human service agencies.[32]

[29] Larson, S.A., et.al.. (2014). In-Home and Residential Long-Term Supports and Services for Persons with Intellectual or Developmental Disabilities: Status and trends through 2012. Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration.
[30] Ibid
[31] Ibid
[32] Texas Health and Human Service System 2014 Report on Customer Service, June 2014.

The Long-Term Services and Supports Quality Review (LTSSQR) is one of the largest surveys conducted to assess the satisfaction, quality of care, and quality of life of individuals who receive long-term services and supports. The most recent LTSSQR was published in January 2013, and is based on data collected in 2009 and 2010.[33]

The following outcomes in services and supports were reported by consumers across programs:

- Most people received the services they needed and were satisfied with information about how to access services and support
- Long-term services and supports facilitate personal goals, health, and well being
- At least three of four people reported feeling happy
- Access to transportation
- Choice to decide how to spend free time

The following areas in need of improvement were reported by consumers across programs (*in no particular order*):

- Community inclusion
- Feeling lonely often
- Access to timely preventive care
- Autonomy to take risks
- Choice of staff or case manager
- Control over transportation and spending money
- Privacy when visiting with guests
- Work opportunities in the community

Consumer satisfaction with services among persons with I/DD is also measured by the National Core Indicators (NCI) survey, a collaborative effort that began in 1997 between the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI). NCI collects data on five core indicators: Individual Outcomes;

[33] *Long-Term Services and Supports Quality Review 2010*. Texas Department of Aging and Disability Services. January 2011:41.

Health, Welfare, and Rights; System Performance; Staff Stability; and Family Indicators. Texas has been an NCI State since 2005-06. NCI is a voluntary effort used by multiple states to evaluate and support efforts to improve system performance and better serve consumers. NCI survey respondents are individuals with developmental disabilities and their families. With approximately 29 states participating, Texas can examine its own outcomes, and measure its progress against national averages of the same measure. Specific results of the NCI survey[34] are highlighted below.

Approximately 81% of the Texas respondents report that they do get the services they need, which is similar to the average of all NCI states (82 percent).

Texas respondents report less choice than the average of responses from other NCI states[35]:

- 46% of Texas respondents reported choosing or having input in choosing where they live, which is lower than the average of all NCI states (60%).
- 72% of Texas respondents reported that they choose or help decide their daily schedule, which is considerably lower than the average of all NCI states (81%).
- 74% of Texas respondents reported helping to make their service plan, which is lower than the average of all NCI states (85%).
- Approximately 59% of Texas respondents chose or were aware they could change their case manager or service coordinator, which is similar to the average of all NCI states (60%). Approximately 54% reported they could request a change if needed.
- 19% of Texas respondents use the Self-Directed Supports Option which is higher than the average of all NCI states (11%). **not all states offer this option*

NCI Indicators also suggest Texas respondents are less involved in community employment[36]:

- Only 9% of Texas respondents reported being in a community paid job, which is lower than the average of all NCI states (15%).
- 69% of Texas respondents go to a day program or do other activities during the day. This is similar to the average of other NCI states (72%).

[34] National Core Indicators Adult Consumer Survey 2012-2013, National Association of State Directors of Developmental Disability Services and Human Service Research Institute, June 2014.
[35] Ibid
[36] National Core Indicators Adult Consumer Survey 2012-2013, National Association of State Directors of Developmental Disability Services and Human Service Research Institute, June 2014.

- Only 16% of Texas respondents reported having community employment as a goal in their service plan, which is much lower than the average of all NCI states (24%).

The quality management expectations for the operation of home and community based services (HCBS) continue to evolve. Most recently, the Centers for Medicare and Medicaid (CMS) issued new (effective March 2014) HCBS quality requirements for HCBS settings and person centered service planning. In addition, CMS revised the HCBS Quality Assurance and Sub-Assurance, which also became operative in March 2014.[37] A full description of the new HCBS rules are provided later in this report. The NCI Survey will serve as a resource to assist Texas with these and other service system reporting outcomes and service goals.

Future Demand

Texas faces difficult policy choices in responding to the needs of its citizens with intellectual and developmental disabilities in the future. This circumstance is fueled by overall population growth and the unmet demand for services, changing expectations among people with developmental disabilities and their families about where and how services are delivered, and diminished funding from state and federal sources. Texas has made significant strides and investments to ensure that individuals have the ability and right to live in the most integrated setting as required by the Americans with Disabilities Act and upheld by the U.S. Supreme Court's Olmstead decision in June 1999. Through Executive Orders GWB 99-2 and RP-13, Texas made a strong commitment to provide community-based services to individuals and ordered the development of a Texas Olmstead plan. Since the development of the Texas Promoting Independence Plan in 2001, over 41,000 Texans with disabilities, both old and young, have moved from institutions to the community, where services on average cost significantly less than in institutions. Legislative appropriations have consistently provided resources for expansion of home and community-based services; however, funds have not kept up with demand resulting in extensive interest lists for these programs.

[37] National Core Indicators Adult Consumer Survey 2012-2013, National Association of State Directors of Developmental Disability Services and Human Service Research Institute, June 2014.

Interest List for Home and Community Based Services

When demand for the Medicaid community-based services and supports outweighs available resources, consumers can choose to put their names on an interest list until services become available. Applicants are placed on interest lists on a first-come, first-served basis and will be contacted when services become available.[38] Service availability occurs when the legislature allocates funds to include more persons in a waiver or when an existing participant vacates services.

The Centers for Medicare and Medicaid Services (CMS) approved the use of managed care strategies in the provision of long term services and supports under the condition that all SSI eligible individuals with a medical necessity for nursing facility services were automatically enrolled in the STAR+PLUS LTSS waiver. This meant that as Medicaid managed care expanded across the state, all of the persons on the Community Based Alternatives (CBA) waiver waiting list were automatically assessed and, if eligible, enrolled in LTSS waiver services. The condition that resulted is the near elimination of the CBA waiting list is not anticipated in future managed care rollouts – specifically for people with I/DD. The number of people on waiting lists for other Medicaid waiver programs serving individuals with I/DD continues to increase. In Texas, it has been calculated that home-and community-based waiver services would have to expand by 334% above current spending to accommodate the needs expressed by the interest list.[39] TCDD and TOPDD recommend that in future rollouts, persons who are SSI eligible should receive long term services and supports across all waivers without a wait.

[38] Interest List Reduction. Department of Aging and Disability Services, Web. 11 Aug. 2012. http://www.dads.state.tx.us/services/interestlist/index.html.
[39] Bragdon, Tarren. *The Case for Inclusion 2012*. United Cerebral Palsy. Washington, DC. 2012:6 of 7.

Home and community based waivers provided long-term services and supports to 29,193 individuals as of June 2012,[40] and the HCS waiver presently has the largest interest list at 72,042.[41] (See Table 3).

Table 3. Interest List Summary Fiscal Years 2013 – 2014

	CBA	STAR+	CLASS	DBMD	MDCP	HCS	Total
Number of Clients on IL - September 1, 2013	6,579	5,034	48,169	543	27,012	67,201	154,538
Total Released/ Removed from IL*	10,091	17,807	1,377	317	3,765	1,372	34,729
Enrolled	1,363	910	62	6	307	445	3,093
In the Pipeline	476	5,947	794	208	1,000	672	9,097
Denied/Declined	8,252	10,950	521	103	2,458	255	22,539
Current IL - August 31, 2014	3	12,564	51,581	428	27,121	72,042	**163,739

* The counts for CBA, CLASS, DBMD, and MDCP include releases from FY12-13 that were still in the pipeline as of August 31, 2013.
** Count is duplicated. The unduplicated count is 112,819. The Unduplicated count without Star+Plus is 100,255.
*August, 2014, Texas Department of Aging and Disability Services

[40] Larson, S.A., Hallas-Muchow, L., Aiken, F., Hewitt, A., Pettingell, S., Anderson, L.L., Moseley, C., Sowers, M., Fay, M.L., Smith, D., & Kardell, Y. (2014). *In-Home and Residential Long-Term Supports and Services for Persons with Intellectual or Developmental Disabilities: Status and trends through 2012*. Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration.
[41] *Interest List Reduction*. Department of Aging and Disability Services, August 2014. Archives retrieved from: http://www.dads.state.tx.us/services/interestlist/index.html.

Individuals can wait over 10 years before receiving HCS services, with 68% waiting up to five years to receive services (See Table 4).

Table 4. Average Wait Times on Interest List - Fiscal Years 2014

Average Wait Times on Interest List	CBA	STAR+	CLASS	DBMD	MDCP	HCS
0-1 years	3	12,415	4,572	126	4,181	6,472
1-2 Years	N/A	141	5,233	105	4,769	7,923
2-3 years	N/A	3	5,574	140	4,735	8,471
3-4 years	N/A	2	6,828	57	5,253	8,584
4-5 years	N/A	N/A	6,967	N/A	4,617	8,939
5-6 years	N/A	N/A	6,243	N/A	3,566	7,834
6-7 years	N/A	N/A	5,504	N/A	N/A	6,162
7-8 years	N/A	N/A	4,779	N/A	N/A	5,210
8-9 years	N/A	N/A	3,083	N/A	N/A	4,143
9-10 years	N/A	N/A	2,348	N/A	N/A	3,209
10-11 years	N/A	N/A	450	N/A	N/A	3,132
11-12 years	N/A	N/A	N/A	N/A	N/A	1,959
12-13 years	N/A	N/A	N/A	N/A	N/A	3
13-14 years	N/A	N/A	N/A	N/A	N/A	1

*Some persons on the DBMD interest list have reached the top of the list multiple times and declined services, yet choose to remain on the list.
August 2014, Texas Department of Aging and Disability Services

In evaluating Texas benchmarks, individuals with developmental disabilities do not receive services with reasonable promptness. This is evident in the service utilization rates in Texas that are far below the national average. When an individual applies for services and is determined eligible, ideally that individual will receive services with reasonable promptness. General standards indicate that individuals with emergency or crisis needs should receive services within 90 days and individuals with critical near-term needs should receive services within six to nine months.[42] In Texas, demand for services exceeds the available service openings, as evident in its large interest list for services.

Promising opportunities exist for Texas to continue to rebalance the LTSS system and assist people to move into the community. Texas was awarded a Balancing Incentives Program grant from the Centers for Medicare and Medicaid Services that is assisting the state in developing the structural changes necessary to support people to live in the community. The grant allows the state to receive a two percent increase in the Federal Medical Assistance Percentage (FMAP) on community services through 2015. Texas also continues to participate in the Money Follows the Person Demonstration that provides enhanced match for eligible populations transitioned from nursing facilities (NF) and large and medium sized intermediate care facilities for individuals with an intellectual disability or related conditions (ICFs/IID). In addition, Texas is developing the Community First Choice option in the Medicaid State Plan and will receive a six percent increase in FMAP for services that support people in their homes once the option is implemented.[43]

Texas Sunset Review of Health and Human Service Agencies

Under state law, the Sunset Advisory Commission regularly reviews state agencies to determine effectiveness, duplication, and ways to make improvements. This biennium, all of the state's health and human services agencies, including the Texas Council for Developmental Disabilities, and the Texas Workforce Commission were reviewed.

The review process began the summer of 2014 and will continue through the 84th Texas Legislative Session in 2015.

[42] Agosta, John, Jon Fortune, Drew Smith, Kerri Melda, Robert Gettings, and Valerie Bradley. *Closing the Gaps in Texas: Improving Services for People with Intellectual and Developmental Disabilities*. Texas Council for Developmental Disabilities. Oct. 2008:
[43] Ibid

The Recommendations of the Sunset Commission[44] have significant implications if approved by the Texas Legislature by ultimately changing the way Texas provides long-term services and supports. While a list of all Sunset Review Recommendations is beyond the scope of this report, it is important to mention the following components of the recommendations that may impact persons with disabilities.

Advisory Roles and Meaningful Stakeholder Input

The Sunset Commission reported that statutory advisory groups are often difficult to administer, inflexible, and not fully accessible to the public. The review also found that many of HHSC's advisory committees are unnecessary, duplicative, and not truly accessible to the public. As these recommendations are discussed, TCDD and TOPDD strongly encourage HHSC to maintain a strategic and robust stakeholder involvement process in long-term care services and supports. The Texas service delivery system cannot be designed, implemented, or effectively evaluated without meaningful input from the individuals and families who receive services. As the Sunset Commission makes its final recommendations, HHSC must seek input that maintains a consumer voice.

System Level Expertise in Developmental Disabilities

The Sunset Commission recommended the consolidation of the current five HHS system agencies into one agency called the Health and Human Services Commission.[45] While this approach may improve administrative function, there is great potential to impact quality by diluting the already limited expertise in I/DD in the state system. Long term care services and supports must be administered and delivered by those who understand the unique aspects of I/DD and how to achieve meaningful outcomes in the service delivery system.

The Texas Council on Developmental Disabilities (TCDD) and the Texas Office of Prevention of Developmental Disabilities (TOPDD) were also reviewed by the Sunset Commission this year. TCDD and TOPDD support the continuation of TOPDD. A detailed analysis of the Sunset Recommendations and rationale for continuation are included in Appendix B.

[44] Health and Human Services Commission: Special Report. Texas Sunset Commission Staff Report Summary. October 6, 2014

[45] Ibid.

Role of Preventive Services

While the state offers many prevention services, it lacks an overall vision for prevention and an integrated plan that brings together the strengths of different disciplines in the system to provide consistent messaging and to build on each other's strengths. The state funds substance abuse prevention, child abuse prevention, child safety, tobacco cessation, etc. State agencies involved in prevention go far beyond those that are under the HHSC umbrella. While cross agency/system advisory groups exist, there does not appear to be requirements for cross-discipline and cross-agency collaboration or coordination or any accountability system to ensure collaboration. Requiring the development of a comprehensive, integrated plan for the integration of prevention would demonstrate a true commitment to prevention. Texas needs to map out measureable goals and strategies so that policy makers can demonstrate to constituents when progress is being made on these important issues.

TOPDD Action on Special Topic Areas

TOPDD facilitates two active task force groups in Texas: a Fetal Alcohol Spectrum Disorder Task Force, known as the FASD Collaborative, and the Child Safety and Injury Prevention (CSIP) Task Force. The membership of these task forces is extremely diverse and includes professionals from the following disciplines: medical, legal, mental health, education, substance abuse treatment and recovery, business, policy and others.

The FASD Collaborative

The FASD Collaborative is implementing the first-ever statewide plan on FASD, which TOPDD created through its FASD Collaborative in 2011. The plan was developed by exploring prevention needs and resources across Texas related to FASD and is a document that guides the work of the Collaborative. It addresses needs on a local, regional and statewide level. The FASD Collaborative has mobilized three active workgroups that are focusing on the following:

- Workgroup 1 Focus: The provision of FASD training and technical assistance to targeted professionals, such as medical and behavioral health providers who work with women of childbearing age
- Workgroup 2 Focus: The identification of existing and development of new Texas based epidemiology and surveillance information
- Workgroup 3 Focus: The development of policies that are guided by both Texas based and national research.

Through this work, TOPDD has engaged local and regional communities to take leadership on these goals and develop local initiatives.

Highlights of Local/Regional Initiatives

- San Antonio: TOPDD partnered with Alpha Home (a chemical dependency treatment center) to implement Project CHOICES, an evidence-based FASD prevention program, building a model that can be utilized across Texas to improve outcomes for children.
- Central Texas: TOPDD has partnered with the Central Texas Perinatal Coalition, to educate medical providers and other professionals who work with pregnant women.
- Houston: TOPDD partners with a host of organizations in Houston, including the Infant and Toddler Court, Houston Area Partnership on FAS, and the Santa Maria Hostel (a treatment facility). TOPDD has hosted several planning sessions targeting the child welfare system, has an ongoing intervention program in partnership with Santa Maria Hostel and has conducted several specialized education sessions in the region. Additionally, TOPDD has coordinated with the court system on educational projects (including as a sponsor the Keeping Infants and Toddlers Safe Conference) and has partnered with the community on several grant applications.
- Cross-Regional Initiatives: In collaboration with the Centers for Disease Control and Prevention and funding through the Meadows Foundation, TOPDD developed the FASD Training Center, a volunteer network of 160 professionals that TOPDD has trained to provide education on FASD on a regional level across Texas.

TOPDD's work on a local level has catapulted the topic of FASD to the top of larger regional and statewide training agendas, including major training events for state agencies. TOPDD's staff must increasingly rely on volunteers to conduct trainings because of the continuous increase in demand for training.

Child Safety and Injury Prevention Task Force

The Executive Committee of TOPDD conducted a needs assessment around child safety and organized key informant interviews to determine what the most pressing issues are in this field. This would help TOPDD to better target the membership for the task force. Several important issues emerged from these discussions:

1. Typically safety organizations focus either on "intentional and unintentional injury." However, this is a false separation. Parents who are accused of maltreatment seldom

intentionally harm their children. The area between intentional and unintentional injuries is extremely gray. In order to increase effectiveness, safety organizations must develop more comprehensive initiatives on prevention. As a result, TOPDD is convening organizations that are traditionally tied to either focus area. TOPDD's child safety award program brings together leaders from diverse communities working on a broad spectrum of child safety areas.

2. There is very little information-sharing or collaboration among safety organizations. Safety leaders need to learn what others are doing in the field, what research-based programs in safety exist in Texas and how to share data and information across systems. TOPDD is using Facebook and developing new communication tools to connect safety leaders on information sharing and data collection.
3. Safety leaders have tremendous knowledge and experience that would be invaluable to policy makers. However, because safety leaders are often grass roots, community-based initiatives, they often lack knowledge about how policies are made and/or changed. TOPDD is developing information that will educate safety advocates how to address policy.

One of the exciting ways that the CSIP is promoting and recognizing injury prevention work in the state of Texas is by honoring individuals and organizations that engage in this work with the J.C. Montgomery Child Safety Award, which was established by TOPDD in 2011.

Highlights of Safety Leaders

TOPDD has honored safety leaders who work in a wide-range of areas such as child protection, law enforcement, water safety, public policy related to safety, medical services, etc. Child safety is an incredibly diverse field and it is important for the state to recognize the many ways that individuals and organizations can promote safety.

Co-occurring Developmental Disabilities and Mental Illness Initiative

TOPDD has launched a new initiative on this issue through a grant from the Hogg Foundation. The goal of this work is to examine systems and policies in Texas to develop strategies that better meet the needs of this population. Many health and human services professionals have no training in identifying and working with people who have both developmental disabilities and mental illness. This can lead to recidivism, the removal of children from a family, incarceration and dangerous, life-threatening outcomes. Too often these problems become multigenerational. This is especially tragic, given that these outcomes are often preventable because they are the result of multiple failures to respond to the array of needs of the individuals.

With a staff of five people, TOPDD has educated over 2,500 professionals across the state and

facilitated over 55 trainings in the past two years. The work of preventing I/DD is extremely important for every Texan. In the coming years, Texas and the nation will experience tremendous growth of the population of older Americans. This will clearly put pressure on our health and human services systems. If Texas can be strategic about preventing disabilities in children, it will have an immediate and long-term impact on the state budget. The numbers related to prevalence and costs per incidence of preventable disability speak volumes.

TOPDD is reaching thousands of Texans and working with a wide range of systems to reduce these costs. Many children with preventable disabilities have tremendous talents, but have life dreams that can never be realized because of their disabilities. Ultimately, the Office seeks to make it possible for all children in Texas to reach their full potential and build a stronger, healthier Texas for generations to come.

Benchmarks for Service Delivery Performance

The goal of the Texas Council for Developmental Disabilities is to create system level change so that all people with disabilities are fully included in their communities and exercise control over their own lives. The Council works to ensure that people with developmental disabilities have opportunities to live in the community of their choice, be independent, have jobs, and have other services and supports needed for full participation in community life.

TCDD evaluates the long-term services and supports system in Texas against the following benchmarks:

1. People with developmental disabilities have access to and receive necessary publically funded services and supports with reasonable promptness.
2. Services and supports are provided in the most integrated setting appropriate to the needs of the individual.
3. The system must promote economy and efficiency in the funding and delivery of services and supports.

This report includes recommendations for how to improve the service delivery system to meet these benchmarks and better serve individuals with developmental disabilities (TCDD), and how to prevent developmental disabilities when possible (TOPDD).

Federal Policy: Impact on Persons with Disabilities

The 83rd Texas Legislature made significant changes to the system of long-term services and support. Most notable legislation includes the implementation of Medicaid managed care and the adoption of Employment First policies. Over the next biennium, Texas must also implement budget and spending changes, respond to Sunset Review recommendations, and work to implement new federal guidelines related to workforce innovation and home and community based services. A summary of how these federal and state policies will impact persons with developmental disabilities follows.

Federal Legislation

Over the 2013-2014 biennium, the United States Congress passed several pieces of legislation that specifically relate to individuals with disabilities. These policies will ultimately strengthen the ability of individuals with developmental disabilities to live, work, be healthy, and participate in their community. The following section describes the impact of these new federal policies.

Affordable Care Act

The Patient Protection and Affordable Care Act[46], has been referred to as the most significant change to the United States health care system since the implementation of Medicare and Medicaid in 1965. While this bill was originally passed by Congress in 2010, the state level implementation of this legislation began January 1, 2014. A recent study found that among adults age 18-64 with cognitive decline, 32.1% had private insurance, 41% Medicaid, and 27% Medicare, leaving 13.6% with no insurance.[47]

Without adequate health care, individuals with I/DD who often have multiple health conditions are at risk for developing secondary disabilities. Compared to adults without disabilities, adults with I/DD are more likely to lead a sedentary lifestyle, have inadequate emotional support, and be in fair or poor health. The Affordable Care Act increases access to insurance coverage for individuals with developmental disabilities, places a greater focus on prevention, improves measurement of patient outcomes and quality of care, and structures a greater commitment to addressing underlying mental health and substance abuse problems.

[46] Pub.L. 111–148, 124 Stat. 119, codified as amended at scattered sections of the Internal Revenue Code and in 42 U.S.C. and Public Law 111–148. *111th United States Congress*. Washington, D.C.: United States Government Printing Office. March 23, 2010. Retrieved 2014.

[47] Altman, B. and Bernstein, A. Disability and Health in the US 2001-2005. Hyattsville MD National Center on Health Statistics 2008

Key provisions of the Affordable Care Act that impact people with disabilities include:

- Allows parents to cover children on their health insurance plans until the child reaches age 26
- Insurance providers may not discriminate against individual on the basis of their preexisting health status
- Increases coverage for habilitative or long-term services and supports
- Provides greater opportunities to access home and community based services through the Community First Choice Option, State Balancing Incentive programs, and Money Follows the Person
- Establishes patient centered medical homes
- Integrates primary care and mental health/substance abuse services
- Requires development of new standards for medical diagnostic exam equipment to ensure it is accessible for people with disabilities
- Requires new standards for data collection in national surveys on disability
- Potential for new funding to develop model curricula to increase ability of health professionals to work with people with disabilities

Rehabilitation versus Habilitation

As mentioned above, a key provision of the ACA is the inclusion of habilitative services. Yet, the scope of habilitation versus rehabilitation for persons with developmental disabilities is not yet defined. The U.S. Department of Health and Human Services (HHS) defines rehabilitation as: "Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings." Other services and devices that are often included are physician and nursing services; recreational therapy; music therapy and cognitive therapy for people with brain injuries and other conditions; psychiatric, behavioral and other developmental services and supports; durable medical equipment (DME), including complex rehabilitation technologies; orthotics and prosthetics; low vision aids; hearing aids and augmentative communication devices; and other assistive technologies and supplies.

These services and devices need to be provided in an array of settings, such as inpatient rehabilitation hospitals and other inpatient or transitional rehabilitation settings, outpatient therapy clinics, community provider offices, at a person's home, and at various levels of intensity, duration and scope, depending on the severity of the condition and the functional impairment presented by the particular individual.

Definitions of habilitation are taken from the National Association of Insurance Commissioners (NAIC): "Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may also include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings."[48] The key difference is that habilitation usually refers to acquiring or learning skills whereas rehabilitation usually involves regaining skills that have been lost or improving or preventing deterioration of skills. Habilitative services are listed in the Affordable Care Act as an essential benefit, yet many insurance companies do not currently recognize habilitative services for coverage.

Advocates for people with disabilities nationwide have expressed support for the NAIC definition plus the Medicaid definition: "Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings."[49] Ensuring that habilitation includes learning a new skill or function is a critical aspect of the definition and coverage for persons with disabilities.

Medicaid Expansion in Texas

The Affordable Care Act offered states the opportunity to expand its Medicaid enrollment to cover more of the uninsured population. New policies would increase eligibility to low-income adult citizens at a higher rate of 133% of the federal poverty level (approximately $15,282 for an individual; $31,322 for a family of four). Many people with disabilities fall into the gap between traditional Medicaid eligibility and the requirements to participate in the insurance exchanges under the Affordable Care Act, and would likely be covered if Medicaid eligibility was expanded.

[48] NAIC Glossary of Terms for the Affordable Care Act (PDF)
[49] Social Security Act, Section 1915(c)(5)(A)

Medicaid expansion in Texas would extend coverage to an estimated 1.2 million uninsured Texans by 2016. Federal funds would cover 100% of the expansion for the first three years, and no less than 90% in subsequent years. This expansion, however, is optional for each state and Texas is not likely to expand coverage.

The expansion does not change current eligibility rules for home and community based services individuals – must meet current rules for determining financial eligibility including any asset test in Texas and the standards for having a disability and qualifying for services. However, Texas would have the opportunity to create new benefits packages for the people newly eligible as a result of the expansion and could add home and community, personal care, and habilitation services that are important to those with long term support needs.

TCDD supports reform measures and principles that provide individuals with consistent access to patient centered, timely, unencumbered, affordable and appropriate health care. Therefore, TCDD supports the expansion of Medicaid for Texas under the federal Affordable Care Act that would have covered an additional 1.2 million Texans by 2016. The Council supports the position that in any consideration of changes to the healthcare financing and delivery system in the United States, the well-being of the patient must be the highest priority.

The Autism CARES Act

One in 68 U.S. children has an autism spectrum disorder (ASD), a 30% increase from 1 in 88 just two years ago, according to the Centers for Disease Control and Prevention.[50] In 2000 and 2002, the autism estimate was about 1 in 150 children. Two years later 1 in 125 8-year-olds was believed to have autism. In 2006, the number grew to 1 in 110, and then the number went up to 1 in 88 based on 2008 data.

The increased prevalence of Autism in the United States led to the reauthorization of the Combating Autism Act of 2011, now called the Autism CARES Act.[51] This bill was signed into law in

[50] "Prevalence of Autism Spectrum Disorder among Children Aged 8 Years – Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2010," Centers for Disease Control and Prevention, March 2014.
[51] Combating Autism Reauthorization Act of 2014 or Autism Collaboration, Accountability, Research, Education, and Support Act of 2014 or Autism CARES Act of 2014 (H.R. 4631; Pub.L. 113–157

August 2014. The Act authorizes $1.3 billion over five years for research into autism while calling for federal agencies to examine and anticipate the needs of children with autism who are "aging out" of current programs and need different assistance as adults.

Other changes in the Autism CARES Act include the designation of a new deputy under the Department of Health and Human Services to oversee federal autism research and services. The bill requires a new government report on the needs of children with autism as they transition to adulthood. The bill also increases the number of family and self-advocate representatives on the Interagency Autism Coordinating Committee (IACC), which guides research on autism.

Achieving a Better Life Experience (ABLE) Act

American families face challenges in saving money for the long-term support needs of a family member with a disability. Perhaps the greatest is the fear of disqualifying a family member from eligibility for much-needed public benefits, such as supplemental income or long-term services and supports through the Medicaid system, through the buildup of assets. The federal legislation known as the Achieving a Better Life Experience (ABLE) Act (S.313 / H.R.647) would give people access to specialized savings accounts. People with disabilities and their families would be able to invest up to $100,000 in these accounts without losing access to Supplemental Security Income, Medicaid services, or other important federal benefits for people with disabilities.[52]

The purpose of the act is to provide secure funding for disability-related expenses on behalf of designated persons with disabilities that will supplement, but not replace, benefits provided through private insurance, the Medicaid program, the Supplemental Security Income program, employment, and other sources. Any person who is receiving SSI or disability benefits under Title II of the Social Security Act would be eligible to use an ABLE account. As a form of a 529 Account, funds in ABLE Act accounts could be spent on tuition and education expenses, housing, transportation, employment support, health expenses, assistive technology, personal assistance, and financial management services. These savings accounts would represent another tool that people and families can choose to avail themselves of; they would not replace other specialized long-term planning tools, such as Supplemental Needs Trusts. The ABLE Act has not yet passed

[52] Adapted from "Achieving a Better Life Experience (ABLE) Act: Fact Sheet" created for the Disability Policy Seminar, available at: http://www.thearc.org/document.doc?id=4638

Congress, but has the support of over 380 co-sponsors and is expected to receive a vote by the end of the 2014 session.

Advancing Fetal Alcohol Spectrum Disorder (FASD) Research, Prevention, and Services Act
Senator Lisa Murkowski introduced S237 "Advancing Fetal Alcohol Spectrum Disorder (FASD) Research, Prevention, and Services Act" in February 2013 and it was assigned to the Senate Committee on Health, Education, Labor, and Pensions, where it did not receive a hearing. The bill directed the Secretary of Health and Human Services (HHS) to: (1) establish and carry out a research agenda for FASD; (2) facilitate surveillance, public health research, and prevention of FASD; and (3) continue the Interagency Coordinating Committee on Fetal Alcohol Syndrome. It also required the Secretary to provide financial assistance to: (1) establish or expand state FASD programs; (2) implement best practices to educate children with FASD, educate members of the criminal justice system on FASD, and educate adoption or foster care agency officials about services for children with FASD; (3) provide transitional services for those affected by prenatal alcohol exposure; (4) develop public service announcements to raise awareness of the risks associated with alcohol consumption during pregnancy; (5) increase awareness and identification of FASD in federally qualified health centers; and (6) provide respite care for caretakers, recruit mentors, and provide educational and supportive services to families of individuals with FASD. The bill has not yet passed, but will be proposed again in the 2015 session.

Workforce Innovation and Opportunity Act
The 2014 passage of the Workforce Innovation and Opportunity Act (WIOA) will improve employment opportunities and economic prospects for all Americans, including those with disabilities. This bill represents a reauthorization of the Workforce Investment Act of 1998 (WIA), including the Rehabilitation Act, through 2020. WIOA has the potential for significant advancement in employment of people with disabilities.

With only 20% of people with developmental disabilities represented in the general community workforce, the bill is designed to help workers with disabilities increase access to jobs, education, job-driven training, and support services that give them the chance to secure jobs, advance their careers, and build assets needed for independent living.

Primary provisions of the WIOA that impact persons with disabilities include:

- A much larger role for public vocational rehabilitation (VR) as people with disabilities make the transition from school to adult life.

- ❖ Required agreements between state VR systems and state Medicaid systems, and state intellectual and developmental disability (I/DD) agencies.
- ❖ A definition of "customized employment" in federal statute, and an updated definition of "supported employment" that includes customized employment.
- ❖ A definition for "competitive integrated employment" as an optimal outcome.
- ❖ Enhanced roles and requirements for the general workforce system and One-Stop Career Centers in meeting the needs of people with disabilities.
- ❖ A number of disability agencies moving from the Department of Education (DOE) to the Department of Health and Human Services, including the Independent Living Program.
- ❖ Changes in performance measures to include entering and retaining employment wages, education, skills and training, and serving employers.
- ❖ Requires that VR agencies allocate at least 15% of their federal funding toward transition efforts.

Sub-minimum Wage

The new policies of the WIOA specifically include efforts intended to limit the use of sub-minimum wage employment. Specifically, individuals age 24 and younger are prohibited from working jobs that pay less than the federal minimum of $7.25 per hour unless they first try vocational rehabilitation services. This updated rule will take effect two years after the law's enactment. Though the bill requires most young people to try competitive employment before working for less than minimum wage, there are exceptions for those who are deemed ineligible for vocational rehabilitation and to allow individuals already earning less than the federal minimum to continue in their jobs. In cases where individuals with disabilities do earn less than minimum wage, the WIOA policy establishes requirements that the individual periodically be provided career counseling by the state and are informed about other work opportunities.

New Rules for Home and Community Based Settings

Over the past five years, the Centers for Medicare and Medicaid Services (CMS) has engaged in ongoing discussions with stakeholders, states and federal partners about the qualities of community-based settings that distinguish them from institutional settings. As a result, CMS issued a final rule to ensure that Medicaid's home and community-based services programs provide full access to the benefits of community living and offer services in the most integrated settings. These new rules, issued in January 2014, significantly change the way home and community-based services will be defined and delivered moving forward.

These new rules apply, or will apply, to all long term services and supports options in Texas.[53] The rule, as part of the Affordable Care Act, supports the Department of Health and Human Services' Community Living Initiative launched in 2009 to develop and implement innovative strategies to increase opportunities for Americans with disabilities and older adults to participate in meaningful community living.

The home and community-based setting provisions in this final rule establish a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The final rule excludes certain settings as permissible settings for the provision of Medicaid home and community-based services. These excluded settings include nursing facilities, institutions for mental disease, intermediate care facilities, and hospitals. Other Medicaid funding authorities support services provided in these institutional settings. The rule supports enhanced quality, and adds protections for individuals receiving services.

Under the final rule, and to be eligible for continued federal funding, home and community-based services must be provided in settings that have the following community qualities based on the needs of the individual included in their person-centered plan[54]:

- ❖ The setting is integrated in and supports full access to the greater community;
- ❖ Is selected by the individual from among setting options;
- ❖ Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- ❖ Optimizes autonomy and independence in making life choices; and
- ❖ Facilitates choice regarding services and who provides them.
- ❖ In addition, the final HCBS rules[55]:
  - o Define and describe the requirements for home and community-based settings appropriate for the provision of HCBS;
  - o Define person-centered planning requirements across the section 1915(c) and 1915(i) HCBS authorities;

[53] Home and Community-based Services (Final Regulation CMS-2249-F/CMS-2296-F; see www.Medicaid.gov/HCBS
[54] Fact Sheet: Summary of Key Provisions of the Home and Community-Based Services (HCBS) Settings Final Rule (CMS 2249-F/2296-F). Centers for Medicare and Medicaid: January 2014
[55] Ibid

- Provide states with the option to combine coverage for multiple target populations into one waiver under section 1915(c), to facilitate streamlined administration of HCBS waivers and to facilitate use of waiver design that focuses on functional needs;
- Allow states to use a five-year renewal cycle to align concurrent waivers and state plan amendments that serve individuals eligible for both Medicaid and Medicare, such as 1915(b) and 1915(c); and
- Define and describe the requirements for community employment services.

The Texas Legislature has instructed state agencies on a number of occasions to make program modifications in the interest of moving the system toward more efficiency and uniformity. The federal HCBS rule gives the state the opportunity to comply with these directives more meaningfully and systematically improve all of the waivers by streamlining their rules and requirements through assessing and developing remediation plans across all of the waivers by topic/service through extensive stakeholder input for each waiver. Many waiver features substantially meet expectations in the federal HCBS rule, but there is great variation in the degree to which each of the waiver's services complies.

Integrated Community Employment

The new HCBS rules offer multiple opportunities to use waiver supports to increase employment opportunities for individuals with disabilities within current policy. While specific guidelines have yet to be released, CMS is asking states questions about waiver participants: Is the individual employed or active in the community outside the setting? Does the individual work in an integrated community setting? If the individual would like to work, is there activity that ensures the option is pursued? Does the individual participate regularly in meaningful non-work activities in integrated community settings for the period of time desired by the individual? These questions demonstrate CMS's commitment to the importance of community based employment for waiver participants.

Implementation Timeline

The implementation of the Home and Community Based Services settings rule is an ongoing process. CMS is currently working with states to provide detailed guidance on each waiver and each component of these new rules. All states must submit to CMS a plan for transitioning their current HCBS system into compliance with the new rule by March 17, 2015. States, like Texas, submitting a 1915(c) waiver renewal or amendment before March 17, 2015, must include a

transition plan in that submission. States then have 120 days from that submission date to submit a transition plan for the remainder of their HCBS system. Texas had one 1915(c) waiver expire before the March 17, 2015, deadline. The CLASS waiver was scheduled for renewal on August 31, 2014.

The Texas Department of Aging and Disability Services (DADS) held an HCBS Rules Stakeholder Meeting in October 2014 and plans to engage stakeholders, including program participants and providers, more meaningfully in the coming months.

Recommendations for Implementation of HCBS Rules

The following section outlines recommendations for how Texas should take advantage of the opportunities offered to individuals through the new HCBS rules:

1. Texas has the opportunity to assess and remediate the waivers in advance of the transition of long-term services and supports into managed care. For this reason, the STAR+PLUS waiver and its accompanying rules, policies and procedures must be included in the purview of a broader HCBS Settings Transition Workgroup.

2. Require the development of a person-centered plan across all home and community based waiver programs. Increase the enforcement to ensure providers are accountable and held to the principles of person centered planning.

3. Texas transition plans for each HCBS program that pays for day habilitation should include strategies that move toward Employment First and Community-based Non-Work (CBNW) and away from the current facility-based day habilitation programs and sheltered employment. Texas day habilitation programs do not typically, but could, provide much more community engagement for participants if required and reimbursed.

4. Prohibit the use of respite in an institutional setting in all home and community based waivers. Texas has prohibited the use of respite in an institutional setting in the HCS waiver. A similar exclusion should be included in the CLASS waiver and Medically Dependent Children Program (MDCP).

5. Engage in an educational campaign regarding the HCBS guidelines to empower self-advocates and their families to fully benefit from the new guidelines. This includes individual privacy, choice of roommates, control over one's schedule and activities, money management, visitors, and community involvement.

6. Ensure that people may have visitors of their choosing at any time, which may conflict with some providers' practices and routines.
7. Residential settings should build capacity for visitability. This barrier should be focused on in the current transition plan.
8. Expand individual options to ensure right to privacy, dignity and respect. Individuals in group homes do not have consumer directed options, which is contrary to the HCBS settings rule that requires individuals receiving Medicaid HCBS to have independence in making life choices, including but not limited to daily activities, physical environment and with whom to interact.

Other considerations for persons with disabilities that should be addressed in the implementation of the HCBS rules include:

- ❖ Co-location and spacing requirements that discriminate against persons with disabilities;
- ❖ Rules that encourage the development or maintenance of maximum self-reliance and independence with a goal of self-sufficiency;
- ❖ A community living options information process that encourages the most integrated settings and includes ongoing information to people in group homes and host homes, not just for those in institutions; and
- ❖ Uniform mandatory participation (program termination) requirements without sufficient due process protections.

The federal HCBS settings rule provides Texas with the opportunity to truly assess and make improvements to waiver programs so that waiver participants will be integrated in and have support for full access to services in the greater community, including opportunities to seek employment and work in competitive integrated settings, to control personal resources, and to engage in community life in the same way as people who are not waiver participants.

Texas State Policy: Impact on Persons with Disabilities

The 83rd Texas Legislature made significant changes to the way long term services and supports are funded and delivered in our state. The following sections provide an analysis of policy decisions made in the past biennium.

Texas State Budget

The 83rd Texas Legislature passed and the Texas Comptroller certified SB 1, the 2014-2015 biennial budget. It includes $94.6 billion in General Revenue (GR), and $197 billion in All Funds. Combined with the supplemental appropriation, the $95 billion GR budget is an increase of less than 8% compared to 2012-13 GR spending. However, after adjusting for population and inflation, the GR for 2014-2015 is 8.4% below the levels in the 2010-2011 budget. For people with disabilities the budget funds many of the requested health and human services Exceptional Items to restore or expand services. The following summarizes the budget decisions made for selected health and human service programs important for people with developmental disabilities.

Department of Aging and Disability Services (DADS)

Medicaid Waiver Programs

DADS requested funding to provide services to 20% of the persons waiting on HCS and CLASS interest lists who are likely eligible for services. The legislature funded services for about 24% of the request for HCS and CLASS services.

Community Expansion		
Waiver	**Request**	**Funded 2014-2015**
HCS	5,566	1,324
CLASS	3,056	712
TxHmL	574	3,000
CBA	982	100
STAR+PLUS	1,116	490
MDCP	238	120
DBMD	16	100
Total Svcs	**11,548**	**5,846**

Promoting Independence

The budget fully funded the DADS request for diversions and transitions from institutions into community waiver programs. New this biennium are HCS services for persons with I/DD to transition from nursing facilities and Child Protective Services group homes. The $28.1M for promoting independence will be used to:

- Transition 400 people from large and medium ICFs into HCS services
- Transition 192 children aging out of foster care into HCS services
- Provide HCS services to 300 persons in crisis to prevent SSLC placement

- Provide CBA services to 100 persons in crisis to prevent nursing home placement
- Provide HCS services to 360 people with I/DD in nursing homes
- Provide HCS services to 25 children living in Child Protective Services group homes

Community First Choice

The budget includes a new basic attendant and habilitation service for 11,902 people with I/DD that would be delivered by managed care organizations (insurance companies). The new service will be made available to persons with a functional need who are also Medicaid eligible in March 2015.

Department of Assistive and Rehabilitative Services (DARS)

Early Childhood Intervention (ECI)

ECI provides services to eligible children with developmental delays that assist them to gain skills or improve development. The ECI request was fully funded to address the increase in the average cost of services that occurred as a result of the 82nd Legislature's decision to narrow eligibility. The budget also included a rider that made $63M of the total ECI appropriation contingent on a requirement that families earning above 400% of the federal poverty level pay 100% of the cost of ECI services. That means that a family of four earning more than $94,200 is required to pay approximately $400 per month for ECI services.

Department of Assistive and Rehabilitative Services (DARS) General Revenue		
Exceptional Items	**Request**	**Funded 2014-2015**
1. Maintain ECI Current Services	$10.8M	$10.8M
2. Expand Autism Services to Unserved Areas	$4.8M	$2.4M
3. Expand Independent Living Centers	$2M	$0
4. Access to Interpreter Services for the Deaf	$1.3M	$700K
5. Deaf & Hard of Hearing Resource Specialists	$840K	$200K
6. Comprehensive Rehab Services for 206 persons	$11.8M	$5.9M

Autism Program

The DARS Autism Program provides intensive, evidence-based treatment to children ages 3-8 with a diagnosis of Autism Spectrum Disorder. The budget funds $2.4M to establish two additional autism service locations and made the funding contingent upon a plan to provide services more efficiently to more children.

Comprehensive Rehabilitation Services

Individuals with a traumatic brain injury or spinal cord injury can receive post-acute rehabilitative services in the CRS program. The budget included added funding to provide CRS services to an additional 103 persons.

Independent Living Centers

The Legislature did not fund the DARS request for $2M for three new Independent Living Centers (ILCs). Instead, a rider was added to require DARS to report on the actual and projected numbers of recipients served by each center and the types of services provided and make recommendations to improve the measurement, collection, and reporting of outcome data related to the centers.

Deaf and Hard of Hearing Services

The legislature funded about 42% of the DARS combined requests for Access to Interpreter Services and Access to Deaf and Hard of Hearing Services.

Department of State Health Services (DSHS)

Children with Special Health Care Needs

The CSHCN program covers services for children with extraordinary medical needs, disabilities, and chronic health conditions across the state. The program pays for medical care, family support services, and related services not otherwise covered. The budget included an additional $6.6M.

Mental Health Funding

The budget included an additional $154.8M to address mental health. This includes funds to eliminate the adult and children's waiting lists for mental health services.

Department of State Health Services (DSHS)	
Workgroup Initiatives	**Funded 2014-2015**
Public MH Awareness Campaign	$1.6 M
School-based training for teachers and staff in prevention and early identification of MH.	$5 M
Crisis Services	$25 M
Expand Community MH for 6,242 Adults and 286 Children	$20 M
Youth Empowerment Service (YES) Waiver Statewide Expansion	$24.4 M
Collaborative Public-Private Partnerships	$25 M
Expand Local MH Authorities to Serve Persons Who Are Underserved	$17 M
Expand NorthSTAR to Serve Persons Who Are Underserved	$6 M
Fund MH Services for Veterans	$4 M
1915i Home & Community Based Services Including Rental Assistance	$24.8 M
10 beds in private residential treatment centers (RTCs) for youth at risk for parental relinquishment of custody to DFPS	$2 M
NEW Investment in Mental Health Services	**$154.8 M**

Health and Human Services Commission (HHSC)

Acquired Brain Injury

The budget provided $2.1M to the Office of Acquired Brain Injury and to increase services and supports for persons with an acquired brain injury.

Attendant Wages

121,000 attendants received wage increases. The lowest wages were raised to $7.50 per hour in FY 2014 and to $7.86 per hour in FY 2015. The $88.7M GR appropriation to increase wages also included $20 million for provider rate enhancement. The original request was for $176M for a $0.50 per hour across-the-board wage increase.

Texas Department of Housing and Community Affairs

$3.8M of the $11.8M appropriated to the Housing Trust Fund was for the Amy Young Barrier Removal Program. This funding is available to fund architectural accessibility modifications in individual homes or rental units.

Prevention of Developmental Disabilities

Funding for prevention is a small fraction of the HHSC budget. Costs for prevention services during childhood are small in comparison with costs associated with caring for people who become more disabled because they did not receive the services that were needed early in life. These costs include juvenile justice or incarceration. Preventable disabilities (especially FASD and preventable mental illnesses), including those caused by trauma and/or abuse/neglect, are often factors in crimes that push children into these systems in the first place.

As the Sunset Commission noted in its report, the state has a tendency to pay for services downstream. The only way to change this is through prevention and to make prevention a priority on a system-wide basis and fund it accordingly. Policies that transform system and funding structures to prioritize funding are recommended.

Study on Alcohol and Controlled Substances Statistics

Current law includes the possession and use of certain drugs among the conduct that constitutes an offense of abandoning or endangering a child. However, these provisions do not apply to an unborn child. Interested parties have expressed concern for the unborn children of mothers who abuse alcohol and certain illegal substances during their pregnancy, specifically noting the long-term health consequences that can be directly attributed to prenatal alcohol or drug abuse.

HB 1396 (83R) adds temporary provisions, set to expire September 1, 2015, to require the Department of Family and Protective Services (DFPS) and the Department of State Health Services (DSHS), using existing resources, to conduct a study on alcohol and controlled substance statistics. The bill requires the study to determine whether either state agency currently compiles the following information: the number of children reported to the department who at birth tested positive for the presence of alcohol or a controlled substance and the controlled substances for which they tested positive; the number of such children who were removed from their homes and have been diagnosed as having a disability or chronic medical condition resulting from the presence of alcohol or controlled substances; and the number of parents who test positive for the presence of a controlled substance during a department investigation of a report of abuse or neglect of the parent's child.

The Co-Occurrence of Developmental Disabilities and Mental Illness

Individuals with co-occurring developmental disabilities and mental illnesses are a particularly vulnerable population of people served by the state mental health and developmental disabilities systems. While their numbers are relatively small, these individuals pose significant service delivery and funding challenges, requiring a coordinated array of treatment interventions and supports that necessitate the collaborative involvement of providers of both public systems.

People with developmental disabilities are three-to-four-times more likely to experience a mental health disorder than the general population.[56] This may be related to chemical imbalances, structural issues in the brain, or problems with connections between structures. Individuals with a co-occurring mental illness and developmental disability are at increased risk of homelessness, institutionalization and incarceration.[57] While early intervention is recommended for children with co-occurring conditions, factors such as poverty, education, and lack of insurance can result in less opportunity for early intervention support.

Despite these needs, services are often organized as mental illnesses or developmental disabilities – but not both. Thus, individuals with co-occurring conditions face specific barriers related to a lack of coordination and collaboration across service systems, as well as gaps in research, clinical expertise, and access to appropriate programs.[58] One service provider describes, "The idea of dual diagnosis (intellectual disability and mental illness) is complex because the diagnosis involves teasing out which portions of the individual's problems are due to intellectual disability, which are due to mental illness, and which are due to learned behavior in a family system. Treatment involves specialized techniques that are sometimes adapted from mental health models to work with people with intellectual disabilities. This specialized treatment is not always attractive to providers given the current funding streams and reimbursement rates in Texas."

[56] Cooper, S., Smiley, E., Morrison, J., Williamson, A., & Allen, L. (2007). Mental ill-health in adults with intellectual disabilities: prevalence and associated factors. British Journal of Psychiatry, 190, 27-35.
[57] The Importance of Integrated Services in a Downturned Economy, NADD Bulletin, Vol. XII, Number 4 (2009).
[58] Silka, V. R., & Hauser, M. J. (1997). Psychiatric assessment of the person with mental retardation. *Psychiatric Annals*, 27(3).

Through a grant from the Hogg Foundation, TOPDD has launched a new initiative to improve coordination and planning of policy efforts across systems to address the needs of people with co-occurring developmental disabilities and mental illness. This is the first time that a state entity has been awarded this two-year, renewable grant. The goals are to: 1) support policy efforts to provide universal and systematic surveillance and screenings for early identification of developmental disabilities and potentially co-occurring disorders; 2) promote incorporation of prevention efforts into all integrated care systems; 3) enable continuous access to integrated services for children at high-risk for co-occurring problems; and 4) develop recommendations for a collaborative response to dual diagnosis and tenets of integrated care across systems. Products of this program will include policy analysis and opportunities for prevention, an analysis of gaps and strengths in the current system, and development of recommendations of how systems can work together to improve prevention and treatment practices.

Recommendations for Serving Individuals with Both Mental Illness and I/DD

1. Increase collaboration between the mental health and developmental disabilities systems and primary care in order to better identify and track individuals with high risk needs, share expertise among providers, increase education for families, and translate research into practice.
2. Increase access to early intervention services and supports for children with co-occurring conditions.

State Supported Living Centers

The state supported living centers (SSLCs) provide campus-based direct services and supports to people with intellectual and developmental disabilities who are medically fragile or have complex behavior support needs at 13 locations — Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, Rio Grande, San Angelo and San Antonio. The Texas Department of Aging and Disability Services (DADS) operates state supported living centers. (Note: The Rio Grande State Center is operated by the Texas Department of State Health Services and provides services through a contract with DADS.) State supported living centers provide 24-hour residential services, comprehensive behavioral treatment services and health care services, including physician services, nursing services and dental services. Other services include skills training; occupational, physical and speech therapies; vocational programs; and services to maintain connections between residents and their families and natural support systems.

Today, the vast majority of people with I/DD live in the community, and the 13 centers house about 3,362 people,[59] down from the 4,337 reported here in 2010.[60] Yet Texas continues to rely more heavily on SSLCs and privately operated intermediate care facilities for individuals with I/DD or related condition (ICFs/ID) than most other states. As of 2012, 12 states reported no state operated facilities serving individuals with I/DD with more than 16 residents. Of the 38 states operating I/DD facilities with 16 or more residents, 20 had 1 or 2 facilities, 16 had 3 to 10 facilities, and 2 had 11 or more facilities (New York with 14 and Texas with 13 I/DD facilities with 16 or more residents).[61]

In Texas, community capacity is managed during the legislative process by capping dollars, service opportunities, or both. Texas has chosen not to eliminate, but to slowly downsize the large SSLCs, maintaining this costly infrastructure in lieu of strengthening capacity to serve people in the community. Despite transitioning many residents out of institutions, Texas has not kept pace with the national trends to reduce the number and size of SSLCs — Texas has not closed a facility since the 1990s.

In evaluating current benchmarks, Texans with I/DD do not receive services within the least restrictive setting appropriate to their needs. TCDD has made similar recommendations in recent biennia to rebalance the system that serves persons with I/DD by expanding cost-effective policies that honor the choices of individuals to live in the most integrated setting to meet their needs, and transferring savings to serve more persons with disabilities in their communities. In 2008, TCDD published an analysis of Texas spending on Medicaid and I/DD services as compared to other states.[62] The trends today are similar as they were in 2008:[63]

- Texas average spending per person for home and community based services was below the national average.

[59] Promoting Independence Advisory Committee Department Activity Report Texas Department of Aging and Disability Services, October 2014.
[60] Agosta, John, Jon Fortune, Drew Smith, Kerri Melda, Robert Gettings, and Valerie Bradley. *Closing the Gaps in Texas: Improving Services for People with Intellectual and Developmental Disabilities*. Texas Council for Developmental Disabilities. Oct. 2008:7
[61] Larson, S.A., et.al (2014). In-Home and Residential Long-Term Supports and Services for Persons with Intellectual or Developmental Disabilities: Status and trends through 2012. Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration.
[62] Agosta, John, Jon Fortune, Drew Smith, Kerri Melda, Robert Gettings, and Valerie Bradley. *Closing the Gaps in Texas: Improving Services for People with Intellectual and Developmental Disabilities*. Texas Council for Developmental Disabilities. Oct. 2008:7
[63] Ibid.

- Texas admits a higher proportion of children to SSLCs than the national average.
- Texas is reducing its census in SSLCs at a slower rate than reduction nationally.
- Texas must enroll a significant number of individuals in HCBS waivers in order to keep up with population growth and increased service demand.

From 2013 to 2014, there were 116 new admissions to SSLCs. Approximately 36% of these were children (42). Although African Americans only make up 11.4% of the Texas population, they make up 30% of admissions to SSLCs (See Table 5). Their disproportionate representation in institutional admissions bears further review.

Table 5. New Admissions to SSLCs by Ethnicity

Ethnicity	Total Number	Percent
White	53	46%
American Indian or Alaska Native	1	1%
Asian	1	1%
Black or African American	35	30%
Multiracial	1	1%
Hispanic or Latino Origin	24	21%
Other/Unknown	1	1%
Total Annual Admissions	116	

*Texas Department of Aging and Disability Services, as of March 31, 2014

In 2014, the Texas SSLC system is responding to three specific policy initiatives to improve the quality of services, build community capacity in order to serve people in the most integrated setting, and deliver services in a cost efficient manner. These include: 1) US Department of Justice Settlement Agreement, 2) Department of Aging and Disability Services SSLC long range plan, and 3) the Sunset Commission Review of the Texas Department of Aging and Disability Services.

US Department of Justice

In June 2009, the State of Texas and the United States Department of Justice (DOJ) entered into a Settlement Agreement regarding services provided to individuals with I/DD in SSLCs as well as the

transition of such individuals to the most integrated setting appropriate to meet their needs and preferences. The Settlement Agreement covers all State Supported Living Centers (SSLCs).

Pursuant to the Settlement Agreement, the SSLCs must be routinely monitored for compliance with the settlement. The parties agreed to delay the Four-Year Report until June 2014. The Settlement Agreement states: "...The parties anticipate the State will have implemented all provisions of the Agreement at each Facility within four years and sustained compliance with each such provision for at least one year..." This expectation was not met, and all facilities had many provisions not yet in compliance.[64]

The DOJ settlement agreement regarding the 13 SSLCs in Texas sought to:

- increase protections of SSLC residents;
- bring supports and services up to accepted professional standards of care;
- provide the most appropriate level of care to SSLC residents; and
- provide residents with information about, and the choice to, transition to the most integrated community placement possible.

The Settlement Agreement with the DOJ required the monitors to provide an assessment of the status of compliance. The assessment provides explicit recommendations about how to improve SSLC services. In Section T – Providing Services in the Most Integrated Setting Appropriate to Meet a Person's Needs, monitors questioned whether the state has the capacity to develop an acceptable community living discharge planning process and specifically recommends that the state work with facilities on the development and implementation of formal process for transition. With respect to Section U – Consent, the assessment discusses the conflict relating to facility directors making decisions for individuals without guardians and considered to be incapacitated.

State Supported Living Center Long-term Plan (DADS)

The Department of Aging and Disability Services Rider 39[65] requires DADS, in coordination with DSHS, "to develop a 10-year plan for the provision of services to individuals residing in SSLCs,

[64] United States v. State of Texas (State Schools) Settlement Agreement. Four Year Report. Texas Department of Aging and Disability Services, June 23, 2014

[65] 83rd Texas Legislature, State Appropriations Request, Department of Aging and Disability Services

considering cross agency issues impacting both SSLCs and state hospitals. Texas Health and Safety Code (HSC), Title 7, Subtitle A, Chapter 533, Subchapter B, Section §533.032(c) also requires development of a long-range plan for SSLCs. In September 2014, though a draft plan was not provided to make comments on, DADS provided an opportunity for public comment on what should be included in it.

TCDD continues to commend DADS for implementing proposals from community advocates that represent improvements to the SSLC system. For example, DADS has made a significant commitment to provide Person Centered Thinking training at all of the SSLCs. Overall transitions are improving, but compared to national averages, the pace is slow and investment too small to truly rebalance the long-term service system.

Texas Sunset Advisory Commission: State Supported Living Centers

The Texas Sunset Advisory Commission adopted final recommendations for the Department of Aging and Disability Services (DADS) that will be proposed during the 84th Texas Legislative Session that begins January 13, 2015. Noting declining enrollment, increasing costs and questionable quality, the Sunset staff made significant and clear recommendations regarding SSLC consolidation.

Sunset Commission staff made the following SSLC specific recommendations:

1. Require DADS to close the Austin SSLC by August 31, 2017.
2. Establish an SSLC Closure Commission to determine an additional five SSLCs to close no later than August 31, 2022.

The Sunset Commission adopted the Austin SSLC closure recommendation and modified the SSLC Closure Commission recommendation by making it an SSLC Restructuring Commission that would be tasked with 'right-sizing' the number of SSLCs required to meet the need for services in Texas. The Restructuring Commission would evaluate SSLCs and submit a final report with recommendations to the 85th Legislature by December 1, 2016. Recommendations of additional SSLC closures would be possible, but that is not a requirement of the Restructuring Commission. Sunset staff also made rebalancing recommendations that would require DADS to invest savings from SSLC closure to "address the need for more consistent crisis support, adequate rates for people with more complex needs, [and] ensuring the safety of DADS' clients in day habilitation facilities ..."[66]

[66] Texas Department of Aging and Disability Services Sunset Staff Report with Hearing Material, Sunset Advisory Commission, June 2014

Recommendations for State Supported Living Centers

The Sunset Advisory Commission's staff recommendations are consistent with TCDD's longstanding rebalancing recommendations and provide substantial supporting evidence that should be used as a primary resource in the development and implementation of the DADS State Supported Living Center Long-term (10-year) Plan.

1. Rebalance the system that serves persons with I/DD by expanding cost-effective policies that honor the choices of individuals to live in the most integrated setting to meet their needs, identifying and providing supports and services to meet the needs of persons when and where they need them, and transferring the inevitable savings so that more persons with disabilities have the opportunity to be included in their communities.

2. Define an expectation for fewer institutions and to bring services up to generally accepted professional standards of care for those remaining. TCDD continues to support a moratorium on new admissions to SSLCs based on the circumstances necessitating the U.S. DOJ involvement in the SSLC system. The Council also supports the position that people with I/DD should have access to high-quality services and supports wherever they live.

3. Develop and implement a peer support program for individuals with I/DD to foster supported decision-making and community transition, and encourage more empowerment and choice. Peer support is currently being used by DSHS at state hospitals.

4. Expand home and community based services as the primary mechanism for addressing the increased service demand in our state. As the population grows, so does the demand for services. Individuals should not be unnecessarily placed in an institution because the state has not funded adequate community supports.

5. Increase funding to reduce waiver interest lists. Waiver interest lists mean that individuals who need community services are not receiving them. Waiting without needed support can increase risk for negative health outcomes, crisis, and unnecessary institutionalization.

Medicaid Managed Care

As Texas and other states continue to transition individuals with I/DD from large congregate SSLC settings to home and community based services, the challenge of how to meet the current and future demand within the state's budget is tremendous. Medicaid Managed Care models offer a financial structure designed to increase savings, provide greater access to services, and serve more people (reduce interest lists for services). The model is also designed to promote higher-quality services, person-centered planning and self-direction to ultimately improve outcomes for people with I/DD. Capitated payment rates are central to improving the cost-effectiveness of services within a managed care environment because they allow the managed care organization (MCO) wide latitude in utilizing available dollars to design interventions that both save money and improve outcomes.

Yet with respect to people with life-long disabilities who will need services for decades, it is important to think in the very long term when determining whether services are cost effective. Cost savings in long-term services and supports may be realized outside the life cycle of a managed care contract. For instance, attention to supports for family caregivers to reduce the stress of care-giving increases the likelihood that families will be able to continue to provide support over extended periods of time, even multiple decades. Upfront investment in employment services may not result in more independence during the contract period but can significantly reduce the need for public resources for many decades into the future. Person-centered services include an aspect of planning beyond the here and now with an eye to the future. People with I/DD have support needs that are not always predictable – any system redesign needs to incorporate considerable flexibility to support each individual as their needs change.

2014 Expansion of Medicaid Managed Care in Texas

In 2013, SB 7 (83R) was passed that requires the transfer of Medicaid long term services and supports for people with I/DD into a single managed care system by 2020. This includes HCS, CLASS, DBMD and TxHmL waivers and the ICF program, but not State Supported Living Centers. As of September 1, 2014, about 84% of Medicaid clients' healthcare services were coordinated

by managed care organizations and by fiscal year 2017, more than 90% of all Medicaid clients are likely to receive services through managed care organizations.[67]

The specific elements of the managed care system as outlined in SB 7 include:

- Acute Medical Services: Medicaid acute care services would be provided through a capitated managed care program (STAR, STAR Kids, or STAR+PLUS) operated by a Managed Care Organization.
- Medically Dependent Children's Program (MDCP): MDCP would be eliminated. MDCP would be replaced by a mandatory STAR Kids capitated managed care program for children.
- Texas Home Living (TxHmL): TxHmL would be transferred to the managed care system first – no later than Sept. 1, 2017. HHSC would be required to determine whether to cease operating the TxHmL waiver because all of the waiver's services are provided via managed care as an entitlement, whether to continue operating the TxHmL waiver to provide those services that are not included in managed care, or eliminate a portion of the services currently available to people receiving services.
- Residential Changes to Reduce Costs: SB 7 would require prior authorization before a person could receive services in a group home in order to restrict access to only those that cannot be served in a less restrictive setting. SB 7 would also require the development of housing options, including the most restrictive settings, to reduce the cost of residential services.
- Voluntary Transition to Managed Care: HCS, CLASS and DBMD waiver participants would not be required to transition to managed care for LTSS but would be offered an option to transition to managed care. However, participants who choose to transition from their waiver program to managed care are not permitted to transfer back to their previous waiver program.
- The Commission would decide whether to continue to operate the waivers and the ICF program for the purpose of providing supplemental services not available in managed care (STAR+PLUS) or for only those who choose to remain in a waiver program.

[67] Sunset Advisory Commission Staff Report, Department of Aging and Disability Services, May 2014. Accessed https://www.sunset.texas.gov.

- Pilot Capitated Managed Care Strategies for Persons with Intellectual and Developmental (I/DD): DADS may test capitated, managed care strategies with a private provider by Sept. 1, 2016 for no longer than two years. The pilots would coordinate services provided through community ICFs and Medicaid waiver programs, and integrate long term services and supports with acute care services.
  A waiver program recipient's pilot participation would be voluntary.
- Community First Choice: A basic attendant and habilitation service for 11,902 people with I/DD was authorized that will be administered by managed care organizations. Cost projections indicate that wages would be about 25% less than current HCS habilitation wages. I/DD Local Authorities will coordinate the new CFC service, but cannot provide the CFC service. Current CLASS, HCS and TxHmL providers will be eligible to provide the new I/DD service.
- Comprehensive Assessment: SB 7 requires DADS to implement a comprehensive assessment and resource allocation process that is intended to provide a uniform mechanism to provide recommendations relating to type, intensity and duration for appropriate and available services based on each person's functional needs.

Implementation Timeline

- September 2014: Acute (medical) care rolled into STAR+PLUS program
- March 2015: Nursing facilities will roll into STAR+PLUS program
- September 2016: MDCP will roll into STAR Kids program;
- September 2017: TxHmL will roll into STAR+PLUS program
- September 2020: All other LTSS waivers will roll into STAR+PLUS program

Opportunities for Prevention in Managed Care

Currently, there are very few places in Texas where children can receive a diagnostic assessment for the disabilities under the FASD umbrella and other complex neurodevelopmental disabilities. Developing reimbursement policies for medical providers that expand their ability to provide assessments of complex disabilities is an essential tool in connecting individuals with services that mitigate their current disabilities and prevent secondary disabilities from developing.

Education, along with system-wide integration of Education, Screening, Brief Intervention and Referral to Treatment (SBIRT) has proven to be an effective tool in the prevention of

developmental disabilities. Education related to the prevention of developmental disabilities could be mandated by the legislature in state operated and state funded programs, and included in contract requirements and MOU's among state entities. Precedence has been set in this area by DSHS, which now requires all state funded chemical dependency treatment agencies to provide education about FASD. This approach is a cost effective and efficient means to reach a large number of people.

The research on SBIRT as a tool to prevent FASD is impressive. Studies across the country (including Texas) demonstrate that Project CHOICES has a 69% success rate in reducing the risk of an alcohol-exposed pregnancy. TOPDD has partnered with several treatment agencies in Texas, where similar positive results were found. Through simple rule changes, SBIRT can become available to all Medicaid clients of childbearing age. Additionally, the multiple systems under the HHSC umbrella could provide countless opportunities for SBIRT. Policies that facilitate the integration of SBIRT and education regarding prevention can pave the way to a healthier state.

Capacity of Managed Care System to Serve Individuals with I/DD

Managed care organizations may not be truly ready to adequately assist people with I/DD in the current model.[68] The MCO must have expertise on how to serve individuals with long term support needs outside of the medical model. MCOs must also be able to recruit and maintain the needed workforce of direct support professionals to assist individuals with daily tasks, support them at home and in the community, and advocate and encourage communication of personal goals. A sustainable and efficient system must also communicate with, and be responsive to, the diverse members of the I/DD community themselves. Decisions about the future service delivery system should be made with the perspectives and active involvement from individuals and family members who are receiving services.

For the most part, discussions regarding the expected benefits of state managed care proposals are limited to "reducing costs" and "coordinating care." However, for people with disabilities, coordinating care should be focused on the outcomes desired for people receiving services, such as a better quality of life, control over their services and supports, full participation in community life, protection of individual rights, employment options for working age adults, etc. In addition to

[68] Analysis and Recommendations for the Implementation of Managed Care in Medicaid and Medicare Programs for People with Disabilities. National Council on Disability. 2012.

making services more cost-effective, the aim of such systemic transformations should be to help people with disabilities live better, richer lives and gain access to the opportunities outlined by the Americans with Disabilities Act.

While managed care offers potential for reducing the institutional bias of Medicaid policy, Texas has made the decision to take state supported living centers services out of the state managed care program. Taking the most expensive support alternative out of the cost calculation not only will decrease any savings that might otherwise occur, but also will provide the option (and incentive) for managed care programs to divert high cost individuals to institutional services, thus potentially increasing the number of people provided services in the most costly support option.[69] This action removes the most significant opportunity to achieve system-wide savings and improve participant outcomes.
If resources are to be managed effectively to ensure that everyone receives services, including those still on waiting lists, all resources must be managed under the same program structure.

Recommendations for Systems Change in Medicaid Managed Care

1. Services system reform should include the whole system that serves persons with I/DD, including all institutions and all waivers for which persons with I/DD are

   eligible. For significant cost efficiencies to be realized, the most expensive services (institutional services) must be included.

2. Address the current and looming direct support workforce shortage by collecting and analyzing trends regarding workforce demographics and wages, developing and promoting a peer support workforce, expanding consumer direction, and restructuring payment methodologies to ensure that the Texas Legislature has the ability to set direct service wages at levels commensurate with the value and scope of the service.

3. Individuals with I/DD and family members receiving services must participate at the design and implementation stage and on an ongoing basis, review information made available about the performance of the managed care program.

[69] Analysis and Recommendations for the Implementation of Managed Care in Medicaid and Medicare Programs for People with Disabilities. National Council on Disability. 2012 Policy Brief.

4. The role of the local authority should be maintained. Local authorities are responsive to their local communities and have access to local resources, and have demonstrated ability to improve quality.
5. The Person Directed Planning (PDP) process and tool developed with substantial stakeholder input should be included in the future I/DD system. As part of the ongoing implementation of Sec. 48 Rider provision (2009), stakeholders have developed and refined a PDP process and tool that should be expanded to the other programs in the system (including SSLCs).
6. Housing options should be fully integrated in the community, in close proximity to goods and services and not in congregate living environments. TCDD does not support including larger residential options in systems redesign, and notes that providers indicate the cost of retrofitting existing homes to accommodate more residents is generally cost prohibitive.
7. Ensuring that identification and diagnostic services for neurodevelopmental disabilities are accessible to all Texas families will mitigate the impact of preventable disabilities.
8. Policies requiring state agencies to develop an education and SBIRT plan in collaboration with TOPDD would allow Texas to use existing resources to make a significant impact in the incidence of developmental disabilities.

Employment First

Work is a fundamental part of adult life for people with and without disabilities. It provides a sense of purpose, shaping who we are and how we fit into our community. Meaningful work has also been associated with positive physical and mental health benefits and is a part of building a healthy lifestyle as a contributing member of society. Because it is essential to people's economic self-sufficiency, as well as self-esteem and well-being, people with disabilities who want to work should be provided the opportunity and support to work competitively within the general workforce. Individually tailored and preference based job development, training, and support should recognize each person's employability and potential contributions to the labor market.

Individuals with disabilities are much less likely to have a job than individuals without disabilities. In June of 2014, about 63% of working-age Americans were employed.[70] By contrast, only 36% of people with disabilities in the United States are employed and only 23.4% of people with cognitive disabilities.[71] Data for Texans with disabilities is similar. Yet, the majority of non-employed people with disabilities would like to be working, and their job preferences are well within the mainstream – 80% said they would like a paid job now or in the future, which is comparable to the 78% of nondisabled, working-age people who are not employed. And like all workers, individuals with disabilities value job security, income, flexibility and chances for advancement and career. These numbers challenge the idea that the low employment rate of people with disabilities is due to low motivation or job preferences – this data suggests the supply is there. With the coming labor shortages as baby boomers retire, people with disabilities represent a valuable and underutilized resource. Technology advances foster greater ease in integrating workers with disabilities in the workplace.

When individuals with disabilities are provided the appropriate supports to earn competitive wages alongside their non-disabled peers, they are given the opportunity to build wealth and assets which lead to a higher quality of life and a greater degree of independence. The poverty rates of people with disabilities are much higher than that of the general population. Approximately 34% of people with disabilities live on a household income of less than $15,000 per year, compared to 12% of people without disabilities. High levels of poverty lead to people with disabilities being dependent on government funded programs. An Employment First policy that holds individuals with disabilities to the same employment standards and responsibilities of any working-age adult can help individuals with disabilities be independent in the community, build assets, reduce dependence on public funds and services, and avoid the costs associated with current programs.

Data from the National Core Indicators Project suggest that only 14.7% of working age adults supported by state I/DD agencies participated in integrated employment.[72] Community

[70] According to the U.S. Bureau of Labor Statistics: "In June, the civilian labor force participation rate was 62.8 percent for the third consecutive month." United States Department of Labor, Bureau of Labor Statistics, Employment Situation Summary, available online at: http://www.bls.gov/news.release/empsit.nr0.htm (accessed on July 30, 2014)

[71] Smith, F.A., & Clark, D.M. 2007. Disability and Occupation. DataNote Series, Data Note XIII. Boston, MA: Institute for Community Inclusion

[72] Human Services Research Institute, National Core Indicators Annual Summary Report 2011-2012

rehabilitation providers (CRPs) reported that only 27% of individuals with I/DD supported by their organization worked in integrated jobs, including both individual jobs and group supported employment.[73] Those who are employed typically work limited hours with low wages.[74] At the same time, participation in facility-based and non-work services has grown, suggesting that employment services remain an add-on rather than a systemic change.

Employment First

Employment First is the principle that integrated competitive employment should be the expected outcome for people with developmental and other disabilities. The 83rd Texas Legislature (2013) passed a statewide Employment First Policy (SB 1226) which establishes that it is the policy of Texas that earning a living wage through competitive employment in the general workforce is the priority and preferred outcome for working-age individuals with disabilities who receive public benefits. Texas joins at least 42 other states with Employment First efforts. SB 1226 requires the Health and Human Services Commission (HHSC), the Texas Education Agency, and the Texas Workforce Commission (TWC) to jointly adopt and implement an Employment First Policy.

The Employment First Task Force developed and approved recommendations outlined in their first report to the Texas Legislature.[75] The recommendations address a broad range of matters regarding policy, procedures, and rule changes that are necessary to allow the Employment First Policy to be jointly adopted and implemented by HHSC, TEA, and TWC. The Task Force's work is integral to understanding policy barriers and opportunities across state agencies to increase innovation and get people to work.

Day Habilitation Services

Day habilitation facilities provide services in a group setting during weekday work hours and are offered to DADS clients through community-based I/DD waiver and intermediate care facility programs. Day habilitation services are designed to help individuals make connections within their communities. Texas and other states developed day habilitation programs, work activities centers and sheltered workshops recognizing the need to have viable day program options for

[73] Butterworth, et al., StateData: The National Report on Employment Services and Outcomes, 2013
[74] Human Services Research Institute, National Core Indicators Annual Summary Report 2011-2012
[75] Texas Employment First Policy And Texas Employment First Task Force Report, Texas Health and Human Services Commission, Fall 2014 http://www.dads.state.tx.us/providers/supportedemployment/EFTFReport.pdf

individuals with I/DD. While these programs were developed to meet real needs, there is debate about whether these services are truly inclusive or can isolate individuals from meaningful involvement in community activities as currently designed.

In fiscal year 2013, Texas spent more than $96 million on day habilitation services. DADS requires program providers to ensure their subcontractors, including day habilitation facilities, provide safe and adequate services. However, these requirements vary across programs, and contracts between facility owners and providers are not required to include basic quality and safety measures.[76]

Despite rising use of these facilities, DADS does not have basic information on how many of its clients attend day habilitation, where the facilities are located, or problems at these facilities. Directing providers to include basic requirements in day habilitation contracts may improve services and add a layer of protection for clients who attend the facilities; however, it is important to note that some long term services and supports providers also operate day habilitation facilities. Thus, the improvement would be minimal if a provider is put in a position to hold itself accountable to contract requirements. Tracking day habilitation information would allow the agency to identify trends and problems at these facilities and help its clients and providers choose a day habilitation facility.

Sub-minimum Wages

Texas currently has more than 100 employers that utilize certificates from the Department of Labor to pay sub-minimum wages to individuals with disabilities working in sheltered workshops or enclaves. Sheltered workshops typically do not promote full inclusion; do not generally teach readily transferrable or relevant work skills; and usually do not provide wages which allow workers to break the cycle of poverty. Some workers with disabilities in Texas earn as little as 1½–10 cents per hour despite working for a profitable local business. In some cases, providing job coaches for individuals to be successfully employed can be less expensive than paying for the costs of sheltered employment.

The new policies of the federal Workforce Innovation and Opportunity Act (WIOA) include efforts intended to limit the use of sub-minimum wage. Specifically, individuals age 24 and younger are prohibited from working jobs that pay less than the federal minimum of $7.25 per hour unless

[76]Ibid.

they first try vocational rehabilitation services. In cases where individuals with disabilities do earn less than minimum wage, the measure requires that they periodically be provided career counseling by their state and are informed about other work opportunities.

Day habilitation and congregate employment programs are incredibly important in the lives of many individuals, but they are considered a model of the past. Agencies and providers must work together with self-advocates and families to design program options that people want and the resources and incentives for providers to make that transition. It is an opportunity for Texas to proactively move forward by ensuring that day programs provided in all Texas waivers align with the principle and the spirit of the Employment First Policy now adopted by the Legislature.

Recommendations for Employment

1. Develop recommendations for policy, procedure, and rules changes that are necessary to allow the Employment First Policy required to be jointly adopted and implemented by the HHSC, TEA, and TWC.
2. Develop a methodology, with broad agency and stakeholder input, to track services and employment outcomes for people with disabilities across agencies.
3. Develop information for students, adults and families about the impact of employment on benefits and how work incentives can be utilized (including Social Security work incentives).
4. Examine potential changes to day habilitation services based on recent federal CMS guidelines (42 CFR 441.301) that define the settings in which states may provide services in home and community-based waivers for people with IDD.
5. Identify a provider payment structure that incentivizes a collaborative approach to integrated, competitive employment outcomes.
6. Establish goals to increase the number of individuals in integrated, competitive employment and to decrease the number of individuals in workshops earning sub-minimum wage.

Guardianship

The Texas Council for Developmental Disabilities supports protecting the civil rights and well-being of people with developmental disabilities. The vast majority of people with disabilities, including those with I/DD, are able to make important decisions without the need for a guardian. With the provision of supports and services, most persons with disabilities are capable of making important decisions such as where they want to live and the type of care they want to receive without the need for a full or limited guardian.

Guardianship is a legal tool that allows a person to make decisions for another person. As a result, it removes the civil rights and privileges of a person by assigning control of their life to someone else. Although state law in Texas directs a court to encourage the development or maintenance of maximum self-reliance and independence, it is not uncommon for courts to create full guardianships that deprive individuals with disabilities of the right to make fundamental decisions about their lives. The broad definition of "incapacity" in Texas Estates Code has a discriminatory impact by enabling a court to appoint a guardian if an adult has a physical or mental condition and is substantially unable to provide food, clothing, or shelter, to care for their physical health, or manage their own financial affairs. Even though individuals with a disability may need supports and services or assistance from others to provide for such needs, they should still be afforded the right to make choices about these aspects of their lives.

There has been an increase in guardianships throughout Texas in part because resources in some communities have not kept pace with needs. In limited cases, DADS serves as the guardian of last resort for persons with diminished capacity. DADS must be appointed a person's guardian by the courts. Guardian services include ensuring appropriate living arrangements, managing estates, and making medical decisions for the person. In fiscal year 2013, DADS provided guardianship services either directly or through contracts to 1,366 persons. Texas has about 46,000 guardianships statewide. In fiscal year 2013, the DADS guardianship program had 99 staff and a budget of about $6.3 million.

Since 1993, legislation favored tailored, limited guardianships. However, year after year, plenary (full) guardianships have been established. Less-restrictive alternatives are being developed and tailored to individual need; yet, the law does not instruct investigators or guardians ad litem to exhaust possible alternatives. If the need can be filled by a guardianship, the process is

abbreviated. The law promotes building capacity of the individual to make their own decisions. Yet, the requirements to dissolve a guardianship are extremely difficult, expensive and/or impossible for most.

The law presumes all people have capacity for decision-making – this includes people with intellectual and developmental disabilities. People with disabilities should be given the opportunity to avoid or limit guardianship through a variety of alternatives to guardianship such as:

- Power of attorney, medical power of attorney, durable power of attorney
- Limited power of attorney for education decisions
- Medicaid waiver home and community based services and supports
- Surrogate Decision Making program for people in ICFs
- Special needs trusts
- Joint checking accounts or debit cards
- Money management programs
- Social Security's Representative Payment Program
- The Consent to Medical Treatment Act lists those family members and other persons, including a clergy member, who can act as surrogate decision-makers in health care decisions when the person lacks the capacity to make a major medical and dental treatment decisions. (Texas Health and Safety Code, Chapter 313)
- Volunteer Supported Decision Making allows people with limited disabilities to choose a supporter to help them understand information, options, responsibilities and consequences in order to make decisions. Supported decision-making is being piloted in Texas

Parents of children with complex neurodevelopmental disabilities may face financial challenges with the costs of providing care. In some instances, neurodevelopmental disabilities can cause the child to become violent and cause safety concerns for the child, family and community. The behavioral and financial factors may result in families facing the difficult decision of relinquishment. It is important that families are not forced to make this choice. Policies that support families in raising children with complex neurodevelopmental disabilities are needed.

Texas Guardianship Reform and Supported Decision-Making Group

The Texas Guardianship Reform and Supported Decision-Making (GRSDM) workgroup came together in June 2013 to look at the need for policy reforms and less restrictive alternatives to guardianship. GRSDM includes individuals and representatives of the legal profession, family members and advocacy organizations that cross age and disability. Some GRSDM participants also contribute to the Working Interdisciplinary Network of Guardianship Stakeholders, a project of the Texas Supreme Court administered by the Office of Court Administration. Both groups are working to improve guardianship and advance alternatives, such as supported decision-making.

The following recommendations were identified by the GRSDM work group to the guardianship system in Texas that would promote the well-being and protect the rights of people with disabilities:

1. Change Term from “Ward” to “Person” would change the impersonal term “ward” to “person under guardianship.”
2. Bill of Rights for Wards and Proposed Wards lists rights that individuals under guardianship get to keep, such as the right to live, work and play in the most integrated setting, visit with people of their choice, and appear before the court to express their preferences or concerns. Rights for a proposed ward include the right to petition the court and due process.
3. Supported Decision-Making Agreement would establish an informal alternative to guardianship where individuals could choose people they trust to help them understand the decisions they need to make and to communicate their decisions to others.
4. Alternatives to Guardianship lists less restrictive alternatives to guardianship, such as a power of attorney or representative payee and directs the court to determine whether alternatives could meet the needs of the person rather than guardianship.
5. Duties of Guardians would improve protections for individuals committed to institutional settings. This proposal calls for guardians to visit a person in an institution every month and provide timely responses to calls, emails or letters about the person.
6. Limits of Guardianship with Services and Supports requires the court to determine if formal and informal supports are in place or available that enable individuals to meet their needs for food, clothing, or shelter, care for their physical or mental health,

manage financial affairs and/or make decisions so that guardianship may be averted or limited.

7. Guardianship and Decisions about Residence states individuals under guardianship should, if possible, be able to make decisions about where they reside.

TCDD supports the DOJ's recommendation for the state to employ an expert to focus on alternatives to guardianship that will support community living for people with disabilities. These alternatives should include the supported decision making methods that were reported to be working well in at least one SSLC.

Individuals with Complex Needs

While many people continue to believe that people with the most complex behavioral and medical support needs require the services provided by state supported living centers, considerable evidence and experience in Texas and other states demonstrates otherwise. In fact, as many as eight times the number of individuals with the highest level of need live in home and community settings than SSLCs.[77] Thus, Texas clearly has both the capability and the capacity, and is currently serving individuals with complex needs in the community. However, the state system can do more to strengthen its capacity to address crisis, prevent unnecessary institutionalization, and provide ongoing behavior support through integrated service models.

People with more complex health care needs often require more intensive medical services coordinated across multiple providers, as well as a wide range of social supports to maintain health and functioning. In 2013, DADS identified obstacles to community placement for people residing in SSLCs, including the need for supports for people with significant challenging behaviors, specialized mental health supports, environmental and transportation modifications, the availability of specialized medical supports, and meaningful employment.[78]

Individuals with I/DD are three-to-five-times more likely to demonstrate challenging behaviors[79] that can result in self-harm, injury to others, destruction of property, and limited community involvement. Many consumers with complex behavioral issues benefit from the extra support of a crisis management team. Crisis support can include respite services, and a clinical team to provide consultation and coordination with the existing service and support system. Some crisis services are offered as a mobile unit where professionals go into the community to conduct assessments, evaluate for appropriate services that may be needed, and provide crisis stabilization. However these strategies may require additional staffing that is not included in current reimbursement levels. TCDD supports the development and implementation of strategies that address the needs of families in crisis to prevent the unnecessary placement of children in any institutional setting.

[77] Texas Department of Aging and Disability Services Sunset Staff Report with Hearing Material, Sunset Advisory Commission, June 2014
[78] Texas Department of Aging and Disability Services Obstacles to Community Referral and Transition. State Supported Living Centers. 2013
[79] What Do NCI Data Reveal About Individuals With Intellectual and Developmental Disabilities Who Need Behavior Support? NASDDDS and HSRI, September 11, 2014

Current community systems often lack integrated clinical and behavioral services. Few counselors and therapists are available in the community with both the experience and desire to provide services to individuals with I/DD. Because of the range and intensity of services needed, individuals with complex needs tend to be the most costly. States must effectively coordinate the full range of medical, mental health, and social services in order to best support the individual. Service delivery systems must be flexible and integrated to deliver better value to these high-need beneficiaries. The state's recent expansion of managed care models provides an opportunity to strengthen the integration between physical and behavioral to address those Individuals with complex needs.

The Department of Aging and Disability Services makes the following recommendations to build the state's capacity to serve individuals with complex needs within the home and community based system:

1. Access to physical and behavioral health services: Improve access to physical and behavioral health services; especially in rural areas (e.g., explore use of telemedicine).
2. Number of physical and behavioral health providers in the community: Increase the number of physical and behavioral health service providers available in the community by undertaking activities to recruit and retain providers.
3. Transition issues: Address issues encountered just before and following transition from an institution to the community to ensure successful transition and prevent re-institutionalization (e.g., crisis response, faster access to Medicaid coverage in the community).
4. Quality of data collected: Improve the accuracy and completeness of data that inform the appropriateness of interventions and quality of services.
5. Education to help people understand what services and supports individuals need: Help individuals, families, and providers understand I/DD and the appropriate services and supports individuals need.
6. Program rules related to service delivery: Review Medicaid waiver program rules to identify ways to improve service delivery, increase efficiency, reduce costs, increase quality, and improve opportunities for self-determination.

7. Evidence-based practices: Implement evidence-based practices that promise the best outcomes.
8. Workforce training: Provide training to create a highly-skilled provider workforce to satisfy the needs of persons with complex needs in the community (e.g., person-centered thinking, behavior management strategies).

Summary

As transition of SSLC residents to more integrated settings continues, further identification, exploration, and expansion of collaboration efforts between SSLCs and local I/DD authorities to both strengthen the transition process and to expand and improve community-based services for persons with complex behavioral and healthcare needs is necessary. Texas is not alone in facing the challenges of serving individuals with developmental disabilities and their families. Over the years, Texas has demonstrated innovation that is improving the experience of those receiving services. Yet, opportunities remain to further integrate prevention into the full range of health and human services, and to improve the service delivery system consistent with the needs and preferences of individuals seeking support, and that meet national performance benchmarks.

Individuals with disabilities want to have access to services in a timely manner without having to wait for services; to receive services in the most integrated setting; and to have significant input and choice in deciding how those services are delivered. Individuals with disabilities have the same goals as their neighbors — they want to have access to quality health care, have meaningful relationships, and be able to work and build assets needed to be independent and productive members of the community.

Both federal and state policies passed this biennium demonstrate efforts to achieve these goals. The prevention goals, policy review, and system recommendations made in this report offer opportunities for Texas to rebalance the long term services and supports system to focus on the outcomes most important to individuals and their families. TCDD and TOPDD offer evidence based practices and other resources of their agencies to state leaders and policy makers over the next two years as they make decisions on how to conduct the business of supporting Texans with developmental disabilities and their families.

Appendix A: Texas Statute on Biennial Disability Report

Government Code

Title IV, Chapter 531

Section 531.0235. Biennial Disability Reports

Sec. 531.0235. BIENNIAL DISABILITY REPORTS. (a) The commissioner shall direct and require the Texas Planning Council for Developmental Disabilities and the Office for the Prevention of Developmental Disabilities to prepare a joint biennial report on the state of services to persons with disabilities in this state. The Texas Planning Council for Developmental Disabilities will serve as the lead agency in convening working meetings, coordinating and completing the report. Not later than December 1 of each even-numbered year, the agencies shall submit the report to the commissioner, governor, lieutenant governor, and speaker of the House of Representatives.

(b) The report will include recommendations addressing the following:

(1) fiscal and program barriers to consumer friendly services;
(2) progress toward a service delivery system individualized to each consumer based on functional needs;
(3) progress on the development of local cross-disability access structures;
(4) projections of future long-term care service needs and availability; and
(5) consumer satisfaction, consumer preferences and desired outcomes.

(c) The commission, Texas Department of Human Services, and other health and human services agencies shall cooperate with the agencies required to prepare the report under Subsection (a).

As enacted by SB 374, 76th Texas Legislature in 1999. The 76th Legislature also changed the name of the Texas Planning Council for Developmental Disabilities to the Texas Council for Developmental Disabilities (HB 1610).

Appendix B: Sunset Advisory Commission Recommendations for TCDD and TOPDD

Texas Council on Developmental Disabilities

The Sunset Advisory Commission issued a report that recommends the continuation of the Texas Council for Developmental Disabilities (TCDD) for 12 years until 2027. Sunset staff found that TCDD and its functions are necessary to ensure that Texas meets the needs of people with developmental disabilities (DD). The report states that TCDD fulfills the critical role of identifying the most pressing needs of Texans with DD. Once the needs are determined, TCDD works to advance public policy and systems change to allow people with DD to gain more control over their own lives.

The report also recommends that TCDD improve its process for tracking grant project outcomes. Specifically, the report recommends that TCDD establish clear expectations for grant project outcomes and track the progress of five-year grant projects designed to continue beyond the TCDD funding period. The report suggests this information will help TCDD to better identify successful outcomes, increase the effectiveness of future efforts, and ultimately improve the long-term impacts on services offered to people with I/DD.

Texas Office for Prevention of Developmental Disabilities

The HHSC Sunset Staff Report recognized that the state has a reactive approach to services and often addresses issues "downstream." Strengthening prevention across agencies and developing a statewide prevention plan would provide a tremendous positive impact. While the state offers many fine prevention services, it could strengthen all of these efforts by creating an overall plan for integrating prevention, providing consistent messaging and building on each other's strengths.

Policies that require state agencies to work with TOPDD to develop a prevention plan, along with the support to do this, would maximize the impact of the state's individual prevention program and position Texas to obtain increased federal funding.

The Sunset Commission staff report has proposed the removal of TOPDD's Executive Committee, along with TOPDD's independence as being "administratively attached to HHSC." It would allow for the functions of the Office to be maintained, but not necessarily the office itself.

There are several reasons why this proposal is problematic:

- It would seriously diminish and possibly eliminate the Office's ability to fundraise (TOPDD has traditionally raised 80% of its funds). In all of its grant applications, TOPDD emphasizes its independence and structure. While technically some foundations are allowed to give to government entities, the fact is that HHSC does not receive foundation support. TOPDD does because of its unique status.
- It would provide complete and absolute power over an organization (TOPDD) to an entity (the state), which provides only 20% of the funding. This is clearly a poor governance structure.
- It would eliminate the Office's public policy work, which is a major part of its mission. Internal HHSC entities have very strong restrictions regarding public policy efforts. Indeed, HHSC employees are required to engage the HHSC external relations department when speaking to legislators. Whereas TOPDD has legislators on the executive committee (that the Sunset proposes to eliminate). These legislators can shepherd policy change. Policy change is absolutely critical to the prevention of developmental disabilities. Public policies can impact all Texans and take immediate effect. To eliminate this would severely limit effectiveness.
- The purpose of the Office is to provide a coordinated, comprehensive approach to the prevention of developmental disabilities. Since Sunset's recommendations only allows the "functions of TOPDD" to exist, these functions may be assigned to various state entities. This would compromise and fragment the prevention of developmental disabilities. Additionally, these entities would not be able to raise the funds that TOPDD does. This could eliminate the progress that Texas has made in integrating the prevention of developmental disabilities across systems.
- If the Office is not in statute, the rider granting the Office an exception to Article IX, Section 8.01 regarding limits in acceptance of monies would be eliminated. According to Article IX, Section 8.01. "(d) An unexpended balance, from a gift or bequest, existing at the beginning of this biennium or at the end of a fiscal year of this biennium is appropriated for use during this biennium for the purpose provided by the grantor." This exception is extremely important to TOPDD since donors do not time donations in relation to the state's fiscal year.

- TOPDD has a 2-year renewable grant with the Hogg Foundation. The contract it has is with TOPDD, not with HHSC. The Foundation would have no obligation to pay the second year of the grant if there is no TOPDD in legislation. Thus the state would be walking away from over $60,000 that had been obligated to TOPDD.
- The Sunset Commission staff report affirmed the need for TCDD, yet it recommended subsuming the prevention of developmental disabilities into HHSC. The voice for prevention of developmental disabilities, provided by TOPDD is just as needed as the voice for the needs of people with developmental disabilities. Without a strong voice for the prevention of developmental disabilities, the increase in the percentage of people who have developmental disabilities that is described in this report is sure to continue.

This would be a serious step backwards when the state is developing mechanisms for the prevention of developmental disabilities through TOPDD. TOPDD needs to maintain its independence and executive committee.

TOPDD's executive committee requested that the Sunset Commission expand TOPDD's mission beyond the prevention of developmental disabilities so it could use its structure to develop more integrated prevention services across systems and build bridges between prevention initiatives statewide.

Special thanks to
Beth T. Stalvey, M.P.H., Ph.D., Technical Editor
for her time, energy and expertise in preparing this report.

2014

Texas Biennial Disability Report

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Declaration of Garth Corbett Exhibit G

539 Aging and Disability Services, Department of

INTRODUCTION
The Department of Aging and Disability Services' (DADS) mission is "to provide a comprehensive array of aging and disability services, supports and opportunities that are easily accessed in local communities." DADS provides a continuum of long-term services and supports for older Texans and individuals with disabilities, licenses and certifies providers of these services and monitors compliance with regulatory requirements. Services are provided through the agency's Access and Intake, State Supported Living Center and Regulatory divisions.

The involvement of stakeholders and coordination with other health and human services agencies are critical to fulfilling the agency's mission. Through this interaction, DADS is better equipped to achieve our shared goals to enhance quality of life and improve services.

PREPARING FOR THE AGING OF TEXANS
Texas' aging population directly affects DADS service delivery. In 2015, the population of Texans 60 years or older is estimated to be 4.6 million, or 16.7 percent of the total population. By 2020, the projection is 5.7 million, or 18.5 percent of the population. By 2040, the projection is 9.7 million, or 21.4 percent. To address this major shift, DADS continues to develop and implement initiatives and programs, including building community capacity to serve persons who are aging or who have disabilities, promoting wellness and increasing access to informal caregiver services.

CONTINUUM OF SERVICES AND SUPPORTS
DADS is responsible for ensuring that a continuum of services and supports is available for individuals with physical as well as intellectual and developmental disabilities (IDD). Individuals facing physical disabilities are provided with options ranging from home-based Primary Home Care (PHC) and Community Attendant Services (CAS) to services in nursing facilities. Individuals with IDD are offered assistance that ranges from community-based services in home-based settings, small group home settings from 3-6 beds and more intensive services in the 13 state supported living centers (SSLC). The agency must be flexible in meeting the needs of, and providing choices for, those it serves, and it must provide those services efficiently so the greatest number of individuals are served within available resources.

One of the agency's most significant responsibilities is the assurance of the health and safety of persons receiving services in both facility- and community-based settings that it operates, contracts with or regulates.

SB 643, 81st Legislature, Regular Session, 2009, provided a framework for the protection and care of individuals with IDD served by public and private providers and in both facility- and community-based settings.

In addition, SCR 77, 81st Legislature, Regular Session, 2009, approved the state's settlement agreement with the U.S. Department of Justice (DOJ), which provides a comprehensive framework for improvements in each of the SSLCs. In January 2010, court-approved independent monitors began semi-annual reviews of each SSLC to measure compliance with the agreement. These reviews are ongoing.

The most recent reports detailing each SSLC's compliance with the settlement agreement can be found on the DADS website. As stipulated in § III.Q of the settlement agreement, the independent monitors in July 2014 also provided the parties and the court an assessment of the status of compliance with each substantive provision of the settlement agreement.
COMMUNITY-BASED SERVICES
In the past 15 years, Texas has seen a dramatic expansion of community-based services, which are critical to allowing older Texans and those with disabilities to achieve and maintain independence and community integration. Demand for services outpaces available funding, despite generous increases from the Legislature in recent sessions. More than 82,400 individuals are enrolled in DADS and STAR+PLUS waiver programs; however, about 113,000 individuals are on interest lists and can wait

as long as 11 years for requested assistance.

Analyzing and anticipating trends in demand for community programs is essential to meeting future needs. DADS and stakeholders have identified emerging issues in the provision of services, including the need to develop system-wide capacity to serve persons with high behavioral health and/or intensive medical needs. DADS has included several major initiatives to further expand community capacity in its legislative appropriation request to the 84th legislature.

IMPROVING LOCAL ACCESS TO LONG-TERM SERVICES AND SUPPORTS
At the local level, long-term services and supports are administered by multiple agencies with varying intake, assessment and eligibility processes, making it challenging for individuals to identify which services are available and where to obtain them. DADS continues to work with its partners in the state's 39 Local Intellectual Disability Authorities and 28 Area Agencies on Aging to coordinate these services. An emerging focus has been to expand the state's network of aging and disability resource centers (ADRCs) to develop a more streamlined "no wrong door" access system for persons seeking services. DADS is expanding the ADRC initiative to include statewide coverage of this integrated "no wrong door" approach.

REGULATORY SERVICES
DADS affects the lives of more than 682,000 Texans through regulation of the state's nursing facilities, adult daycare providers, assisted living facilities, intermediate care facilities for persons with intellectual disabilities, home health and hospice agencies and community-based services for persons with intellectual disabilities provided through the Home and Community-based Services and Texas Home Living Medicaid waiver programs. DADS conducts routine regulatory inspections and complaint investigations in each of these settings to ensure that individuals receive high-quality services and are protected from abuse, neglect, and/or exploitation.

OPPORTUNITIES FOR BEST PRACTICES AND INNOVATION
The DADS LAR represents a comprehensive approach to meeting the present and future needs of Texans across the array of services, based on input from the DADS Advisory Council and stakeholders. DADS seeks to use information gathered from its regulatory, contracting and direct service operations as well as extensive input from stakeholders to best structure efficient and effective service delivery systems for Texans who are aging or who have disabilities. We request sufficient funding to maintain our current services and improve our systems to meet the state's future growth, being mindful of the state's finite resources.

BASELINE REQUEST
The FY2016–17 baseline request will serve an estimated 142,611 Texans, with 121,692 served in community settings. The baseline request totals almost $8.2 billion in all funds (AF) over the biennium, $3.4 billion in general revenue-related funds (GRR). This is a reduction of $3.5 billion in AF from the FY2014-15 base budget of $11.7 billion. The biennial GRR reduction is $1.4 billion, from a base of $4.8 billion, largely due to individuals receiving or slated to receive Community-Based Alternatives (CBA), nursing facility (NF), or Medically Dependent Children Program (MDCP) services through STAR+PLUS Medicaid managed care at HHSC instead of DADS.

The funding request for DADS has been significantly affected by the expansion of STAR+PLUS managed care over the past six years. The phased movement of CBA into STAR+PLUS has shifted a substantial portion of DADS clients with physical disabilities to HHSC over that time period. In March 2015, the provisions of Senate Bill 7, 83rd Legislature, Regular Session, 2013, will be evident as NFs move into Medicaid managed care. SB 7 also lays out a schedule for piloting and moving most of the remaining DADS Medicaid waiver programs to STAR+PLUS in future years. MDCP, for example, is slated to move to HHSC in September 2016. Each successive expansion of Medicaid managed care has moved an increasing number of individuals previously served by DADS to HHSC services.

In accordance with the instructions, the base request does not include approximately $53.5 million in GR to serve individuals who are currently receiving services or are

expected to receive services by the end of FY2015. Continuing services to these individuals will be addressed in our exceptional items.

EXCEPTIONAL ITEMS
DADS programs touch the lives of numerous Texans, many of whom will require long-term services and supports to achieve or maintain their independence or protect their health and safety. This exceptional item request is made to better serve individuals in the models of care they seek. This request attempts to address these needs, while recognizing the reality of the state's fiscal constraints.

The DADS FY2016–17 biennial exceptional item request includes nine items totaling $532.3 million in GR and $1.3 billion in AF. It affects the entire range of the agency's functions and responsibilities. Several of the items relate to developing new or expanding existing options for individuals in need of complex medical and behavioral services in community-based settings. The request also provides the 13 state supported living centers (SSLCs) with much-needed resources. Under the request, additional funding is also provided to strengthen the agency's regulatory functions.

MAINTENANCE OF CURRENT SERVICE LEVELS
DADS has two exceptional items associated with maintaining expected service levels. These items total approximately $77.2 million in GR and $167.4 million in AF. These funds would be used to continue services to eligible individuals and prevent deficits in agency entitlement and waiver programs.

* Caseload – In order to continue services to individuals receiving assistance in the FY2014–15 biennium, DADS requests $53.5 million in GR and $112.0 million in AF. This amount is necessary to annualize appropriations primarily for persons to be served in non-entitlement programs expected to be served at the end of FY2015. The FY2014–15 appropriations bill included funding to expand community-based services and assumed the steady ramp-up of those services over the biennium. Failure to recognize all who are receiving services at the end of the fiscal biennium could result in the loss of services for some individuals, particularly persons enrolled in the HCS program, receiving services on August 31, 2015.

* Cost Trends – Client-related increases in cost and acuity are expected to trigger a need for approximately $23.7 million in GR and $55.4 million in AF over the next biennium. The majority of these funds are tied to increases in DADS entitlement programs, over which the agency has minimal discretion in service provision. This estimate was based on cost increases observed in the current biennium of up to 4 percent in some of the agency's largest programs. The lack of funding for this item could result in expenditure deficits in entitlement programs.

REDUCING COMMUNITY WAIVER PROGRAM INTEREST LISTS
DADS has two exceptional items totaling approximately $336.3 million in GR and $810.8 million in AF focused on providing community-based services to individuals with intellectual and developmental disabilities (IDD). Taken together, these programs would potentially serve more than 16,600 individuals in the community. These items were heavily supported by agency stakeholders and the DADS Council and represent best practices found in Texas and other states.

* Community Expansion – This item would result in an increase of 15,145 in DADS slots for community-based services. The targeted decrease in individuals on community-based care interest lists will come as the result of new Medicaid waiver and non-Medicaid slots over the biennium. This reduction will cost approximately $305.0 million in GR and $725.7 million in AF. For STAR+PLUS CBA and DBMD, this amount represents full funding of those interest lists. For HCS, MDCP, Texas Home Living, CLASS, and Title XX services, funding would serve 20 percent of the estimated number of eligible individuals on the interest lists who would likely accept services. Finally, the interest lists for In-Home and Family Support and IDD community services would see a reduction of 10 percent from FY 2014-15 levels. The request includes funding for acute care, drug and administrative costs at HHSC, as well as long-term care and administrative costs at DADS.

* Promoting Independence Slots – Experience has shown that there is an increasing demand by individuals for community-based services. To fully comply with federal statutory expectations set out in the 1999 Olmstead litigation, Texas has made tremendous investment in community care in previous biennia. To continue this momentum, DADS requests $31.2 million in GR and $85.1 million in AF to fund 500 slots for individuals moving from large and medium-sized Intermediate Care Facilities for Individuals with an Intellectual Disability (ICFs/IID), 216 slots for children aging out of foster care, and 400 crisis slots for people at imminent risk of entering an ICF/IID. This item also includes 120 slots for moving individuals with IDD from state hospitals and 25 slots for DFPS children transitioning from a general residence operations facility.

ENHANCING COMMUNITY IDD SERVICES FOR PERSONS WITH COMPLEX MEDICAL AND/OR BEHAVIORAL NEEDS
While Texas has invested a great deal in community-based care for persons with intellectual or developmental disabilities, options for community-based services for persons with complex medical and/or mental health issues remain a significant challenge. This fact has been noted by numerous stakeholders as well as Texas Sunset Commission staff this year. To address this issue, DADS is requesting $41.1 million in GR and $58.3 million in AF to expand crisis respite and behavioral intervention programs, targeted services for persons with medical or psychological needs, an increased ICF and HCS rate to encourage the active treatment of these issues, and more intensive service coordination for SSLC residents transitioning to the community. These state funds will be leveraged with local dollars to further increase benefits for individuals with a dual diagnosis or critical medical care issues.

COMPLYING WITH FEDERAL PASRR REQUIREMENTS
In an effort to comply with federal Preadmission Screening and Resident Review (PASRR) requirements applying to all persons who have an intellectual or developmental disability who are entering or seeking admission to an NF, DADS is requesting $43.3 million in GR and $117.7 in AF for the FY 2016-17 biennium. Roughly one-half of this funding would be used to create 1,300 HCS and 200 TxHmL slots to be used by individuals moving or being diverted from an NF. These program expansions further support the state’s promoting independence initiative through expansion of specialized community-based care for individuals with an intellectual or developmental disability. The expenditure of these funds, however, is largely offset by the amount that HCS and TxHmL slots will lower expected new NF admissions for the biennium. This item also contains funds to provide the federally mandated full range of specialized services and intensive service coordination to eligible individuals in NFs or who have recently transitioned from a nursing facility to a community setting. Proper screening and the provision of specialized services are essential to the state’s compliance with federal PASRR requirements.

PROTECTING VULNERABLE TEXANS AND IMPROVING SSLC OPERATIONS
DADS is requesting approximately $32.3 million in GR and $153.8 million in AF to improve the agency’s guardianship, respite, and ombudsman services, as well as increase the HCS funding limit for dental expenditures, install sprinkler systems in small HCS homes required by recently expanded life safety code requirements, and further strengthen the agency’s ability to regulate the growing programs it oversees. Significant efforts also will be made to upgrade facilities, vehicles, and quality improvement programs at the SSLCs.

* Protecting Vulnerable Texans – In this request, DADS would utilize approximately $21.2 million in GR and $41.8 million in AF to make changes within the agency to maintain the safety of individuals receiving DADS care. Hiring additional staff in the DADS guardianship program, increasing the number of assisted living facility contract ombudsmen, and expanding the agency’s Lifespan Respite Care program are all necessary to keep pace with the increasing demands of an expanding long-term care service delivery system in the state. Also under this item, the HCS funding limit for dental expenses would be increased from $1,000 to $2,000 per individual per year to fund the increasing cost of routine and specialized dental services for persons in this waiver program; assistance would be provided to small HCS facilities for fire sprinkler systems required by a recent increase in requirements in the life safety code designed to better protect occupants from the risk of fire; and increased staff necessary to continue the agency’s statutorily mandated regulatory activities in programs that continue to expand in relation to the growing number of persons who are aging or who have disabilities in Texas.

* Improving Support for SSLC Residents – Texas' 13 SSLCs serve approximately 3,400 individuals per month and include facilities for medical services, therapy, vocational programs, and other services. Residential and programming support buildings range in age from 35 years for many and some as old as 100 years. This item requests $11.2 million in GR and $112 million in AF, including $94 million in bond proceeds, to make necessary life safety repairs and renovations at SSLCs. This amount would also finance a 10-year replacement plan for vehicles used to transport individuals, make further quality improvement efforts, and finance a possible reclassification of Qualified Intellectual Disabilities Professionals (QIDP).

The insufficiency of trained and tenured staff who provide direct clinical support for residents adversely affects all SSLCs. This has been a central theme of the reports from the independent monitors who evaluate efforts to achieve compliance with the settlement agreement with the U.S. Department of Justice. The requested reclassification of QIDPs correlate with an HHS enterprise effort to increase salaries for registered and vocational nurses as well as direct support professionals and other positions experiencing high turnover.

AGING AND DISABILITY RESOURCE CENTER (ADRC) IMPROVEMENTS
Finally, DADS is requesting $2.2 million in GR and AF to support the addition of a veterans' resource navigation specialist at each of Texas' 22 ADRCs. These specialists would ensure veterans seeking services have streamlined access to the complex systems of benefits and programs to which they are entitled. These resource navigators will work with existing veteran support systems to provide information, referral, and assistance to veterans regarding VA benefits, healthcare systems, and military support referral sources.

HHSC's LAR and the HHS consolidated budget will include several DADS-related items. These include enterprise-level information technology projects and much-needed salary increases for nurses, SSLC direct support professionals, custodians, laundry workers, and food service workers, where turnover has reached very high levels.

We appreciate your consideration of our Legislative Appropriations Request and look forward to working with the 84rd Legislature to address the needs of Texas' citizens who are aging or have disabilities.

Exhibit 4
Declaration of Edwin Marino, Jr.

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

ERIC STEWARD, by his next friend
and mother, Lillian Minor, *et al.*,
Plaintiffs,
v.
GREG ABBOTT, Governor of the State of Texas, *et al.*,
Defendants.

THE UNITED STATES OF AMERICA,
Plaintiff-Intervenor,
v.
THE STATE OF TEXAS,
Defendant.

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

DECLARATION OF EDWIN MARINO, Jr. REGARDING SUPPLEMENTAL EXHIBITS IN SUPPORT OF PLAINTIFFS' SECOND AMENDED MOTION FOR CLASS CERTIFICATION

I, Edwin Marino, Jr., am an attorney with Disability Rights Texas. I have held this position for seven years. I make this declaration based upon my personal knowledge and am competent to testify thereto.

1. I am directly involved with the individual advocacy efforts on behalf of Thomas Johnson, Johnny Kent, and Joe Morrell, three of the Named Plaintiffs in this matter. Mr. Johnson, Mr. Kent and Mr. Morell all currently reside at the Terrace West nursing facility in Midland, Texas. I have worked with Mr. Johnson, Mr. Kent, and Mr. Morrell for approximately eight months. During that time, I have visited Mr. Johnson approximately six times, Mr. Kent six times, and Mr. Morrell six times. I also

attend the Service Planning Team meetings for Mr. Kent, Mr. Morrell and Mr. Johnson. The individuals involved in the Service Planning Team meetings usually include the nursing facility administrator and staff, a representative from the Local Authority and the men themselves. Disability Rights Texas staff communicate regularly with their case manager from the Permian Basin Local Authority, Luizama Botello, and the administrator of the nursing facility, Dave Johnson (no relation to Thomas Johnson). Additionally, in the course of my advocacy on behalf of Mr. Johnson, Mr. Kent and Mr. Morell, I have reviewed their medical and other records. Based upon my regular communications with and on behalf of Mr. Johnson, Mr. Kent, and Mr. Morell, I have personal knowledge of their living arrangements, conditions of care, treatment and support needs, and their wishes and desires with respect community placement and related services.

2. I have also worked with Leonard Barefield, who formerly resided at Terrace West. I attended meetings of his Service Planning Team which included Mr. Barefield, representatives of the Local Authority, nursing facility administrators and staff, and representatives of the provider who provides Mr. Barefield's group home services. Disability Rights Texas staff continues to communicate regularly with his case manager from his current community services provider in Lubbock, Texas. I have personal knowledge of his current and previous living arrangements, conditions of care, treatment and support needs, and his wishes and desires with respect to his community placement.

Joe Morrell

3. Mr. Morrell moved to the Terrace West nursing facility in Midland, Texas almost three years ago on or about January of 2013. Prior to residing at the Terrace West nursing facility, Mr. Morrell resided at a nursing facility in Odessa, Texas for approximately four years. It is my understanding that Mr. Morrell was placed in the nursing facility in Odessa after he was rescued in 2008 by law enforcement officials from an abusive living and work situation where he was forced to live in a dilapidated bunkhouse and work on an isolated turkey farm in rural Iowa.

4. Mr. Morrell is 72 years old and has an intellectual disability, impaired speech, and glaucoma that impairs his ability to see, particularly in his eye. Mr. Morrell also has wounds on his legs that require ongoing medical treatment and monitoring. Mr. Morrell is highly independent and can clearly articulate what he wants and needs.

5. It is my understanding that, during the six years he has lived in nursing facilities in Texas and the approximately 30 years that he lived in the bunkhouse while indentured at the turkey farm in Iowa, Mr. Morrell has never had an opportunity to live in the community.

6. Mr. Morrell has expressed an interest in leaving his current nursing facility placement and learning more about his options for community living. He has been found eligible for Medicaid-funded Home and Community-based services "HCS" waiver services.

7. Mr. Morrell has repeatedly expressed over a period of years an interest in moving to the community. Any progress toward Mr. Morrell's express goal of leaving

the nursing facility has come as a result of Disability Rights Texas's continuing to advocate for him. His service coordinator and his service planning team have not actively taken steps to move him towards his goal.

8. Although most of his PASRR reviews since December of 2010 have indicated that Mr. Morrell is in need of specialized services, he has not been assessed for or given specialized services, besides service coordination. Mr. Morrell is interested in and may benefit from day habilitation, orientation and mobility training and use of an assistive device as part of specialized services.

9. Mr. Morrell's assessment and review records indicate that the PASRR review process has failed to identify his preferences and need for specialized services. For example, Mr. Morrell's records in 2012 and again in 2015 fail to indicate the outcomes of his PASRR review and assessment for specialized services and, in his May, 2013 PASRR record, entitled "Section E, Alternate Placement Preferences:" the process failed to identify or record Mr. Morrell's preferences. Nothing in Mr. Morell's records reflects any systemic oversight to detect or correct these PASRR process failures. True and correct excerpts from Mr. Morrell's PASRR records are attached hereto as Exhibit A.

10. Mr. Morrell is very friendly, outgoing and nice. In the nursing facility, he spends most of his time in his room watching television, and doesn't have many opportunities to interact with people. If he were given the opportunity to visit and see group homes, he could see how group homes operate and how moving to the community can increase his quality of life. He is very interested in moving to a home in the community.

11. Although he has expressed an interest in learning about community living options over an extended period of time, and he will likely benefit from community living, Mr. Morrell's service coordinator and service planning team are only now in the process of setting up his first visit to a group home and this is being done only after Disability Rights Texas's advocacy.

12. Without additional specialized services and an opportunity to move to the community, it appears that Mr. Morrell will deteriorate and his ability to do things such as activities of daily living and other independent living skills, among others, could diminish.

Johnny Kent

13. Mr. Kent moved to the Terrace West nursing facility in Midland, Texas almost six years ago on or about December of 2008. It is my understanding that Mr. Kent was placed at the Terrace West nursing facility after he was rescued in 2008 by law enforcement officials from an abusive living and work situation where he was forced to live in a dilapidated bunkhouse and work on an isolated turkey farm in rural Iowa for approximately 30 years.

14. Mr. Kent is 65 years old and has an intellectual disability, dementia and medical problems, including high blood pressure, and arthritis. Mr. Kent can articulate what he wants and needs. Mr. Kent can do his activities of daily living independently, such as dressing and hygiene, although he is supervised to a certain degree and receives assistance in the shower. Mr. Kent has problems walking and often drags his feet, has an unsteady gait, and is at risk for falling. Mr. Kent also has slurred speech. He has recently had a seizure that may have further complications in the future.

15. Beginning in 2011, and almost consistently, Mr. Kent's need for specialized services, including occupational therapy, physical therapy, and speech therapy, to address these problems has been documented in his medical and other records. Mr. Kent's service planning team and nursing facility treatment providers have been aware of and have discussed Mr. Kent's need for specialized services but they did not even begin to meet Mr. Kent's need for these specialized services to prevent his regression in walking and speaking until recently. Mr. Kent is not yet receiving specialized services.

16. Mr. Kent's assessment and review records indicate that the PASRR process is inconsistent and fails to recognize Mr. Kent's need for specialized services. For example, although Mr. Kent's records in 2011 identify his need for specialized services, his PASRR records for June 4, August 12, and September 30, 2015, all fail to indicate the outcomes of his PASRR review and assessment for specialized services. Nothing in Mr. Kent's records reflects any systemic oversight to detect or correct these PASRR process failures. True and correct excerpts from Mr. Kent's medical and PASRR records are attached hereto as Exhibit B.

17. Because of his disabilities, Mr. Kent has sometimes engaged in hoarding behavior, pats people on the head without their consent, and has eaten cigarette stubs. Although these behaviors are well documented, and his service coordinator and service planning team are aware of these behavior problems, to my knowledge, Mr. Kent has not been offered any assessment or specialized services to help him address these problems.

18. If Mr. Kent does not receive the specialized services that he needs, it appears that his condition will deteriorate and his ability to do things such as activities of daily living and other independent living skills, among others could diminish.

19. Mr. Kent's primary daily activity is working in the cafeteria in the nursing facility, where he cleans up after lunch, essentially serving as a bus boy. Mr. Kent is not paid for this activity. It is also my understanding that Mr. Kent does not often get out into the community, although he has expressed that he enjoys community outings.

20. Mr. Kent is also interested in learning about and receiving day habilitation services.

Thomas Johnson

21. Mr. Johnson moved to the Terrace West nursing facility in Midland, Texas almost six years ago on or about December of 2008. It is my understanding that Mr. Johnson was placed at the Terrace West nursing facility after he was rescued in 2008 by law enforcement officials from an abusive living and work situation where he was force to live for approximately 30 years in a dilapidated bunkhouse and work on an isolated turkey farm in rural Iowa.

22. Mr. Johnson is 63 years old and has an intellectual disability, dementia, mental health conditions, and cataracts. Mr. Johnson also has impaired speech. However, Mr. Johnson can articulate what he wants and needs. Mr. Johnson can do his activities of daily living independently, although he needs assistance with setting up his clothes to get dressed, preparing for showers and similar activities, as well as other assistance. However, Mr. Johnson has problems with balance and is unsteady on his feet and is at risk for falling. Mr. Johnson also has cataracts and therefore needs

ongoing eye care and glasses. As result of his mental illness Mr. Johnson also has experienced hallucinations for which he needs psychiatric medications to manage.

23. Beginning in March 2011 and to date, Mr. Johnson has been assessed to need specialized services, including occupational therapy and physical therapy, among others, to address his problems. Mr. Johnson's service planning team and nursing facility treatment providers have been aware of and have discussed Mr. Johnson's need for specialized services but they did not even begin to meet Mr. Johnson's need for these specialized services to prevent his regression in walking and speaking until recently. At this time, Mr. Johnson is not receiving specialized services.

24. Mr. Johnson is currently expressing an interest in receiving day habilitation. Mr. Johnson has also expressed an interest in continuing to be told about what it would be like to live in the community in the event that something appropriate becomes available and he decides to transition from his current nursing facility placement to his own home in the community. He has been found eligible for HCS waiver services.

25. Although Mr. Johnson has expressed an interest in learning about community living, his service coordinator and service planning team have been slow to respond to his interest and his needs.

26. Mr. Johnson has on occasion said he is "bored" and that he "has nothing to do," but his service planning team has not acknowledged or responded to these statements. Also, the service planning team has not responded to his need for physical therapy. The service planning team also delayed for months meeting Mr. Johnson's need for new eyeglasses, at first ignoring the problem and then, in response to advocacy from Disability Rights Texas, finally giving Mr. Johnson his old pair of glasses back

that had been repaired. It was not until well after the beginning of November when he finally received a new pair of glasses.

27. If Mr. Johnson does not receive the specialized services that he needs, it appears that his condition will deteriorate and his ability to do things such as activities of daily living and other independent living skills, among others, will likely diminish.

Leonard Barefield

28. Mr. Barefield moved to the Terrace West nursing facility in Midland, Texas in December of 2008. It is my understanding that Mr. Barefield was placed at the Terrace West nursing facility after he was rescued in 2008 by law enforcement officials from an abusive living and work situation where he was forced to live in a dilapidated bunkhouse and work on an isolated turkey farm in rural Iowa for approximately 30 years.

29. Mr. Barefield was born, it is believed, in 1944. Mr. Barefield has been diagnosed with an intellectual disability and other medical problems including hearing loss, a speech impediment, and mental health-related issues. Mr. Barefield's speech impediment can make Mr. Barefield difficult to understand at times, but he is capable of explaining what he wants and needs. Mr. Barefield can do his activities of daily living independently, such as dressing and hygiene, although he is supervised to a certain degree in his daily living activities.

30. It appears that beginning in 2011, Mr. Barefield was assessed and found to need specialized services. Mr. Barefield's Service Planning Team and nursing facility treatment providers were aware of and had discussed Mr. Barefield's need for specialized services but they did not actively seek specialized services. Nor, it seems,

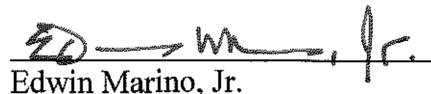
did the service coordination team or nursing facility actively seek a placement in the community for Mr. Barefield.

31. It appears to me that it was not until March 2015, after Mr. Barefield's advocates and attorneys became involved, that a concerted and focused effort began to deliver specialized services to Mr. Barefield and to seek transition into the community.

32. Mr. Barefield's transition into the community did not actually occur until on or about September 1, 2015. It seems that it was only after Mr. Barefield's advocates outside of the Local Authority and the Nursing Facility assisted in coordinating communications between the Local Authority, the Nursing Facility, and HCS providers that the transition process moved forward. It appeared to me that if Mr. Barefield did not have advocates working on his behalf, the PASSR-related services, including transition to the community, may not actually have occurred.

I swear under the penalty of perjury under the laws of the United States that the foregoing is true and correct to the best of my knowledge.

Dated this the 18th day of November, 2015, at Austin, Texas.



Edwin Marino, Jr.

Exhibit 5
Declaration of Ernesto Sanchez

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

ERIC STEWARD, by his next friend
and mother, Lillian Minor, *et al.*,
Plaintiffs,
v.
GREG ABBOTT, Governor of the State of Texas, *et al.*,
Defendants.

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

THE UNITED STATES OF AMERICA,
Plaintiff-Intervenor,
v.
THE STATE OF TEXAS,
Defendant.

DECLARATION OF ERNESTO SANCHEZ REGARDING SUPPLEMENTAL DOCUMENTS IN SUPPORT OF PLAINTIFFS' SECOND AMENDED MOTION FOR CLASS CERTIFICATION

I, Ernesto Sanchez, declare that:

1. I am a Senior Advocate with Disability Rights Texas. I have held this position for 11 years. I make this declaration based upon my personal knowledge and am competent to testify thereto.

2. I am directly involved with the individual advocacy efforts on behalf of Maria Hernandez, one of the Named Plaintiffs in this matter. As part of my advocacy efforts on behalf of Ms. Hernandez, I often go to see her at the nursing facility at which she currently resides. Over the past year, I have visited with her approximately nine times. I also speak regularly with her

mother and legal guardian, Diane Hernandez, her Service Coordinator, and Ms. Hernandez's service planning team from the Alamo Local Authority. In addition, I often attend meetings of her service planning team, which regularly include her mother, the Local Authority, and nursing facility staff. I also frequently speak with her care providers at her nursing facility. In addition, I have attended some medical appointments with Ms. Hernandez and her mother in the community.

3. During the course of my advocacy on behalf of Ms. Hernandez, I have, at various times, reviewed her medical records. I most recently reviewed her nursing facility medical records on or about November 9, 2015, and reviewed her records from the Alamo Local Authority on or about late October 2015.

4. Based upon my extensive work with Ms. Hernandez and Diane Hernandez, as Ms. Hernandez's advocate, as described above, I have personal knowledge of her living arrangements and conditions of her care.

5. Ms. Hernandez is 26 years old, has cerebral palsy, quadriplegia, and rheumatoid arthritis. She is non-verbal and has seizure disorder. She is alert, loves to interact with people, and is highly responsive to her mother's presence. She works hard at trying to communicate with people.

6. Ms. Hernandez currently resides in the Meridian nursing facility in San Antonio, Texas where she has lived for approximately the past eight-and-a half years. Ms. Hernandez's mother and legal guardian, Diane Hernandez, would like for Ms. Hernandez to transition from the Meridian nursing facility to a home in the community with appropriate community supports.

7. On November 18, 2013, a licensed nurse, Rose Servantes, employed by the Alamo Local Authority, the local entity that contracts with the Texas Department of Aging and Disability Services and is responsible for coordinating community services for Ms. Hernandez, conducted a

comprehensive nursing assessment of Ms. Hernandez. In her written assessment, Ms. Servantes concluded that "A community base[d] home setting would be possible if all the services and supports that Ms. Hernandez is currently receiving can be provided." November 18, 2013 Comprehensive Nursing Assessment. A true and accurate copy of the November 18, 2013 Comprehensive Nursing Assessment conducted by Ms. Servantes is attached hereto as Exhibit A.

8. The State of Texas has also determined that Ms. Hernandez is qualified to live in the community as Ms. Hernandez has been found eligible for Medicaid-funded Home and Community-based Services ("HCS") services, and was awarded an HCS waiver slot on December 13, 2013, but is still waiting to move out of her nursing facility.

9. Ms. Hernadez's ability to live in the community has been recently confirmed by her service planning team and service coordinator at Ms. Hernandez's June 2015 service planning team meeting during which Ms. Hernandez's Individual Service Plan ("ISP")/Transition Plan was updated. The June 11, 2015 Service Planning Team Notes, which are part of the ISP/Transition Plan, state that "[i]t was agreed upon that all [Ms. Hernandez's] medical needs can be met in the community, with a community setting." A true and accurate copy of the Individual Service Plan/Transition Plan for Ms. Hernandez is attached hereto as Exhibit B.

10. Diane Hernandez, on behalf of Ms. Hernandez, has accepted the offer of the HCS slot so that Ms. Hernandez could transition to the community. Diane Hernandez has selected HCS provider Premieant, Inc. ("Premieant"), to support Ms. Hernandez in the community.

11. At the request of Diane Hernandez, I have been working with her and Ms. Hernandez to advocate that Ms. Hernandez receive all of the services that she needs so that she can transition to the community successfully. As part of these efforts, Diane Hernandez and I have

started actively working with Premieant to identify an appropriate house in the community for Ms. Hernandez to live in so that she can transition from Meridian. These efforts are ongoing.

12. Ms. Hernandez has some challenging medical needs. As described in her transition plan, Ms. Hernandez will require comprehensive medical services and other supports in the community. Therefore, on or about March of 2015, Disability Rights Texas hired independent nursing consultant, Elaine Klingemann, to evaluate Ms. Hernandez's needs for services in order to transition to the community and for specialized services while she waits at Meridian to transition to the community.

13. Ms. Klingemann conducted her assessment of Ms. Hernandez on or about April 17, 2015. As a result of her assessment, Ms. Klingemann identified the supports that Ms. Hernandez would need to live in the community. These services included: 1) a residential setting in a 3-4 bedroom single-level home; 2) a custodial and skilled care provider available 24 hours per day for seven days per week for the first 30-60 days after leaving the nursing facility during which new providers should be trained on how to provide the nursing and care services to Ms. Hernandez. This recommendation included a proposal for 24-hour services of a licensed vocational nurse ("LVN") for the first three weeks after transition, after which the LVN services would be reduced to 16 hours per day for the next 30-45 days, and then reduced to approximately16 hours a week thereafter; 3) personal care assistance; 4) PEG tube feeding; 5) reintegration back into the community which would include getting Ms. Hernandez out of bed daily, a day program, and social re-entry with family or other residents of the home; 6) community outings; and 7) transportation to medical appointments. A true and accurate copy of Ms. Klingemann's recommendations is attached hereto as Exhibit C.

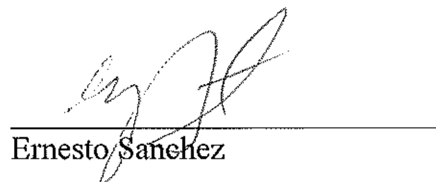
14. I gave a copy of Ms. Klingemann's recommendations to Ms. Hernandez's service coordinator and to some of the members of her service planning team as well as to Ms. Hernandez's care planning team at Meridian. On or about June of 2015, Ms. Klingemann participated by phone in a meeting of Ms. Hernandez's Service Planning Team members who were responsible for community transition services for Ms. Hernandez at which I was present. During the meeting, Ms. Klingemann presented her recommendations to Ms. Hernandez's Service Planning Team.

15. Identification of the community services and supports Ms. Hernandez would need to successfully live in the community goes back to June of 2013. On or about June of 2013, an independent physical therapist, Cari Dixon, PT, who was retained by Disability Rights Texas to evaluate Ms. Hernandez's physical therapy needs, also identified specific physical therapy supports and services that Ms. Hernandez would need to live in the community. These recommendations included: consultation by a physical therapist working with Ms. Hernandez with an assistive technology professional as well as consultation provided by the physical therapist to Ms. Hernandez's community living direct care staff to ensure they understand how to transfer Ms. Hernandez safely, understand her equipment, and how to carry out a home physical therapy program to help her with range of motion. A true and accurate copy of Ms. Dixon's June 11, 2013 Physical Therapy Evaluation for Ms. Hernandez is attached hereto as Exhibit D.

16. Ms. Hernandez is still waiting to move to the community, which has necessitated requesting multiple extensions of her HCS waiver. Consequently, she continues to reside in her nursing facility where she has almost no opportunities for socialization and no access to community activities.

I swear under the penalty of perjury under the laws of the United States that the foregoing is true and correct to the best of my knowledge.

Dated this the 19th day of November, 2015, at San Antonio, Texas.



Ernesto Sanchez