



2020 Revised Texas Promoting Independence Plan

As Required by

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Regular Session, 2011 and

Executive Order RP-13

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Executive Summary

The 2020 Revised Texas Promoting Independence Plan (Plan) is the tenth update to the original Plan submitted in January 2001. Texas's Plan is a direct response to the United States (U.S.) Supreme Court's *Olmstead* ruling, which requires states, within certain conditions, to provide individuals an opportunity to live in the most integrated setting appropriate to their needs to receive long-term services and supports (LTSS).¹ The Plan and the subsequent Promoting Independence Initiative (Initiative) to implement the Plan are far reaching in their scope and enactment efforts. The Initiative includes all LTSS and the state's efforts to improve the provision of community-based alternatives, ensuring these programs in Texas effectively foster independence and acceptance of people with disabilities, and provide opportunities for people to live productive lives in their home communities.

The biennial revision of the Plan provides documentation of progress and challenges, as well as recommendations for improvement. The 2020 Plan is organized in a strategic plan framework with clearly defined and measurable goals to assess ongoing progress in rebalancing the LTSS system.

The Plan applies to an individual with a disability who is residing in or exiting an institution including a nursing facility, a public or private large or medium intermediate care facility for an individual with an intellectual disability (ICF/IID), an institution for mental disease (IMD) or a general residential operations (GRO) facility for children.² The Plan pertains to children and adults.

Key findings and updates since the 2018 report include:

- Increased number of individuals transitioned from an institution in calendar year 2019 (2,176 people) as compared to calendar year 2018 (2,120 people);
- Enrollment trending favorably to meet legislative appropriations allocated to interest list reduction to enroll an additional 1,628 individuals into the 1915(c) Medicaid waivers including Community Living Assistance and Support Services (CLASS), Deaf-blind with Multiple Disabilities (DBMD), Home and

¹ *Olmstead v. L.C. ex rel. Zimring*, 119 S.Ct. 2176, 2190 (1999).

² Texas Government Code. Sec. 531.0244. ENSURING APPROPRIATE CARE SETTING FOR PERSONS WITH DISABILITIES. Sections 531.042, 531, 0422.

Community-based Services (HCS), Medically Dependent Children Program (MDCP) and Texas Home Living (TxHmL) ;

- Extension of the Texas Money Follows the Person Demonstration (MFPD) authorization through 2024;
- Increased housing units for those exiting institutions by partnering with the Texas Department of Housing and Community Affairs (TDHCA) in Department of Housing and Urban Development's (HUD) Project 811 Project Rental Assistance beginning in 2015;
- Expanded housing partnerships to include Texas State Affordable Housing Corporation (TSAHC) to create up to 30 additional housing opportunities in Dallas and Travis counties;
- Increased involvement of the HHS Office of the Ombudsman in managed care complaint resolutions;
- Expanded available crisis services for individuals with an intellectual or developmental disability (IDD); and,
- Received legislative direction to develop a pilot program to deliver home and community-based services for individuals who have IDD or a traumatic brain injury (TBI) or other individuals with similar functional needs who are not currently being served in an IDD waiver or ICF/IID.

1. Introduction

Executive Order RP-13³ and Texas Government Code, Section 531.0244⁴ direct the Health and Human Services Commission (HHSC) to develop a plan to ensure appropriate care settings for individuals with disabilities. The provision of a system of services and supports is required to foster independence and productivity, including meaningful opportunities for an individual with a disability to live in the most appropriate care setting. In 2002, Governor Rick Perry issued Executive Order RP-13 to reinforce and broaden the scope of the Initiative. The Plan serves as an analysis of the availability, application, and efficacy of existing community-based supports for individuals with disabilities. HHSC is required to report on the Plan's implementation status every other year.

The 2020 Plan is the tenth revision of the Plan originally submitted in January 2001,⁵ which described how Texas will provide community-based options within the LTSS system. The Plan is in direct response to the Supreme Court's *Olmstead* ruling, which requires states, with certain conditions, to provide individuals an opportunity to live in the most integrated setting appropriate to their needs to receive LTSS.⁶

The state's accomplishments since 2001 in developing and providing community options for all Texans are significant. The LTSS system continues to evolve and is different than it was in 2001. The Legislature significantly increased appropriations for the number of community waiver slots throughout the past decade. It also expanded community access through State of Texas Access Reform+PLUS (STAR+PLUS), the Texas Medicaid managed care program for adults who are elderly or who have disabilities. The Plan provides the comprehensive working plan in response to *Olmstead*.

The Plan includes the following sections.

³ Executive Order RP-13 follows Executive Order GWB 99-2 as the second community-based alternatives Executive Order. See Appendix A for Executive Order GWB 99-2 and Appendix B for Executive Order RP-13.

⁴ As enacted by S.B. 367, 77th Legislature, Regular Session, 2001.

⁵ As required by Governor George W. Bush's Executive Order GWB 99-2.

⁶ For more information about the *Olmstead* decision, majority opinion written by Justice Ginsburg, go to: http://www.ada.gov/olmstead/olmstead_about.htm.

Section 2 sets forth the vision and mission which provides an overarching guidance for the activities in the Plan, underscoring the state's commitment to a comprehensive, effectively working plan to continue to expand opportunities for individuals to live in the most integrated setting.

Sections 3 and 4 provide an update and analyses of the extent to which Texas is providing services in the most integrated setting.

Section 5 discusses planned activities and objectives related to the Plan over the next two biennia. Each of the eight goals includes strategies to achieve the goal, in reasonable timeframes with measures that can be supported with current or newly collected data in the next update to the Plan. Some of the benchmark data will allow us to measure and compare improvement year over year.

2. Background

The Initiative includes all LTSS and the state's efforts to improve the provision of community-based alternatives, ensuring these programs in Texas effectively foster independence and acceptance of people with disabilities, and provide opportunities for people to live productive lives in their home communities. To fully understand the purpose, comprehensive nature, and implications of the Initiative within the state, it is important to start with the history of the Initiative including relevant information related to the *Olmstead* decision. *Olmstead* was filed in Georgia, on behalf of two individuals with mental and cognitive disabilities living in state-operated institutions.⁷ They claimed a right to care in an integrated setting based on the guarantees under Title II of the Americans with Disabilities Act of 1990 (ADA).⁸

In 1999, the Supreme Court held in *Olmstead* that the unnecessary institutionalization of persons with disabilities constitutes unlawful discrimination under the ADA. The ruling requires states to serve persons with disabilities in community settings, rather than in institutions, when:

- The state's treatment professionals have determined community placement is appropriate.
- The transfer from institutional care to a less restrictive setting is not opposed by the affected individual.
- The placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with disabilities.⁹

The U.S. Congress instructed the U.S. Attorney General to issue regulations implementing the ADA Title II discrimination proscriptions. One such regulation, known as the "integration regulation," requires a public entity to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."¹⁰

Another ADA regulation requires states to "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service,

⁷ *Olmstead*, *supra* note 1, at 2183.

⁸ 42 U.S.C. Section 12131 *et seq.*

⁹ *Olmstead v. L.C.*, 119 S.Ct. 2176, 2190

¹⁰ 28 CFR Section 35.130(d).

program or activity.”¹¹ Fundamental alteration of a program takes into account three factors:

- The cost of providing services to the individual in the most integrated setting appropriate;
- The resources available to the state; and
- How the provision of services affects the ability of the state to meet the needs of others with disabilities.¹²

The Supreme Court suggested a state could establish compliance with Title II of the ADA if it demonstrates it has a: “comprehensive, effectively working plan for placing qualified persons¹³ with mental disabilities in less restrictive settings, and a waiting list that moves at a reasonable pace not controlled by the state’s endeavors to keep its institutions fully populated.”¹⁴

Following the *Olmstead* decision, HHSC embarked on the Initiative and appointed the Promoting Independence Advisory Board¹⁵. The Promoting Independence Advisory Board assisted HHSC in crafting the state’s initial response to the decision. They met during fiscal years 1999 and 2000.

In 2001, the Legislature codified many of the provisions in the original Plan and re-named the Promoting Independence Advisory Board the Interagency Task Force on Appropriate Care Settings for Persons with Disabilities.¹⁶ The Task Force was commonly referred to as the Promoting Independence Advisory Committee (PIAC). In accordance with Texas Government Code, Section 531.02441, the PIAC was set to expire effective September 1, 2017.

Stakeholder Input Promoting Independence Workgroup

In January 2018 HHSC convened a Promoting Independence Workgroup (PIW) comprising representatives of many of the same organizations that participated in

¹¹ 28 CFR Section 35.130(b)(7)(1998).

¹² *Olmstead v. L.C.*, 119 S.Ct. 2176, 2188 -2189.

¹³ To be a “qualified” individual with a disability, the person must meet the essential eligibility requirements for receipt of services or participation in a public entity’s programs, activities, or services (119,S.Ct. 2176, *2188/ 42 U.S.C. Subchapter. 12132, Subchpt.12131 (2)).

¹⁴ *Olmstead v. L.C.*, 119 S.Ct. 2176, 2189 - 2190.

¹⁵ As directed by Executive Order GWB 99-2

¹⁶ Senate Bill (S.B.) 367, 77th Legislature, Regular Session, 2001.

the PIAC. The PIW includes representatives from provider organizations, disability rights organizations, managed care organizations, children’s advocacy groups, individuals receiving services, family members, Aging and Disability Resource Center (ADRCs) and the Texas Workforce Commission (TWC). (See Appendix C for a list of organizations.) Collectively, the disability groups represent older adults and individuals with physical disabilities, IDD or related conditions¹⁷.

PIAC’s initial charge was to assist the Texas Health and Human Services (HHS) system with the development of a comprehensive, effective working plan to ensure appropriate care settings for persons with disabilities. When the PIAC ceased operating, the requirement to produce a stakeholder report also ended. To provide continuity, the PIW provides similar guidance to HHSC by presenting recommendations for the update of the 2018 and 2020 reports.¹⁸

Vision, Mission and Guiding Principles

Vision: Individuals have the right to live in the most integrated setting of choice to receive LTSS that effectively foster independence and provides for a quality life.

Mission: The mission of the Initiative is to implement a comprehensive, effectively working plan that provides a system of services and support that fosters independence and productivity and provides meaningful opportunities for a person with a disability to live in the most integrated setting.

The goals for continued progress include:

Goal 1: Increase access to and strengthen the community-based service array.

Goal 2: Continue to transition children from institutions to family-based settings and enhance community-based supports for children with behavior support needs.

Goal 3: Strengthen managed care support for transitions to and remaining in the community.

Goal 4: Increase access to comprehensive behavioral health services to support individuals to transition to and remain in the community.

Goal 5: Maintain and improve relocation services.

Goal 6: Continue to expand housing opportunities for individuals exiting institutions.

Goal 7: Support community-integrated employment of persons with disabilities.

Goal 8: Improve recruitment and retention of direct service workforce.

¹⁷ A related condition is a disability, other than an intellectual disability, that originated before age 22 and affects a person's ability to function in daily life.

¹⁸ See Appendix E for recommendations from the PIW.

Stakeholder Involvement

PIW stakeholders reviewed the changes to the LTSS system identified in the original Plan in 2001, and with that in mind, noted emerging recommendations in 2020, such as:

- Flexible funding needs to be operationalized so that funding follows individuals, within certain parameters, as they move from an institution to community-based services rather than a specific number of slots being allocated by the Legislature per biennium.
- Ensuring that information is available, and services options are explained, at the first point of intake or entry, in a way that allows individuals and/or their representatives and families to make an informed choice.
- Eligibility requirements should be aligned across waivers so that TxHmL eligibility aligns with other waivers.
- Outreach and educational materials are needed so people can use the systems in place: STAR+PLUS Home and Community Based Services (HCBS), Community First Choice (CFC), and all existing avenues for diversion to avoid institutionalization.
- Supports and services should be sufficient and flexible to meet to variety of needs, including health, employment, and independence.
- A single comprehensive process is needed to assess needs and preferences regardless of the program or population.

HHSC priorities align with several of the PIW recommendations, including to improve outreach and education given the changing landscape with Medicaid managed care expansion and the recent addition of a new state plan service, CFC. Outreach and education is included as a strategy to meet Goal 1, increase access to services. The educational materials can also be used when individuals initially reach out to the ADRC, local intellectual and developmental disability authorities (LIDDA) or local mental health authorities (LMHA) front door to services. The No Wrong Door system is designed to streamline public access to LTSS. ADRCs, including LIDDAs and LMHAs serve as a key point of access to person centered LTSS specialized information, referral and assistance and provide one-stop access to information for people who need help finding LTSS. ADRCs help navigate complex information regarding funding sources, multiple intake systems, and eligibility processes.

HHSC also agrees with developing a single assessment tool which is a key recommendation of HHSC's Intellectual or Developmental Disability System

Redesign Advisory Committee (IDD SRAC).¹⁹ This is noted as a strategy to address Goal 3, strengthen managed care support for transitions and remaining in the community.

The remainder of the recommendations listed above are more complex, would take longer to implement and/or require legislative action. Similarly, making eligibility criteria consistent across waivers would require more in-depth study of the impact on costs, the people served, as well as federal waiver approval. Although HHSC priorities do not incorporate all the stakeholder recommendations at this time, other changes are identified to meet the intended goals of this Plan. See appendix E for a complete list of stakeholder recommendations.

Alignment with other HHSC Strategic Plans

HHSC staff and workgroups maintain multiple strategic plans aimed at improving services for individuals with IDD or a related condition, individuals with behavioral health needs, residents of state supported living centers (SSLCs), and individual with disabilities. In addition, in 2019 the Legislature required HHSC to develop a strategic plan related to community attendant recruitment and retention.²⁰

Guiding principles in this report align across the respective strategic plans. Common themes include dignity, choice, community integration, strong service coordination, and comprehensive array of services.

Recognizing the significant progress achieved over the last 20 years, the Initiative and the Plan maintain an emphasis on improving access and availability of community-based services, meeting statutory requirements, and compliance with the Olmstead decision. The Plan is dedicated to building upon previous achievements, promoting individual self-determination, and improving availability of community-based options. The 2020 Plan builds upon the original Plan and subsequent revisions. While much has been accomplished, efforts must continue to ensure individuals have appropriate community-based options when considering their LTSS.

¹⁹ <https://hhs.texas.gov/reports/2018/10/implementation-acute-care-services-long-term-services-supports-system-redesign-individuals>

²⁰ 2020-21 General Appropriations Act, House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 157).

3. Success Moving Individuals to Integrated Settings

This section demonstrates actions HHS has taken to move people with disabilities forward in recent years and since the inception of the Plan.

Key Achievements

Since 2001, Texas has made significant progress in transforming a previously institutional-based LTSS system to a community-based LTSS system, by:

- Shifting expenditures for LTSS from institutional costs to less costly services delivered within the community²¹; and
- Transitioning over 53,296 individuals from institutional settings to living in the community.

This progress has been achieved through appropriations by past Legislatures and policies instituted throughout HHS. Texas continues to make significant contributions to the Initiative through expanding opportunities for improved service coordination and delivery of community-based services.

Progress Since the Last Biennium Update

Extension of Texas MFPD

MFPD is a federal initiative designed to help states rebalance their LTSS by providing grant funds and enhanced match for community services delivered within the first 365 days after a qualified individual exists a qualified institution. MFPD targets individuals who had been in an institution continuously for at least 90 days and who may have complex needs.²² The Texas MFPD was authorized through 2024. The extension of the MFPD will allow Texas to support individuals to transition to the most integrated setting of their choice. It supports building the infrastructure to ensure needed supports, such as transition services, local contact agencies for referrals to transition from institutions, quality community-based services, and housing will be in place to support transition. HHSC's request to the Centers for Medicare and Medicaid Services (CMS) to continue with MFPD shows the state's commitment to building and maintaining an effectively working system for individuals transitioning from institutions.

²¹ <https://www.medicaid.gov/medicaid/ltss/downloads/balancing/mfp-field-reports-18.pdf>

²² Deficit Reduction Act of 2005 §6071, Pub. L. No. 109-171 (2005).

Expanded housing opportunities through Section 811, Project Rental Assistance (PRA)

HHSC is partnering with the THDCA to create an additional 444 housing units, with Section 811 Project Rental Assistance (PRA), for individuals exiting institutions, those with mental health issues, and youth exiting the foster care system. HHSC partnered with the Texas Department of Housing and Community Affairs (TDHCA) to operate HUD's Project 811 PRA. Texas leads the other 26 Section 811, PRA states in number of units built and filled²³. Based in part on Texas' efforts to create community-integrated housing options for persons with disabilities and TDHCA's ongoing collaboration with HHSC to jointly operate a housing voucher program (see Project Access, below), TDHCA was awarded funding from HUD fiscal year 2012 Section 811 PRA Program Demonstration round to support approximately 350 units of affordable, accessible, and integrated housing. Texas applied for and was approved by HUD for an additional \$12 million to support approximately 296 additional units under HUD's fiscal year 2013 Section 811 PRA Program round. HUD recently awarded TDHCA its "fiscal year 2019 Award" of approximately \$7 million to serve about 130 households.

Being the national leader in Section 811 PRA helps the state to identify challenges and barriers before other states. The strong interest in Section 811 PRA and outreach lead to longer than expected interest lists. Texas became aware that the housing units were disproportionately filled by those who could move in immediately after the unit became available and did not need to wait for eligibility or service plan approval. To address this, HHSC and TDHCA initiated policy changes so the program could more easily serve all intended target populations. In addition, to maximize the impact of the Section 811 PRA Program, TDHCA is implementing its first Risk Mitigation Fund (RMF) through grant funding provided through HHSC under the Money Follows the Person Interagency Cooperation Contract. These changes are discussed in more detail in the housing section of this report.

Built new housing partnerships to include Texas State Affordable Housing Corporation (TSAHC)

The new partnership between TSAHC and HHSC will result in up to 30 additional housing opportunities in Dallas and Travis counties over the next two fiscal years.

Expanded crisis service for individuals with IDD

Crisis intervention and crisis respite are designed to support individuals to maintain their independence in the community and to prevent unnecessary

²³ <https://www.hudexchange.info/programs/811-pra/pr-program-grantees-and-awards/>

institutionalization. HHSC directed all 39 LIDDAs statewide to provide crisis intervention and crisis respite services. In fiscal year 2018, 3,253 individuals received crisis intervention services and 4,023 individuals received such services in fiscal year 2019. In fiscal year 2018, 766 individuals received crisis respite services and 869 individuals received crisis respite services in fiscal year 2019.

Developing community-based services for an unserved population

HHSC is in the planning stages to operate a pilot program to provide LTSS to those who are not currently being served in an IDD waiver or ICF/IID: individuals in STAR+PLUS with IDD, a TBI, or similar functional needs as those with IDD and are not receiving services elsewhere. HHSC has established a new advisory committee, the STAR+PLUS Pilot Program Workgroup, to advise on the pilot program. ²⁴

Studied interest lists to determine ways to reduce the interest list

To determine the cause of wait times for waivers and possible means of reducing waiver interest lists, HHSC reviewed other state practices, factors affecting interest list growth and characteristics of those on the interest list, as well as strategies to eliminate the interest list and the cost to eliminate the list.²⁵ HHSC continues to consider the study's findings and approaches to more efficiently provide access to waiver services. More details about upcoming activities are included in the interest list reduction section below.

Supported the community-based workforce

HHSC held a cross-agency forum to inform the development of a strategic plan for improving the recruitment and retention of community attendants. Implementing the strategic plan over the next several biennia will help the state advance its *Olmstead* Plan by working to increase the number of direct service workers available to serve people in community settings.

Held listening sessions to hear from stakeholders

In fiscal year 2020, HHSC hosted seven disability listening sessions across the state to understand the issues that are important to stakeholders. In response to these listening sessions, HHSC developed a Disability Services Action Plan to serve as a

²⁴ H.B. 4533, 86th Legislature, Regular Session, 2019.

²⁵ <https://hhs.texas.gov/reports/2020/09/medicaid-waiver-programs-interest-list-study>; 2020-21 General Appropriations Act, H.B. 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 42)

road map to improve services and support for all people with a disability through improved coordination within HHS and collaboration with external partners.²⁶

Strengthened oversight of managed care organizations

HHSC centralized most complaints and inquiries, with the exception of those sent directly to the MCO, in the Ombudsman's office beginning in 2015. In accordance with Government Code Section 531.0213(d)(5), HHSC collects and maintains statistical information on a regional basis regarding calls received by the Ombudsman Managed Care Assistance Team (OMCAT) and publishes quarterly reports that: list the number of calls received by the region; identify trends in delivery and access problems; identify recurring barriers in the Medicaid system; and indicate other problems identified with Medicaid managed care. One of the issues monitored is transitions to the community. Improved oversight helps HHSC, MCOs and providers address problems more quickly and change policy, if need be, to prevent barriers to individuals living in the most integrated setting.

Progress Since the Initiative began in 2001

Texas has made significant strides to implement a working Plan to foster independence, choice and freedom to live in the most integrated setting of choice.

Participation in the federal Money Follows the Person Rebalancing Demonstration Grant (MFPD) since 2008

HHSC has earned approximately \$42 million²⁷ in enhanced funding through fiscal year 2020 to support individuals who want to relocate from an institution to a community setting. Texas' participation facilitated the transition of 10,887 people since 2008, expansion of housing opportunities, the implementation of a quality-based monitoring system for community-based services, utilization of the Minimum Data Set (MDS) to identify individuals who want to transition and provided additional transition support.

Closure of large ICF/IIDs

HHSC reduced the number of residents in large ICF/IIDs from over 1000 in 2009 to around 300 in 2019, with the majority of former ICF/IID residents enrolling in the HCS community-based waiver program. The voluntary closure program was a

²⁶ Disability Services Action Plan, <https://hhs.texas.gov/reports/2020/08/disability-services-action-plan>

²⁷ CMS approved CY2020 Money Follows the Person Budget. Unpublished.

benefit offered by MFPD, beginning in 2011. See Section 4, Institutional Census in this Plan.

Adding diversion opportunities

HHSC added diversion opportunities for adults with Social Security Income (SSI) Medicaid in the legacy Community Based Alternatives (CBA) waiver program (STAR+PLUS HCBS replaced the CBA program, as discussed below) for those in nursing facilities in 2011 and for adults and children at imminent risk of institutionalization to community waiver programs for people with IDD, effective September 2008. Diversion allows an individual who meets the following criteria to be enrolled in a waiver without going into the institution or being placed on the interest list. Each waiver program has specific criteria for accessing diversion, but at a minimum, the criteria includes:

- the individual is at imminent risk of institutionalization;
- existing community-services are inadequate to meet the individual's needs; and,
- the individual meets the required level of care and other qualification to be enrolled in a waiver.

Codifying the requirements to inform individuals in institutions of their right to learn about community options across facility setting

The outreach and education activities across setting include the following.

Using the MDS to identify individuals in nursing facilities who expressed interest in learning more about living in the community

The MDS is a health status screening and assessment tool used for all residents of long term care Medicaid certified nursing facilities. HHSC creates a monthly report from the MDS to provide information to the MCO or LIDDA for outreach about community options. Having an effective identification process is a critical component to the state's Plan. MCOs, by contract, are required to review the MDS and to provide information about community options to anyone who expresses an interest in relocating.

Sharing Community Living Options Information with People in State Supported Living Centers

Contracted LIDDAs perform activities to provide information and education about community living options to persons who are 22 years of age or older residing in a SSLC, or to the person's legally authorized representative (LAR). The process is called Community Living with a SSLC in their catchment area. In fiscal year 2020,

the LIDDAs shared CLOIP information with 2032 individuals. The LIDDA is responsible for the following under CLOIP:

- providing information about community living options information to all persons living in the assigned SSLC and their LAR at least one time per year;
- completing the CLOIP Instrument and provide a written report to the SSLC and designated LIDDA no later than 14 calendar days prior to the person's SSLC annual planning meeting;
- attending the SSLC annual planning meeting in person or by teleconference, unless the resident or their LAR has specifically requested the LIDDA not participate; and
- submitting choice information through the Client Assignment and Registration System and the Mental and Behavioral Health Outpatient Data Warehouse.

Community Living Options for People with IDD in Nursing Facilities

Community Living Options (CLO) for people with IDD in nursing facilities is a process by which the LIDDA provides information to an individual and/or legally authorized representative (LAR) about the range of community living services, supports and programs the individual may be eligible for, and discusses services and supports the individual will need to live in the community, as well as individual preferences, and barriers to community living. CLO must be presented in a manner that the LAR and individual will understand fully. Since CLO is an option the individual and/or LAR can decline to participate in the CLO process; such a decision must be documented.

Expanding managed care incrementally to statewide coverage

By September 1, 2014, HHSC had expanded the STAR+PLUS managed care program statewide. STAR+PLUS services individuals with physical disabilities or who are elderly. Per legislative direction, the STAR+PLUS HCBS program was also expanded statewide and replaced the CBA program. Part of this expansion also included eliminating an interest list for individuals with SSI eligible for the STAR+PLUS HCBS program. Participating in the Promoting Independence initiative became an MCO contract requirement.

Expansion also included a dual demonstration project designed to offer a new way to serve people who are eligible for both Medicare and Medicaid, known as dual eligibles. The Dual Eligible Integrated Care Demonstration Project, or Dual Demonstration, is a fully integrated managed care model for individuals age 21 and older who are dually eligible for Medicare and Medicaid and required to be enrolled

in the STAR+PLUS program. This capitated model involves a three-party contract between an MCO with an existing STAR+PLUS contract, HHSC, and CMS for the provision of the full array of Medicaid and Medicare services. The goal of the project is to better coordinate the care those dual eligible members receive by testing a model where one health plan delivers both Medicare and Medicaid services to improve coordination of services for dual eligibles, enhance quality of care, and reduce costs for both the state and the federal government. Since 2017, about 70 percent of MFPD participants who transitioned to the community are also in the dual demonstration project.

Including nursing facilities in a managed care model

In March of 2015, HHSC carved nursing facility services into the STAR+PLUS service array and directed MCOs to take responsibility for relocation services and ensure transitions to the community occur. This increases the possibility that transitions from nursing facility occur more seamlessly. MCOs have a presence in the nursing facility due to service coordination contractual requirements and to address any Money Follows the Person requests. MCOs and relocation contractors partner to maximize resources for service planning and transition assessments, purchasing transition items and being present on the day of transition. The nursing facility carve-in is important to the Plan because funding can be transferred from the state plan nursing facility (an entitlement) to community-based waiver services for which there is usually an interest list. If the individual selects to transition to the STAR+PLUS HCBS waiver and has Medicaid, there is no wait. This is a significant change for moving individuals from facilities to STAR+PLUS HCBS.

Implementing Community First Choice, effective June 1, 2015

HHSC began offering a state plan personal assistance services/habilitation to those who qualify and meet an institutional level of need in June 2015. CFC is a significant contributor to the Plan because qualified individuals, including those enrolled in Medicaid on an interest list for waiver services, can receive services through CFC while they wait for a waiver slot.

Expanding statewide, in September 2015, the Youth Empowerment Services (YES) 1915(c) waiver

YES is a comprehensive home and community-based services waiver for children, ages 3 through 18, at risk of institutionalization or out-of-home placement due to their serious emotional disturbance. The YES waiver continues to be a focus of the Plan for reducing institutionalization and out-of-home placements.

Forged partnerships with housing agency partners to increase access to affordable housing

HHSC and TDHCA partnered to increase housing opportunities for individuals who wish to leave an institution to live in the community. Texas' Section 811 PRA Program complements the State's voluntary affirmative Olmstead planning and implementation that has been underway for over 20 years. To ensure housing is addressed for those transitioning, effective September 1, 2015, HHSC modified managed care contracts to add requirements for the STAR+PLUS program. MCO service coordinators are now required to coordinate with the Section 811 PRA Program on an ongoing basis.

Decreasing the number of children under age 22 in institutions

One of the key assumptions of the Plan is that all children reside in as close to a family setting as possible. From 2002 through February 2019, the number of children in all institution types (including HCS group homes) decreased by 30 percent.

Adding Transition Support Teams (TST)

In 2015, HHSC implemented TST to provide support to individuals with IDD transitioning from institutional settings or who need additional supports to maintain success living in their communities. The focus of the support is primarily on individuals who may have significant medical, behavioral and/or psychiatric support needs. The TSTs provide educational activities and materials, technical assistance, and consultative case reviews to aid community providers, LIDDAs and other community partners who support individuals with IDD.

Adding LIDDA Enhanced Community Coordination (ECC)

In 2015, HHSC added ECC in which service coordinators provide enhanced monitoring and flexible supports to aid in the successful community experience of individuals with IDD who are diverting from or leaving institutional settings and enrolling in HCS or TxHmL waiver programs. The ECC service coordinator ensures individuals are linked to critical supports and receive person centered services for one year following a transition or diversion. Flexible supports are intended to provide one-time financial support to ensure the success of an individual's community living. Flexible supports that may be provided through ECC include but are not limited to one-time rental assistance, adaptive aids, home modifications, tuition assistance, and others.

Consolidation of Multiple Agencies into a Single Health and Human Services Commission

The Legislature directed two large-scale reorganizations of the HHS system to streamline services to ensure they are provided in the most coordinated, responsive and cost-effective manner possible. H.B. 2292, 78th Legislature, Regular Session, 2003, consolidated functions of 12 health and human service agencies into five new agencies under the leadership of HHSC. The second legislatively-directed organizational change, S. B. 200, 84th Legislature, Regular Session, 2015, involved transformation of the HHS system by combining functions from several agencies into HHSC in two stages. In the first stage, effective September 1, 2016:

- Client services programs from the Department of Aging and Disability Services (DADS), Department of Assistive and Rehabilitative Services (DARS), and Department of State Health Services (DSHS) transferred to HHSC;
- Prevention and early intervention services transferred to Department of Family and Protective Services (DFPS) from HHSC and DSHS; and
- DARS was abolished and its vocational rehabilitation-related programs moved to the Texas Workforce Commission.

On September 1, 2017, facility and regulatory functions from DADS and DSHS transferred to HHSC and DADS was abolished. Each of the separate legacy agencies contributed to the building of and moving the Plan forward. With services and programs administered by fewer agencies, it became easier to collaborate and communicate about the Plan.

4. Current Picture of Transitions, LTSS Recipients and Services

This section provides a snapshot of people who use LTSS and the services they receive. Where possible, indicators are included to assess the degree of progress over time in meeting the goals outlined in the initial Plan in 2001. Collectively, the data presented in this section illustrate that Texas has made significant and continuous progress in supporting individuals with a disability to live in the most integrated setting of choice, including:

- Transitioning at least 2,000 persons from institutions to community per year since 2001;
- Decreasing censuses of people residing in institutional settings since 2009;
- Continued growth in community-based expenditures from 2007 to 2019;
- Only 10 percent reinstitutionalization among the MFPD participants since 2008.

The LTSS system is generally defined by CMS as including services that support an individual with ongoing, day-to-day activities, rather than treat or cure a disease or condition. Individuals typically eligible for LTSS include adults age 65 and older and those with physical or intellectual disabilities. LTSS may be delivered through managed care or fee-for-service (FFS). States, including Texas, are trying to rebalance their systems by moving toward spending more of their Medicaid dollars on LTSS delivered in the community as opposed to LTSS delivered in an institution.

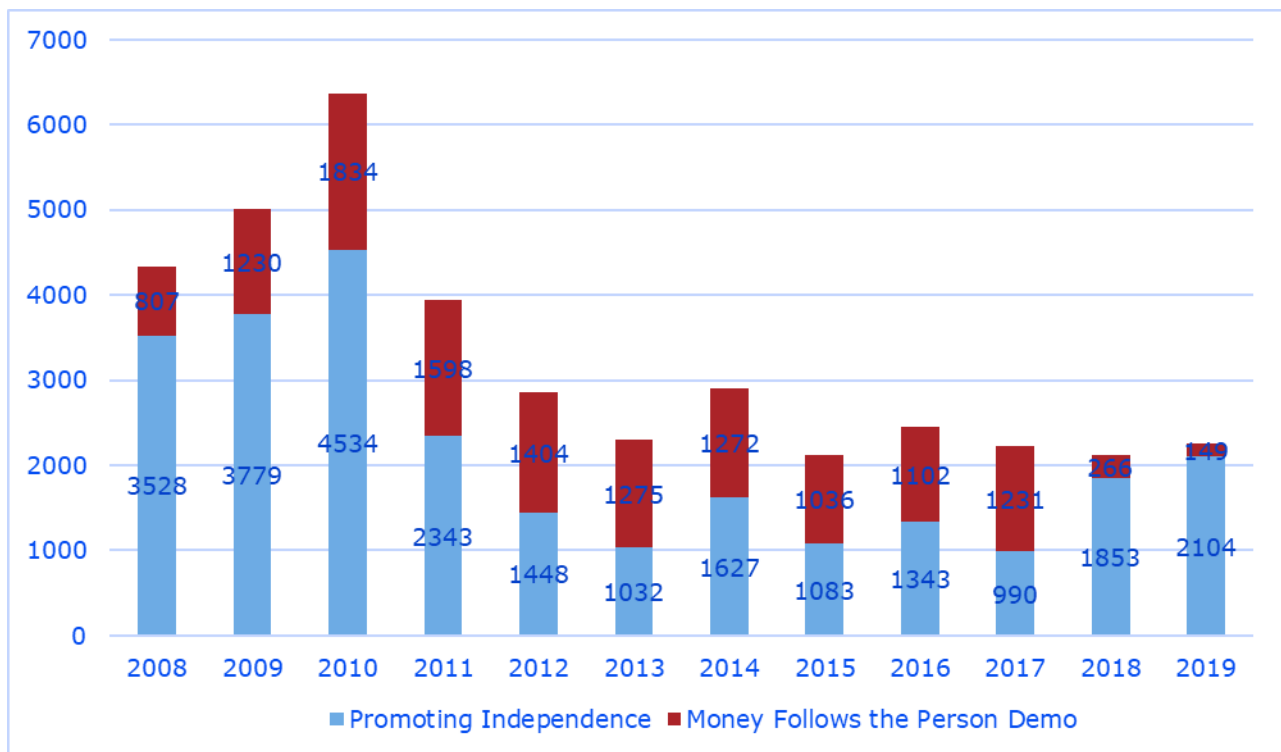
Transitions

The data in this section provide snapshots over time of progress made in moving individuals from institutional care to community-based settings.

The Initiative and MFPD combined have had a significant impact in Texas. The 81st, 82nd, 83rd, and 84th Texas Legislatures appropriated a significant amount of general revenue (GR) to the community-based programs to reduce waiver interest lists and support individuals in transitioning from institutional to community-based settings. HHSC has been able to meet the transition needs of all who ask and are qualified to transition even when there have been minimal to no appropriations. HHSC fulfills these requests by filling attrition slots. Attrition slots are created when previously funded HCS slots are permanently discharged by an individual after enrollment and when HHSC determines there is capacity in the waiver.

As Figure 1 indicates, since its implementation in 2003, 25,332 people transitioned to the community under the Texas Initiative. The MFPD has helped another other 13,000 individuals transition from institutional to community-based services. The combined total of transitions since 2003 is 38,332. In a MFPD evaluation by Mathematica, Texas led all 44 MFPD states in the cumulative number of transitions at 11,433 at the time of the 2016 final report.²⁸ In 2019, the total number of transitions was 2,176, compared with 2,120 the previous year.

Figure 1. Texas Promoting Independence and Money Follows the Person Demonstration Transitions 2008-2019

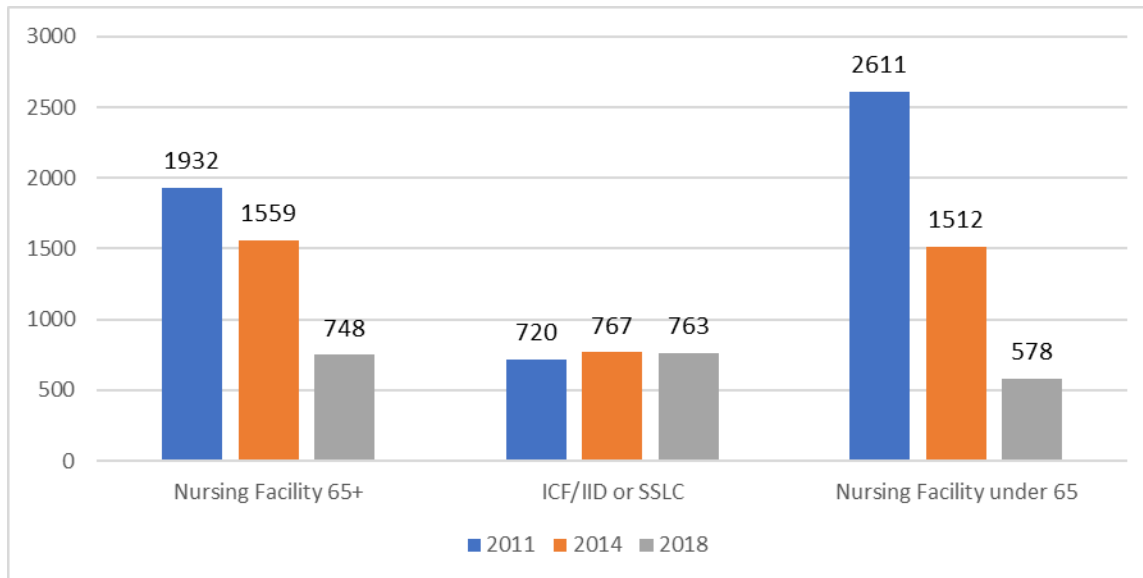


Source: HHSC QAI/datamart. Report number 10. MFP Demo, Newly Enrolled participants by Target Population, with MFP transitions combined with PI transitions.

Figure 2 shows transitions by facility type and population by calendar year over the course of the MFPD demonstration. The majority of transitions among those in a nursing facility, especially under age 65, occurred in the early part of the demonstration.

²⁸ Mathematic Policy Research. Money Follows the Person Demonstration: Overview of State Grantee Progress, January to December 2016. September 15, 2017.

Figure 2. Number of Transitions over Time by Population

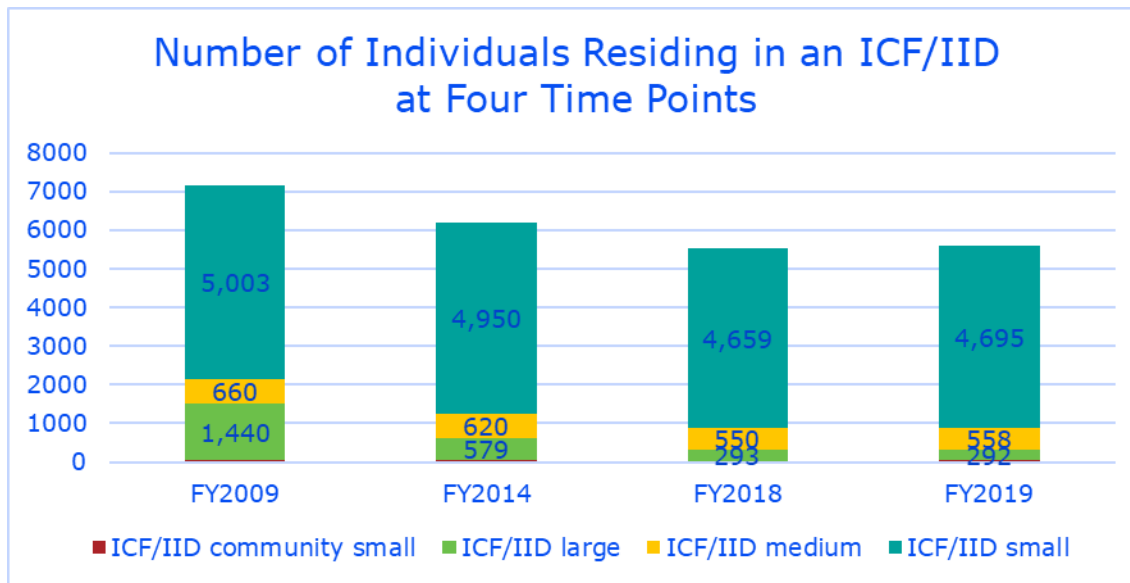


Source: HHSC QAI/datamart. Report number 10. MFP Demo, Newly Enrolled Participants by Target Population, with MFP transitions combined with PI transitions.

Institutional Census

To fully assess LTSS rebalancing it is also important to look at enrollment patterns in LTSS institutions such as nursing facilities and ICF/IIDs, over time. Figure 3 shows a notable decrease in individuals residing in large private ICFs/IIDs from over 1,000 people in 2009 to 300 people in 2019. This downward shift is due, in part, to MFPD using savings from enhanced match to provide financial incentives to multiple large ICFs/IIDs for closure since 2009. There is also a decrease in small community based ICFs/IIDs from 59 in 2009 to 36 in 2019.

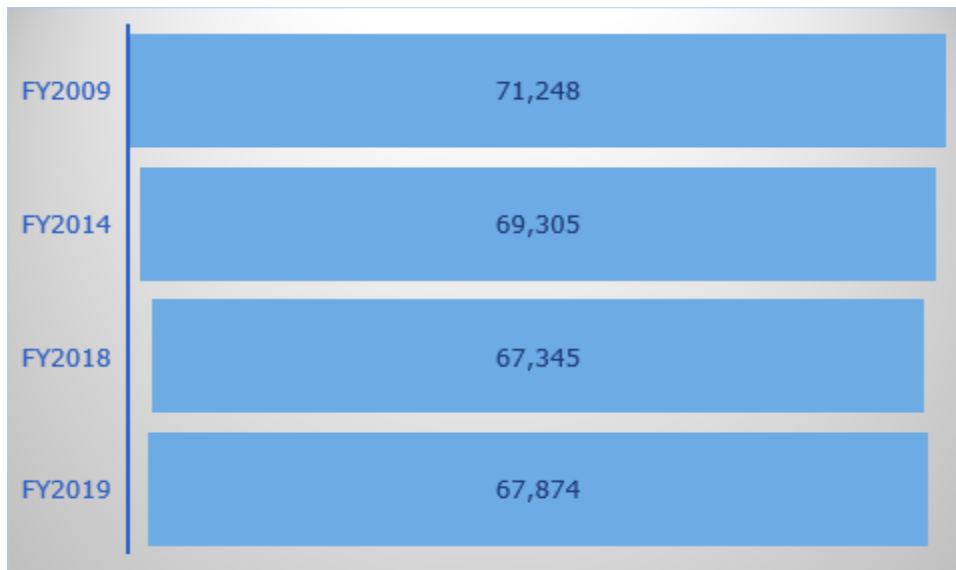
Figure 3 Number of Individuals Residing In a Community ICF/IID at Four Points in Time



Source: HHSC QAI Datamart. Data from Service Authorization System (SAS). Adhoc requested report. July 2020.

The nursing facility census also shows a decreasing pattern. In addition, HHSC believes that it has implemented a system which leverages MCOs to reduce transition time. Prior to nursing facility carve-in to managed care in 2015 the statewide nursing facility census was relatively high. Managed care carve-in signaled significant change for the nursing facilities. Nursing facilities contract with the MCOs rather than the state, and the health plans reimburse the nursing facilities for services provided to members in STAR+PLUS. The MCOs can more easily divert individuals who currently have Medicaid and who are in crisis or at risk of entering a nursing facility by using the upgrade process into STAR+PLUS HCBS. This is true only if a person has SSI. In addition, the LIDDAs have been able to divert individuals with IDD who are at risk of entering a nursing facility as well as transition individuals with IDD from nursing facilities when appropriate and consistent with their preferences. Figure 4 illustrates the number of individuals authorized for nursing facility services over time.

Figure 4. Average number of People Per Month Authorized for Nursing Facility Services at Four Points in Time. (Unduplicated count)

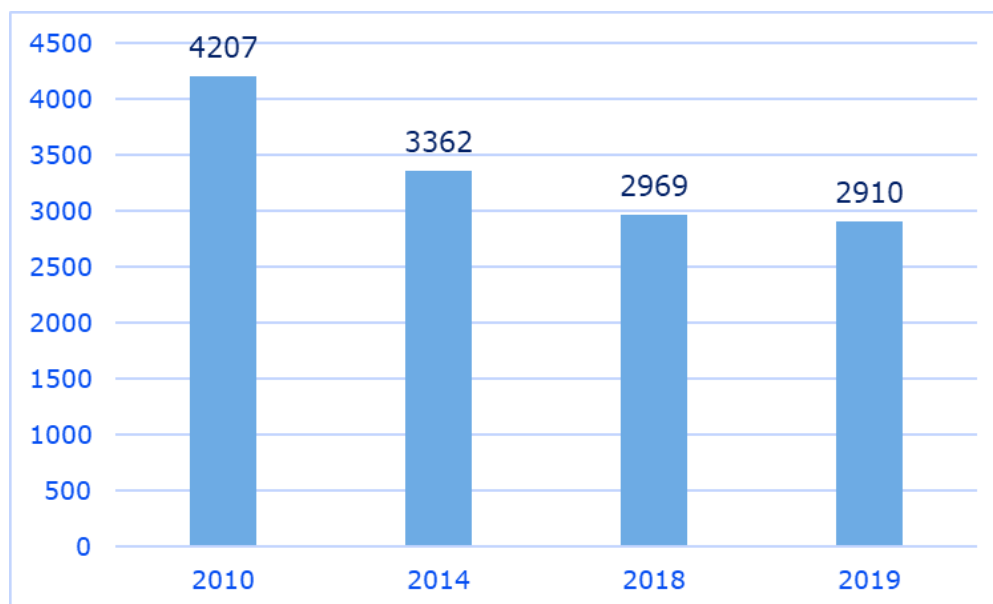


Source: HHSC QAI Datamart. Data from Service Authorization System (SAS). Adhoc Report. October 27, 2020.

In fiscal year 2019, SSLCs served over 2,900 people with IDD. Over the last decade the number of people served in a SSLC has steadily decreased by a total of 31 percent. This can largely be attributed to diversion and transition opportunities into HCS, the increase of available services within communities for people with IDD and to the SSLCs continued efforts for people to live in the most integrated setting.²⁹ Figure 5 shows the decrease in the SSLC census from 2010 to 2019.

²⁹ Reimagining the Future: A Report on Maximizing Resources Long Range Planning for the State Supported Living Centers, 2020 @ <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/maximizing-resources-long-range-planning-sslc-july-2020.pdf>

Figure 5. State Supported Living Center Census



Source: Reimagining the Future: A Report on Maximizing Resources Long Range Planning for the State Supported Living Centers, Table 2.

Reinstitutionalization

MFPD grantees were required to track the rate of reinstitutionalization during the 365 days of MFP enrollment among their participant populations. A reinstitutionalization is defined as any admission to a hospital, nursing home, intermediate care facility for people with intellectual disabilities, or IMD, regardless of length of stay. As of December 2019, 10 percent of all Texas MFPD participants since 2008 returned to an institution. The primary reason cited was a deterioration in health which caused a stay in an acute care facility followed by a long-term stay in a nursing facility. Reinstitutionalization broken down by type of disability indicated among older adults that 8 percent returned to a facility. Of individuals with IDD, 10 percent returned and among those with physical disabilities 12 percent returned.

Transition Time After the Assessment is Complete

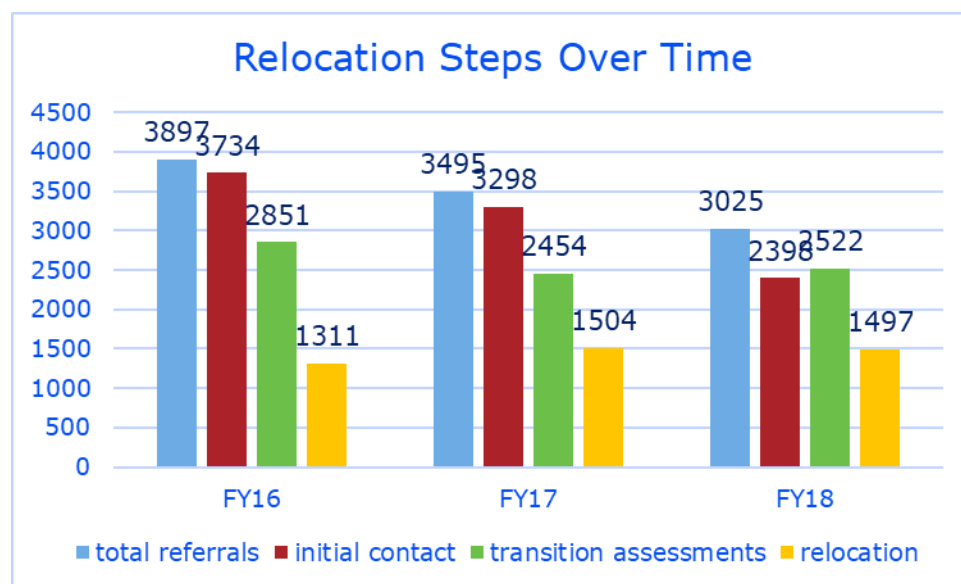
In calendar year (CY) 2018, almost two-thirds of the nursing facility residents enrolling into STAR+PLUS transitioned to the community within three months of

requesting to exit from an institution. A smaller number, 12 percent, took up to a year or longer.³⁰

Transition Steps

The information below in Figure 6 is based on three years of data collected by the community-based relocation contractors from 2016 through 2018. It pertains primarily to individuals who want to transition to STAR+PLUS HCBS. The data shows individuals who expressed interest in relocating from a nursing facility to the community. For each fiscal year, it shows the number referred for information about relocation through the number who relocated for that year. Since referrals come from multiple sources, an individual can have several referrals. Some who request to transition do not request transition support. The difference between the number originally referred and those who relocated can be attributed to individuals changing their minds about relocating, a decline in health status, not meeting eligibility requirements, or death.

Figure 6. Relocation Steps Over Time



Data Source: Relocation Performance Indicators, Relocation Contractor Salesforce Reports to MCOs, 2019.

³⁰ This information is limited to nursing facility residents who transitioned into STAR+PLUS HCBS, in 2018, the last year of full enrollment into the MFP demonstration.

Rebalancing of LTSS

States historically have relied on these traditional measures of the degree to which an LTSS system is rebalanced: increase in the number of people using community-based services compared to institutional services and increase in the percentage of LTSS expenditures spent on community-based services. Figure 7 demonstrates the number of home and community-based services program participants over time.

Utilization of LTSS Over Time

Figure 7. Number of Program Participants per Month Over Time by Fiscal Year (unduplicated)

	2009	2014	2018	2019	
CLASS	4,196	5,017	5,774	5,611	
DBMD	162	189	368	363	
HCS	15,926	21,911	27,752	27,947	
MDCP	5,006	6,462	6,218	6,056	
TXHML	1,523	6,818	6,458	6,207	
STAR+PLUS HCBS			25,361	57,313	

Source: HHSC QAI Datamart. Data from Service Authorization System (SAS). Adhoc Report. August, 2020. STAR+ PLUS data comes from <https://hhs.texas.gov/reports/2018/10/implementation-acute-care-services-long-term-services-supports-system-redesign-individuals>.

Total Community based Expenditures

Figure 8 shows the state's community-based expenditures increased by 67 percent from 2007 to 2019, changing from \$2.200 million to \$7.100 million. The increase is likely due to the addition of Community First Choice, managed care expansion especially in rural areas, and community attendant base wage increase and general increases in costs due to inflation. This kind of expansion of the state's cost is expected for systems rebalancing LTSS.

Figure 8 Total Expenditures for Home and Community-based Services, 2007 – 2020

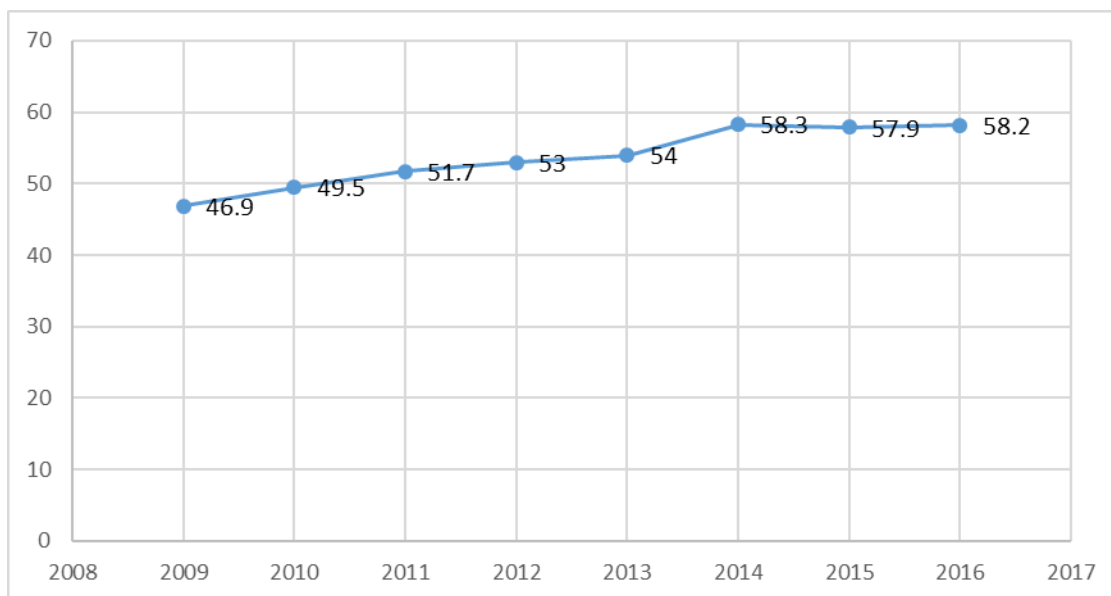
Year	Total Home and Community-based Expenditures
2007	\$2,279,588,000
2008	\$2,593,913,000
2009	\$2,735,440,000
2010	\$3,198,703,824
2011	\$3,378,861,461
2012	\$3,514,015,909
2013	\$4,138,709,476
2014	\$5,091,930,189
2015	\$5,139,961,553
2016	\$6,433,853,587
2018	\$7,101,878,806

Year	Total Home and Community-based Expenditures
2019	\$7,117,436,644

Source: MFPD Calendar Year 2020 Annual Budget, Maintenance of Effort

The percentage of Texas LTSS expenditures on community services initially increased over time. As shown in Figure 9, in 2016, community services accounted for 58.2 percent of LTSS expenditures, compared with 46.9 percent in 2009, when the MFPD project began collecting data.³¹ Since 2014 the percentage of LTSS expenditures on community services has remained relatively the same, even though the amount spent on community services has increased.

Figure 9. Texas Medicaid LTSS Community-based Expenditures by Federal Fiscal Year



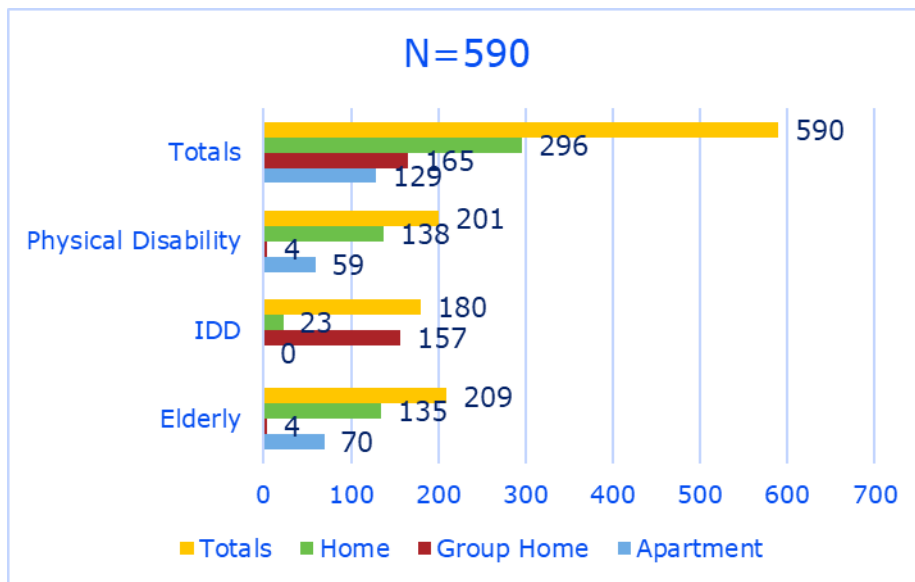
Living Arrangements

As shown in Figure 10, information from the MFPD semi-annual report shows people with physical disabilities moved to their own homes while people with IDD or a related condition opted for a group home. The group home preference for people

³¹ <https://www.medicaid.gov/medicaid/ltss/downloads/balancing/mfp-field-reports-18.pdf>, <https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltsexpenditures2016.pdf>

with IDD likely has to do with the residential components offered in the HCS waiver program. Apartment referenced in the chart below refers to an assisted living apartment with a private cooking and bathing area.

Figure 10. Living Arrangements after Transition: Money Follows the Person Participants, June through January 2018



Source: 16 MFP Demo Semi-annual CMS Qualified Residence Report Semi-Annual By Target Population and Qualified Residence Type, Datamart, Report Generated 7/25/2019.

5. Goals for Continued Progress

Expansion of community-based services was central to the initial 2001 Plan. It remains a fundamental component to the Plan updates every biennium.

The state will continue to strengthen successful existing projects that move the state forward in increasing access to and building the community-based service array. For the next biennium, the state will enhance its focus on individuals with complex medical needs, such as individuals utilizing a ventilator, or individuals with behavioral health needs that trigger a long-term return to an institution. Other areas of focus will include interest list reduction, the STAR+PLUS pilot program associated with the IDD system redesign, and direct service workforce recruitment and retention.

Historically, each legislative session, HHSC brings forward several exceptional items focused on community-based LTSS. For the 2022-23 biennium, the HHSC Legislative Appropriations Request seeks funding for:

1. Reduction in community-based services interest lists and transitions from institutions to the community as well as diversion from institutions;
2. Providing the IT infrastructure to expand services to support individuals with IDD and fragile medical needs in a managed care model; and
3. Working to comply with rules related to requiring states to ensure all HCBS settings integrate individuals in and provide full access to community life, integrated work environments, and control of personal resources based on a CMS extension for state compliance to March 23, 2023.³²

The state will progress forward with the Plan and maximize the use of available funding through changes in policy, rules, operational manuals, and contracts as discussed below. The following section describes goals, strategies, and benchmarks to measure progress. The benchmarks allow the state to measure progress over time. They are drawn from various measures required by existing funding resources, or contracts and centralized in the Plan. Some of the benchmarks are useful for helping the state set targets for moving the Plan forward. Informal criteria for selecting benchmarks included: availability, usefulness for accountability, and potential for improvement. A summary of the goals, strategies and measures can also be found in Appendix D.

³² <http://www.medicaid.gov/HCBS>

Goal 1: Increase access to services and strengthen the community-based service array.

Strategy 1.1: Continue to offer slots for transitioning from institutions to community-based services either through seeking legislative appropriations to fund Promoting Independence (PI) slots or by attrition.

An integral component to the original 2001 Plan was a flexible funding mechanism which would allow individuals to transition from an institution to the community without going on the interest list. Since 2001, the Initiative, and MFPD, through legislative appropriations, have been successful in shaping LTSS public policy by providing community living opportunities for over 38,000 individuals in nursing facilities, SSLCs, and large and medium community ICF/IID who transitioned to the community, as well as services diverting the need for institutional care. The PI Priority Groups are defined in Texas Government Code 531.0244 and, in addition to the above described ICF/IID slots, include HCS waiver slots for those exiting state hospitals, as well as children exiting DFPS foster care or DFPS conservatorship at GRO facilities.

The state's approach to supporting individuals and families returning or remaining in their community as an alternative to institutional placement is implemented through two types of legislatively directed diversion categories for the HCS program; one specifically targets individuals at imminent risk of nursing facility placement, and the second supports those at imminent risk of being placed in an SSLC. HHSC contracts with LIDDAs to support and assist individuals with access to HCS diversion slots for both categories and to provide ongoing support and choice to ensure individuals live in the most integrated setting appropriate to their needs.

In the 2016-17 biennium, the Legislature funded 2,561 PI slots.³³ Funding during the 2018-19 biennium included:

- 325 for residents of SSLCs and large ICFs/IID;
- 110 for DFPS children aging out of foster care;
- 150 for individuals with IDD moving from nursing facilities; and
- 150 for individuals with IDD diverted from nursing facility placement.

For the FY 2020-2021 biennium, HHSC developed a plan to use attrition in the HCS waiver to support specific target groups, which include individuals being diverted

³³ 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, Department of Aging and Disability Services, Rider 31).

from admission to an institution and those transitioning to the community from an institution. HHSC determines attrition capacity based on permanent discharges from the waiver and service costs.

HHSC is using attrition slots during the 2020-21 biennium to provide the opportunity for HCS enrollment to those individuals in PI priority groups and crisis situations that put the individual at risk of institutionalization. For the biennium attrition slots are utilized for the following PI and crisis groups:

- Crisis Diversion
- Nursing Facility Transition
- Nursing Facility Diversion
- Nursing Facility Transition for Children
- SSLC Promoting Independence
- Child Protective Services (CPS) Aging Out of Conservatorship

Through the use of this attrition plan, HHSC has been able to offer the opportunity for HCS enrollment to each individual (who met eligibility criteria for the slot and waiver) for whom a request has been submitted during the 2020-21 biennium. As of the second quarter of FY2020, 189 PI priority slots have been filled, with 256 pending enrollment.³⁴

Strategy 1.1 is included in the IDD SRAC recommendations and the IDD Strategic Plan.

Strategy 1.2 Continue Reduction in Community-based Services Interest Lists

Texas has five 1915(c) Medicaid waiver programs and one HCBS program in the 1115 waiver, which serve people who have a physical, intellectual or developmental disability or a related condition. Community-based services and supports delivered via Medicaid waiver programs are in high demand and interest consistently outweighs available resources. Interest list numbers reflect individuals who have demonstrated interest in a waiver but have not yet been assessed for financial or functional eligibility.

The interest list includes individuals requesting services in the following community-based programs:

- CLASS

³⁴ <https://hhs.texas.gov/reports/2020/08/waiver-slot-enrollment-progress-report-september-2020>

- DBMD
- HCS
- MDCP
- TxHmL
- STAR+ PLUS HCBS

Because individuals can request to be on the list for multiple programs, counts for enrolled or denied/declined may be duplicated. Individuals are placed on a first come first served basis, however, placement on an interest list does not necessarily mean the individual is eligible for the program. Eligibility is assessed by a service coordinator or case manager once an individual's name comes to the top of the list. In August 2020 of the 40,125 interest lists releases, 29,153 declined, withdrew or did not meet eligibility requirements; 4,446 enrolled in a waiver program; and another 4,597 were in the assessment, service planning, or provider selection process.³⁵ In the 2020-21 biennium, most of the interest list slot releases were for STAR+PLUS HCBS and MDCP.³⁶

As of August 31, 2020, the number of individuals on each program interest list included the following duplicated counts:

- 77,264 for CLASS
- 907 for DBMD
- 107,318 for HCS
- 6,840 for MDCP
- 18,051 for STAR+PLUS
- 90,459 for TxHmL

It is important to look at the unduplicated counts on the interest list. In July 2020, 163,998 unduplicated individuals were on the HHS Medicaid community-based programs interest lists.³⁷

Interest list wait times vary by waiver program. According to June 2020 data, the wait exceeded five years for nearly 60 percent of those interested in the HCS, CLASS and TxHmL programs.³⁸ Approximately 25 percent of individuals on the HCS interest list have been on the list for ten years or more. In contrast, the wait time for the STAR+PLUS HCBS program is less than a year.

³⁵ <https://hhs.texas.gov/about-hhs/records-statistics/interest-list-reduction>

³⁶ Releases include those who enrolled, denied or declined, or are in the process of enrollment.

³⁷ Unduplicated count is defined as the number of unique people on at least one of the six interest lists.

³⁸ <https://hhs.texas.gov/about-hhs/records-statistics/interest-list-reduction>

Strategies to Address the Interest List

To address interest list reduction, Texas uses a combination of traditional legislative requests for appropriations and newer strategies, not reliant on appropriations, such as using attrition to fill interest lists slots, informing families about the CFC services for those who qualify and researching the specific characteristics of the interest lists in Texas.

First, HHSC has consistently requested legislative appropriations to reduce the interest list since the PI Initiative began in 2001. Historically, the agency requested, and the Legislature funded a percentage reduction in the interest lists. Most recently, the 86th Texas Legislature provided funding for HHSC to reduce interest lists by enrolling an additional 1,628 individuals, by August 31, 2021 in the following waivers³⁹:

- 1,320 individuals enrolled in HCS;
- 240 individuals enrolled in CLASS;
- 60 individuals enrolled in MDCP; and
- 8 individuals enrolled in DBMD.

Rider 20 also directed HHSC to produce an enrollment report and three subsequent status reports to provide an update on filling the interest list slots. As of the second quarter of fiscal year 2020, HHSC released 6,535 new waiver enrollment offers, across all programs, during the first and second quarters of 2020. The waiver enrollment process can take up to five months to complete. There were 3,696 accepted slot offers in process and pending confirmation of waiver program eligibility at the end of the second quarter. Of those offers, only 438 individuals completed waiver enrollment into the programs. HHSC staff indicate the enrollment process is trending favorably, despite the impact of COVID-19. ⁴⁰

To continue to move forward with interest list reduction, HHSC requested appropriations for the 2022-23 biennium to fund an additional 3,512 people in for

³⁹ 2020-21 General Appropriations Act, House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, Health and Human Services Commission, Rider 20)

⁴⁰ The Families First Coronavirus Response Act requires states to maintain Medicaid eligibility for all individuals who were eligible on or after March 18, 2020 through the end of the month in which COVID-19 public health emergency expires to receive an additional 6.2 percent Federal Medical Assistance Percentage through the end of the federal fiscal quarter in which the PHE expires. This policy has impacted the number of people who would have become ineligible for a waiver program during the PHE and therefore, the number of new individuals enrolling in waivers during the PHE.

community-based services from the interest list.⁴¹ Specifically, the request includes funding to enroll an additional:

- 224 individuals in CLASS;
- 13 individuals in DBMD;
- 2,057 individuals in HCS;
- 185 individuals in TxHmL;
- 220 individuals in MDCP; and
- 812 individuals in STAR+PLUS HCBS.

Second, to address concerns about individuals waiting for services, HHSC implemented CFC, a Medicaid 1915 (k) state plan option,⁴² in 2015. CFC provides an opportunity for people with IDD not currently receiving services in an IDD waiver to receive personal assistance and habilitation services while they are on the interest list. CFC services are provided by LTSS providers, including home and community support services agencies and service provider agencies for the IDD waiver programs. CFC services include:

- Personal assistance services
- Habilitation services
- Emergency response services
- Support management.

Third, to address wait times, the Legislature directed HHSC to work in consultation and collaboration with the IDD SRAC to conduct a study of the interest lists and develop strategies to eliminate the interest lists for STAR+PLUS HCBS and the HCS, CLASS, DBMD, MDCP, and TxHmL waivers.⁴³ HHSC updated the Statewide IDD Strategic Plan, pending publication, to include the strategies identified in the interest list report. To support coordinated communication across stakeholder groups, the Rider 42 strategies will also be an on-going addition to this and future Promoting Independence Plans.

The strategies identified in the interest list report are primarily based on how other states reformed their systems for interest list management. Many incorporate elements of the IDD SRAC recommendations located in Appendix C of its report.⁴⁴

⁴¹ The amount requested is based on caseload growth.

⁴² Social Security Act § 1915(k)

⁴³ H.B.1, 86th Leg., R.S., 2019, General Appropriations Act, Art. II, HHSC, Rider 42.

⁴⁴ <https://hhs.texas.gov/reports/2018/10/implementation-acute-care-services-long-term-services-supports-system-redesign-individuals>

The strategies fall into three categories, each needing legislative direction:

1. Addressing gaps in real-time information about the needs of individuals currently on waiver interests lists to better understand and manage timely access to services thereby addressing risks to health and safety or institutionalization.
2. Prioritizing certain populations and individuals with the highest level of service needs, similar to priorities other states have implemented.
3. Considering any interest list reduction allocations and targeting additional funding for priority populations.

Strategy 1.3 Conduct education and outreach about CFC and community options available through transitions and diversion.

While a person waits to be assigned a slot or assessed for waiver eligibility, some service needs may be met through other services or programs, such as CFC, GR, or Title XX funded services, until the individual's name reaches the top of the interest list. CFC provides an opportunity for people not currently receiving services in a waiver to receive personal assistance, habilitation services, ERS, and support management while they are on the interest list. As discussed above, in June 2015, the CFC option became available, expanding basic attendant and habilitation services to individuals with disabilities meeting the criteria for an institutional level of care. Federal law allows the CFC option under Section 1915(k) of the Social Security Act. CFC services are provided in home and community-based settings. Services are not time- or age-limited and continue as long as eligible individuals need services and reside in their own homes or family home settings.

In fiscal year 2019, there were an average of 2,736 non-waiver recipients receiving CFC services each month through STAR, STAR Kids, STAR Health, STAR+PLUS and Dual Demonstration. With the implementation of CFC, individuals are receiving personal assistance services and habilitation while they are on the interest list.

Stakeholders raised the importance of education and outreach related to CFC and other state plan services as needing to be revisited as part of the PI Initiative. Broader education and outreach could help individuals better understand these services. Improving CFC outreach and education is also included in the Implementation of Acute Care Services and Long-term Services and Supports System Redesign for Individuals with an Intellectual or Developmental Disability report and the Disability Services Action Plan.

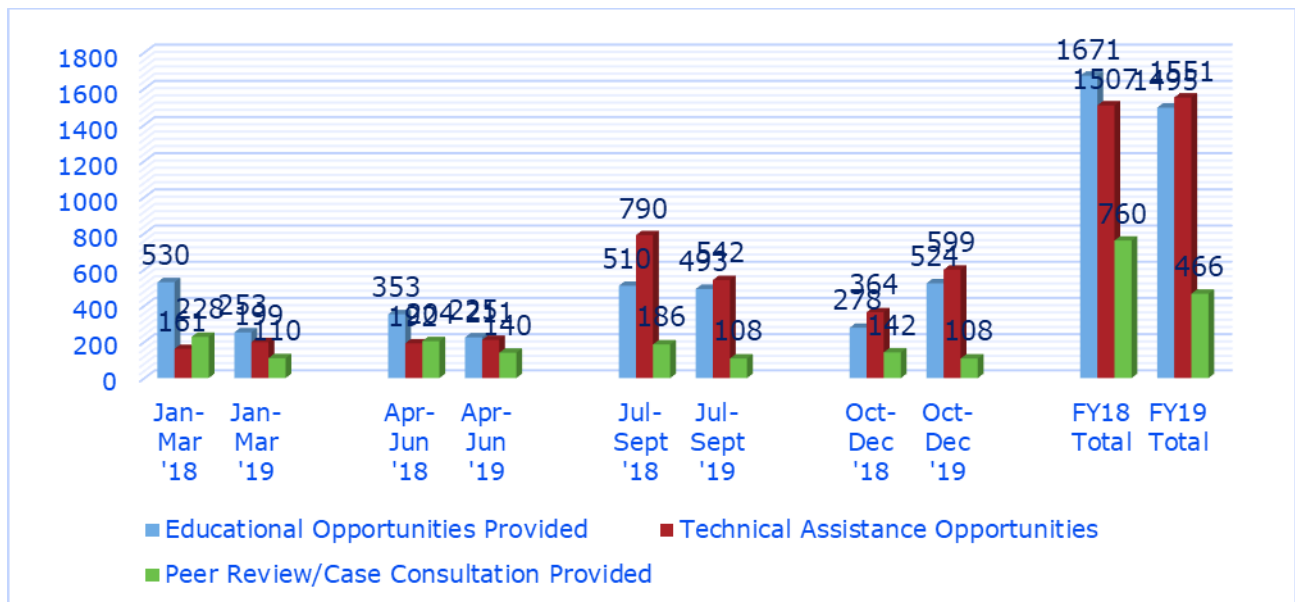
Strategy 1.4 Ensure Individual Receive Existing Community-based Services to Meet Challenging Behavioral or Medical Needs

Many individuals in institutional settings who are seeking to transition to the community have complex medical, psychiatric, and behavioral health needs, creating challenges to living successfully in the most integrated community setting. An integral part of the Initiative is to improve, expand or create new services in the LTSS service array and delivery system help address such challenges by providing greater choice for these individuals.

Transition Support Teams

The purpose of the TST is to provide support to individuals transitioning from institutional settings or who need additional supports to maintain success living in their communities. The focus of the support is primarily on individuals who may have significant medical, behavioral and/or psychiatric support needs. The TSTs provide educational activities and materials, technical assistance, and consultative case reviews to aid community providers, LIDDAs and other community partners who support individuals with IDD. Figure 11 shows the types of supports provided by the TSTs.

Figure 61 Types of Supports Provided by Transition Support Teams.

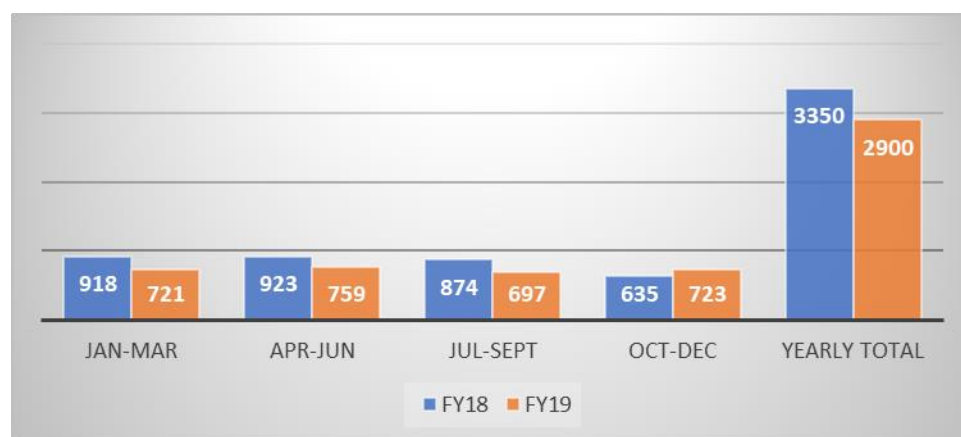


Source: LIDDA MFPD quarterly reports.

Enhanced Community Coordination

The LIDDA Enhanced Community Coordination (ECC) service coordinators provide enhanced monitoring and flexible supports to aid in the successful community experience of individuals with IDD who are diverting from or leaving institutional settings. The ECC service coordinator ensures individuals are linked to critical supports and receive person centered services for one year following a transition or diversion. Flexible supports are intended to provide one-time financial support to ensure the success of an individual's community living. Flexible supports that may be provided through ECC include but are not limited to one-time rental deposit support, adaptive aids, home modifications, tuition assistance, and others.⁴⁵ Figure 12 shows the number of ECC services delivered.

Figure 72. Enhanced Community Coordination Number of Service Opportunities Provided



Source: LIDDA MFPD quarterly reports.

Crisis Intervention

In 2015, the 84th Legislature allocated \$18.6 million over the 2016-17 biennium for LIDDAs to provide crisis intervention and crisis respite support to individuals with IDD who may have behavioral health or mental health support needs. Crisis intervention and crisis respite are designed to support individuals to maintain their independence in the community and to prevent unnecessary institutionalization. Currently, all 39 LIDDAs statewide are directed to provide crisis intervention and crisis respite services. In 2017, the 85th Legislature subsequently allocated an additional \$6 million for the 2018-19 biennium (i.e., a total of \$24.6 million) to sustain crisis intervention and crisis respite service levels. In 2019, the 86th

⁴⁵ For more information, see <https://hhs.texas.gov/laws-regulations/handbooks/idd-pasrr/section-6000-transition-nf-community>

Legislature allocated \$4million to expand crisis services and respite over the 2020-21 biennium.

Crisis Intervention Specialists (CIS)

Crisis intervention specialists ensure individuals with IDD are receiving the necessary services and supports to mitigate and resolve crisis events. The CIS works with the Service Coordinator to identify individuals in need of crisis assistance and offers prevention strategies, training, and support services. The CIS also provides consultation and collaborates with the statewide mental health Mobile Crisis Outreach Teams (MCOT) to ensure the integration and understanding of mental health support needs of people with IDD. Further, the CIS develops treatment plans and goals for individuals being referred to crisis respite.

Crisis Respite

Crisis respite includes short-term respite for individuals with IDD and includes both out-of-home and in-home options. Out-of-home crisis respite provides therapeutic support in a safe environment with staff on-site providing 24-hour supervision to a person who is demonstrating a crisis that cannot be stabilized in a less intensive setting. Out-of-home crisis respite is provided in a setting for which the state provides oversight, such as an ICF/IID, an HCS group home, a Department of State Health Services (DSHS)-authorized crisis respite facility or crisis residential facility. In-home crisis respite provides therapeutic support to a person who is demonstrating a crisis in the person’s home when it is deemed clinically appropriate for the person to remain in his or her natural environment and it is anticipated the crisis can be stabilized within a 72-hour period. Figures 13 and 14 provide information about the number of individuals receiving crisis intervention and crisis respite services in fiscal year 2018 and fiscal year 2019.

Figure 13. Number of individuals who used crisis or respite services in FY18

	FY18 Q1	FY18 Q2	FY18 Q3	FY18 Q4	FY18 Totals
Crisis Intervention Services	668	771	927	887	3,253
Crisis Respite	167	172	208	219	766

Figure 14. Number of individuals who used crisis or respite services in FY19

	FY19 Q1	FY19 Q2	FY19 Q3	FY19 Q4	FY19 Totals
Crisis Intervention Services	917	949	1107	1050	4,023
Crisis Respite	215	221	206	227	869

Habilitative Specialized Add-on Services

CMS approved a Medicaid state plan amendment, effective December 1, 2017, to expand the habilitative specialized services available to Medicaid recipients residing in a Medicaid-certified nursing facility who are 21 years of age or older and who have been found through the Pre-admission Screening and Resident Review (PASRR) process to need such services. These services help prepare individuals for transition to the community. Specialized add-on services are provided by community-based providers, not by the nursing facility staff. Each allowable specialized add-on service includes transportation between the nursing facility and the service site. Allowable specialized add-on services are behavioral support, employment assistance, supported employment, day habilitation, and independent living skills training.

Day Habilitation

Day habilitation programs can play an important role in supporting people with disabilities to be as independent as possible and increase meaningful involvement in their community. Effective March 2014, CMS issued new regulations requiring states to ensure that all HCBS settings integrate individuals in and provide full access to the community, including engagement in community life, integrated work environments, and control of personal resources. CMS initially gave states until March 2019 to comply with the regulation, but in June 2017, issued an extension until March 2022. In July 2020 CMS provided an additional one-year extension due to COVID-19, giving states until March 2023 to comply. Any state with HCBS must develop a statewide transition plan outlining its current compliance and plans for compliance and submit it to CMS for approval. This plan must include results from assessments including internal reviews of current policy, interviews with individuals receiving services, and self-assessments of providers delivering services. Based on information obtained in part through these assessments, HHSC requested funding from the Legislature for FY 2021 to support replacing the current day habilitation service with a new, more integrated service called Individualized Skills and

Socialization (ISS). This exceptional item was not funded. However, the Legislature directed HHSC to develop a plan to replace current day habilitation services in waiver programs for individuals with IDD with more integrated services. HHSC must submit a plan to the Legislative Budget Board, Governor, Lieutenant Governor, Speaker of the House, and members of the Senate Finance Committee and House Appropriations Committee by January 1, 2021. The plan shall be considered approved unless the Legislative Budget Board or the Governor issues a written disapproval within 15 business days⁴⁶. HHSC included a placeholder exceptional item request to fund ISS for the 2022-23 biennium, pending publication of the Rider 21 report.

Strategy 1.5 Continue Person-Centered Planning

Federal rules for all Medicaid HCBS, including CFC, require person-centered service planning, also referred to as person-centered planning (PCP). Using a PCP process, a service plan and objectives are developed based on a person's preferences, strengths, and clinical and support needs. Person-centeredness balances what is important for the person's health and safety with what is important to the person for their well-being and quality of life. Person-centered service planning considers non-clinical concepts such as self-determination, dignity, community inclusion, and the belief that every person is the expert on their own life, has the potential for a personally defined high quality life, and can meaningfully contribute to society.

To comply with federal and state regulations, HHSC requires people who facilitate person-centered service plans for CFC and HCBS to complete training within six months of hire, as of September 1, 2019. The state and its partners, including LIDDAs, The University of Texas Center for Disability Studies, and The Learning Community for Person-Centered Practices have been working to build the infrastructure to successfully comply by training more certified Person-Centered Thinking (PCT) trainers.

Training

HHSC offered various levels of training to service coordinators, case managers, and providers to support individual's choices to live the life they envision in the most integrated setting. Since 2014, 19 certified PCT trainers have been trained on behalf of the state. The state has supported employees of LIDDAs, Councils of Governments, MCOs and provider agencies in becoming PCT Trainers. Through grant funding:

⁴⁶ 2020-21 General Appropriations Act, H. B.1, 86th Leg., R.S., 2019 (Article II, HHSC, Rider 21).

- two HHSC staff and one private provider staff became certified PCT Mentor Trainers in December 2018; and
- two HHSC certified PCT Mentor Trainers were certified as PCT Coaching Trainers in October 2017.

In addition, MFPD funded an initiative to certify six people as People Planning Together (PPT) co-facilitators who receive services for IDD. PPT co-facilitators with lived experience partner with a PCT trainer to train people with IDD to create their own person-centered plans and better communicate and partner with service providers. HHSC requires service coordinators and case managers from LIDDAs, MCOs, and private providers to complete a face-to-face two-day training. In the past four years, more than 1,936 have completed this training. This training continues to be offered in collaboration with community partners. Overviews of person-centered practices have been provided to various groups, including potential and current providers for the Consumer Directed Services (CDS) option for service delivery, CLASS, and DBMD services, and at conferences upon request. As of July 8, 2020, 7,678 people, including people from other states, had successfully completed the online PCP Training that launched in February 2017. The free training is accessible at: <https://hhs.texas.gov/services/disability/person-centered-planning/person-centered-planning-waiver-program-providers/person-centered-planning-pcp-training-providers>.

PCT training continues to expand to other state staff, such as social workers and case managers, CPS employees, and nursing staff within utilization review teams. PCT training also continues to be offered at nursing facilities across the state. PCT Coaching training began in 2019, with both in person and webinar sessions. PCT Coaches participate in a six-month mentored process and learn how to provide informal training and support others within their organizations to identify naturally occurring opportunities to practice and improve PCT skills. PCT Coaching helps embed person-centeredness within the operation of any organization.

National Technical Assistance Award

In March 2019, HHSC was awarded one of 15 three-year technical assistance grants by the National Center on Advancement of Person-Centered Practices and Systems (NCAPPS) to align policy and practice with person centered principles across the state for all populations across the lifespan.

As of February 28, 2020, HHSC had established a PCP Steering Committee and the draft of a strategic plan to ensure person-centered thinking, planning, and practice occurs throughout the HHSC system. By the end of the grant, HHSC will have created a PCP framework and accompanying tools, guidance, rules, policies and

procedures, including adaptations for use with all populations served by programs administered by HHSC.

Goal 2: Continue to transition children from institutions to family-based settings and enhance community-based supports for children with behavior support needs.

Moving children out of institutions into the most integrated family setting possible continues to be a major focus of the Plan, requiring on-going collaboration between DFPS and HHSC.

Strategy 2.1 Transitioning Children to Family-Based Settings

From 2002 through February 2020, the number of children in all institution types (including HCS group homes) decreased by 30 percent, and the number of children in all institution types excluding HCS decreased by 64 percent. The decrease includes a 95 percent decrease in children residing in large ICFs/IID, a 68-percent decrease in nursing facilities, and a 61 percent decrease in all institutions serving more than four persons.⁴⁷

As of February 29, 2020, 1,106 children were living in all types of institutions, including HCS residential settings. Of the 1,106 children living in institutions:

- The majority (65 percent) were young adults, ages 18 to 21.
- More than half (57 percent) were in HCS.
- A relatively small number (7 percent) resided in an NF.
- The majority (96 percent) had a current permanency plan.⁴⁸

The HHSC permanency plan contractor, EveryChild, Inc., directly assisted a total of 244 children in nursing facilities between September 1, 2019, and February 29, 2020. Of these 244, 31 returned home or moved to a family-based alternative. EveryChild, Inc. continues to explore family-based options for children living in institutional settings. Of the 31, 12 returned home and 19 used family-based alternatives.

⁴⁷ See the *HHSC Permanency Planning Report – July 2020* at: <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/permanency-planning-family-based-alternatives-july-2020.pdf>

⁴⁸ See the *HHSC Permanency Planning Report – July 2020*.

Increased resources have allowed families and LARs to choose family-based care instead of institutional care for children. Resources critical to helping children move to, or remain in, family homes or family-based alternatives include:

- Reserved capacity in the HCS waiver program and continued funding of reserved capacity slots;
- HCS host home/companion care services; and
- Expansion of family-based alternatives through coordinated efforts by EveryChild, Inc., and waiver program providers.

These opportunities have significantly improved the lives of individuals under age 22 and their families.

HHSC, DFPS, EveryChild, Inc., and LIDDA representatives collaborated to improve permanency planning and support children.

HHSC used attrition slots in the biennium for the following HCS targeted groups, listed in Rider 20. As part of crisis diversion, HHSC has released 48 slots for children aging out of foster care. Of those, HHSC approved enrollment of 17 children and an additional 30 children were in the enrollment process as of February 29, 2020.

As of February 29, 2020, HHSC has released four slots to serve children transitioning from a nursing facility. Of those, HHSC approved enrollment of one child with an additional three children in the enrollment process. Slots for children transitioning from a nursing facility continue to be released.

Although progress continues, the July 2020 Permanency Plan and Family-based Alternatives report noted challenges moving children from institutions to family or family-based settings including:

- Limitations in community capacity to serve children in non-institutional settings.
- Increase in number of children residing in GROs.
- Growth in waiver program interest lists.
- The need for higher physical, medical, or behavioral supports for some children to live successfully in non-institutional settings.

Strategy 2.2 Community-Based Supports for Children with Serious Emotional Disturbances

The 1915(c) YES waiver program provides intensive home and community-based services for children 3 to 19 years of age, up until the day before their 19th

birthday, who are at risk of institutionalization or out-of-home placement due to their serious emotional disturbance. YES services are family-centered, coordinated and effective at preventing out-of-home placement and promoting lifelong independence and self-defined success. The program aims to:

- Reduce the amount of time children and youth are out of their home and community because of a mental health need.
- Prevent entry into the DFPS foster care system and relinquishment of parental custody.
- Expand available mental health services and supports.
- Ensure families have access to nontraditional support services as determined in a family-centered planning process.
- Improve the lives of youth and families.

Children enrolled in YES are eligible for all Medicaid behavioral health services in addition to the specific YES service array. YES services include community living supports, family supports, employment assistance, supported employment, supportive family-based alternatives, transition services, minor home modifications, adaptive aids and supports, respite, specialized therapies (animal-assisted therapy, art therapy, music therapy, recreational therapy, and nutritional counseling), nonmedical transportation, and paraprofessional services.

The 2014-2015 General Appropriations Act, S. B. 1, 83rd Legislature, Regular Session, 2013 (Article II, HHSC, Rider 90) directed statewide expansion of the YES Waiver, making YES accessible to eligible children in every county. Beginning September 1, 2015, HHSC expanded YES statewide. In addition, effective July 10, 2016, HHSC expanded the population served in the YES Waiver to include children and youth who are in DFPS conservatorship. Enrollment in the YES waiver continues to increase, although the rate of enrollment during fiscal year 2020 was less than prior years. The reduction is attributed to reduced engagement associated with COVID-19.

The YES Waiver program served 2,864 participants in fiscal year 2019, including approximately 110 children under DFPS conservatorship. In fiscal year 2020, the program served 2,751 participants, including approximately 151 children under DFPS conservatorship.

Effective April 1, 2018, CMS approved the YES Waiver for an additional five years.

HHSC continues using an open enrollment process to expand the network of YES comprehensive waiver providers (CWPs), responsible for the delivery of all services in the array. The 39 LMHAs/Local Behavioral Health Authority (LBHAs) serving as

waiver administrators also may serve as the CWP to assure services are available across the state. As of August 2020, HHSC also contracts with five private providers serving as a YES CWP in the state.

Goal 3. Strengthen managed care support for transitions to and remaining in the community.

Strategy 3.1 Continue Long Term Services and Supports Medicaid Managed Care Expansion

HHSC contracts with MCOs to serve individuals enrolled in Texas Medicaid and pays a monthly per member per month capitation rate for each member enrolled in an MCO.⁴⁹ The MCO is responsible for the delivery of all medically-necessary covered Medicaid services in the same amount, duration, and scope as the traditional Medicaid benefit package authorized under the Medicaid State Plan and outlined in program handbooks. Over the past several years, per legislative direction, HHSC has moved more LTSS for older adults and people with disabilities into the managed care model. As of 2019, 94 percent of individuals eligible for Medicaid are enrolled in managed care⁵⁰. Legislation over the past decade has required HHSC to expand managed care, starting with the incremental expansion of STAR+PLUS, the carve in of acute care services for those with IDD and nursing facility carve in. The implementation of the STAR Kids program is the most recent change.

STAR Kids

S.B. 7, 83rd Legislature, Regular Session, 2013, directed HHSC to establish a mandatory, capitated STAR Kids managed care program to provide Medicaid benefits to children and young adults with disabilities. S.B. 7 also requires the STAR Kids program to incorporate the services provided under MDCP. In state fiscal year

⁴⁹ Through actuarially sound methodologies, Texas develops a per member per month (PMPM) rate, or capitation rate, for each risk group within each of the state's service areas for its various Medicaid and Children's Health Insurance Program (CHIP) managed care programs. These capitation rates differ across risk groups and service areas, but are the same for each Managed Care Organization (MCO) within a service area. The managed care rate-setting process involves a series of mathematical adjustments to arrive at the final rates paid to the MCOs. Capitation rates are derived primarily from MCO historical claims experience, also called encounter data. In case of possible fluctuations in claims cost, a risk margin is typically added. While the calculation method remains largely the same, how capitation rates are determined varies by program. Capitation rates, paid monthly to MCOs, constitute the primary way the state pays for services. See Encounter Data and Per

⁵⁰ Health and Human Services Commission. Texas Medicaid and CHIP Reference Guide, 12th Edition, 2018.

2020, an average of 163,043 eligible children and young adults were enrolled in STAR Kids each month.

HHSC implemented STAR Kids on November 1, 2016. Texas contracts with 9 Medicaid MCOs to operate the STAR Kids program. Enrollment in STAR Kids is required for children age 20 and younger who:

- Receive Supplemental Security Income (SSI);
- Receive SSI and Medicare;
- Live in a community-based, intermediate care facility for individuals with an intellectual disability or related condition, or a nursing facility;
- Receive services through a Medicaid Buy-In program; or
- Receive services through any of the following 1915(c) Medicaid waiver programs:
 - ▶ MDCP⁵¹;
 - ▶ CLASS;
 - ▶ DBMD;
 - ▶ HCS;
 - ▶ TxHmL; or
 - ▶ YES.

MDCP enrollees began receiving their acute care and LTSS through STAR Kids when the program implemented. STAR Kids provides all medically necessary or functionally necessary Medicaid services and the benefits of the MDCP waiver to eligible individuals. STAR Kids is designed to improve outcomes, coordination of care, and access to services, while reducing administrative complexity and unnecessary institutionalization.

STAR Kids Screening and Assessment Instrument

The MCOs are required to conduct an assessment for every child or young adult in STAR Kids to identify needed services and determine eligibility for MDCP. The assessment tool used is called the STAR Kids Screening and Assessment Instrument (SK-SAI). The SK-SAI is a pediatric assessment that is comprehensive, holistic, person-centered, and scientifically valid and reliable. The SK-SAI is used to assess the needs of children and young adults in STAR Kids, including: nursing needs, personal care needs, CFC eligibility, and MDCP waiver eligibility. Information gathered with the SK-SAI is used to create an individual service plan (ISP) for each member, identify potential referrals for additional services, and establish medical necessity for MDCP. Revisions to the SK-SAI are slated to deploy on November

⁵¹ MDCP members receiving services through STAR Health are excluded from STAR Kids.

2021 after much concentrated effort on the part of HHSC staff and external stakeholders.

Quality Oversight

Given the impact of this program on families and the managed care system, HHSC determined it was necessary to have a thorough evaluation of the implementation of the new program and development of quality measures that fit the unique qualities of the program. In the summer of 2016, the state's External Quality Review Organization (EQRO)⁵² began a multi-year study to evaluate the implementation of STAR Kids and develop a set of quality measures for the STAR Kids population. During the study, the EQRO evaluated and monitored utilization, quality of care and satisfaction with care in STAR Kids. The STAR Kids Focus Study Summary report (November 2019) is the final report in the multi-year study summer 2016 through fall 2019.

For the study, the EQRO:

- Conducted a comprehensive literature review and assessed performance measures from nationally recognized measure sets to develop an appropriate measurement framework for STAR Kids to guide performance monitoring efforts;
- Conducted a caregiver survey⁵³ prior to implementation and a follow-up survey with the same caregivers 18 months after implementation;
- Used claims, encounter, and enrollment data to calculate administrative quality measures⁵⁴ for STAR Kids members pre and post implementation;
- Used claims, encounter, and enrollment data to calculate administrative quality measures⁵⁵ for STAR Kids members pre and post implementation;
- Interviewed STAR Kids managed care organizations (MCOs) regarding challenges and successes encountered during implementation; and
- Assessed the feasibility of using SK-SAI, National Core Indicator Children Family Survey (NCI-CFS), and ISP data to enhance quality monitoring.

⁵² States providing Medicaid through a managed care model are federally required to have an EQRO. The University of Florida's Institute for Child Health Policy is Texas' EQRO.

⁵³ The caregiver survey incorporated items from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey for Children with Chronic Conditions (Version 5.0), and the National Survey of Children's Health (NSCH).

⁵⁴ Administrative measure sources included: the Healthcare Effectiveness Data and Information Set (HEDIS); the Agency for Healthcare Research and Quality (AHRQ) Pediatric Quality Indicators (PDIs); and 3M measures of potentially preventable events (PPEs).

⁵⁵ Administrative measure sources included: the Healthcare Effectiveness Data and Information Set (HEDIS); the Agency for Healthcare Research and Quality (AHRQ) Pediatric Quality Indicators (PDIs); and 3M measures of potentially preventable events (PPEs).

The EQRO sampled participants from four random samples of children, adolescents, and young adults 20 years of age and younger (as of November 1, 2016) which resulted in one sample for each of the following four service groups:

- MDCP
- Waiver programs for children with IDD
- Fee-for-service-SSI
- STAR+PLUS-SSI⁵⁶

Using survey and administrative measure data, the EQRO conducted statistical analyses to identify significant changes in member experiences and outcomes attributable to STAR Kids implementation. The results of the statistical analysis showing the impact of STAR Kids implementation after controlling for demographic and health status factors demonstrated some statistically significant changes that can reasonably be attributed to STAR Kids implementation:

- improved access to specialized services for members not in a waiver;
- improved access to care coordination; and
- increased health care expenditures.

Utilization Review

To strengthen clinical oversight of the MCO's administered activities, HHSC has a dedicated utilization review team who conducted a review of MDCP in both STAR Kids and STAR Health in fiscal year 2020 using a valid random sample at the level of the MCO. The sample size is 2,089 members and reviews began in December 2019.

Because of the COVID-19 public health emergency, utilization review nurses are not conducting home visits as part of this review. A process has been implemented that allows the nurses to conduct the reviews telephonically.

STAR Kids Advisory Committee

The STAR Kids Managed Care Advisory Committee, created by S.B. 7 advises HHSC on the establishment and implementation of the STAR Kids Medicaid managed care program. The STAR Kids Advisory Committee recently published their annual report.⁵⁷

⁵⁶ Children and young adults 20 years of age and under were allowed to enroll in STAR+PLUS prior to the implementation of STAR Kids.

⁵⁷ <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/star-kids-adv-comm-annual-report-jan-2020.pdf>

IDD System Redesign

Government Code Chapter 534 directs HHSC to design and implement an acute care and LTSS system for individuals with IDD to improve outcomes; improve access to quality, person-centered, efficient, and cost-effective services; and implement a capitated, managed care delivery system and the federal CFC.

In September 2014, HHSC transitioned acute care services for eligible adults enrolled in Medicaid IDD waiver programs and ICFs/IID from FFS to managed care. Now individuals of all ages in IDD waiver programs receive their acute care services through the following managed care programs: STAR+PLUS, STAR Kids, and STAR Health.

The Medicaid IDD waiver programs currently provide LTSS for individuals with IDD in home and community-based settings in a FFS model.

- TxHmL provides selected essential services and supports to people with IDD living in their family homes or their own homes.
- HCS provides individualized services and supports for people with IDD who live with their family, in their own home, or in other community settings, such as small group homes serving four or fewer people.
- CLASS provides services to people with related conditions as an alternative to placement in an ICF/IID.
- DBMD provides services to people who are deaf-blind with multiple disabilities as an alternative to institutional placement, and focuses on increasing opportunities for individuals served to communicate and interact with their environment.

H.B. 4533, 86th Legislature, Regular Session, 2019, amended Texas Government Code, Chapter 534⁵⁸ and directed HHSC to establish a pilot program prior to the transition of LTSS to managed care for individuals with IDD. The pilot program will operate through the STAR+PLUS Medicaid managed care program, operate through up to two MCOs in one service area, and test the delivery of LTSS for people with IDD or people with similar functional needs through managed care. The pilot program must implement by September 1, 2023, operate for at least 24 months, and include an evaluation. HB 4533 establishes a pilot program workgroup to work in collaboration with HHSC and the IDD SRAC. The information gained through the pilot program will be used to inform the final stage of the IDD LTSS system

⁵⁸ Texas Government Code, Chapter 534, SUBCHAPTER C:
<https://statutes.capitol.texas.gov/Docs/GV/htm/GV.534.htm>

redesign to transition of some or all Medicaid IDD waiver and ICF/IID services into managed care.

HB 4533 also requires a dental study to evaluate dental benefits provided through certain Medicaid waiver programs and Medicaid managed care to determine which set of benefits is most cost-effective in reducing emergency department (ED) visits and inpatient hospital admissions due to poor oral health. The findings will inform recommendations regarding which dental services benefits should be provided to participants in the STAR+PLUS Pilot Program.

Additionally, HB 4533 updates the timeline for the phased transition of IDD LTSS and requires a plan for the transition of all or a portion of services provided through IDD waivers and ICF/IID services to managed care.⁵⁹ HB 4533 directs HHSC to transition all or a portion of the TxHmL waiver program to managed care by September 1, 2027; the CLASS waiver program by September 1, 2029; and nonresidential services in the HCS waiver program and the DBMD waiver program by September 1, 2031. HHSC must conduct a second pilot to test the feasibility and cost efficiency of transitioning HCS and DBMD residential services and ICF/IID services to managed care.⁶⁰ In fiscal year 2019, an average of 562,538 individuals were enrolled in STAR+PLUS each month. Of that total, approximately 16,909 individuals were also enrolled in an IDD waiver or ICF/IID each month.

IDD SRAC

S.B. created the IDD SRAC to work in consultation with HHSC to implement the provisions of managed care expansion legislation affecting individuals with IDD. IDD SRAC collaborated with HHSC to identify and address challenges related to the coordination of acute care and LTSS, and to identify barriers and impacts of upcoming LTSS transitions to managed care for all involved stakeholders.

IDD SRAC subcommittees include:

- Transition to Managed Care
- Day Habilitation and Employment Services
- System Adequacy

⁵⁹ Texas Government Code, Chapter 534, SUBCHAPTER E:
<https://statutes.capitol.texas.gov/Docs/GV/htm/GV.534.htm>

⁶⁰ <https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/resources/ltss-waivers.pdf>

IDD SRAC meets quarterly and subcommittees meet bi-monthly and as needed to address specific issues. Consistent with the recommendations from the PIW, the recommendations focused on:

- Improving quality and continuity of services and supports;
- Addressing barriers to transition IDD LTSS to managed care;
- Increasing independence and community inclusion; and
- Addressing barriers to system adequacy including rates, interest list allocation, and network adequacy.

Goal 4: Increase access to comprehensive behavioral health services to support individuals to transition to and remain in the community.

HHSC continues to undertake activities designed to improve access to comprehensive behavioral health services within the home and community-based services array. Behavioral health issues are one of the key reasons people return to institutions.

4.1 Continue Peer Support Services as a Medicaid Benefit

Texas Government Code, Section 531.0999, as added by House Bill (H.B.) 1486, 85th Legislature, Regular Session, 2017, directed HHSC to create a Medicaid benefit for peer support services. The bill also directed HHSC to adopt rules establishing training requirements for peer specialists to enable the provision of services to persons with mental illness or persons with substance use conditions.

Persons with mental health or substance use conditions need support while in recovery. These conditions can impair an individual's ability to make effective decisions and receiving support from someone who has walked the road of recovery themselves can be invaluable.

Peer support is an evidence-based practice in which peers use their lived experiences recovering from mental health or substance use conditions, along with skills learned in formal training, to deliver strengths-based, person-centered services. Peer supports are provided in combination with other mental health and substance use services.

The federal Substance Abuse and Mental Health Services Administration recommends peer support services because they help people engage in the recovery process and reduce the likelihood of relapse. Research to date suggests peer support services may result in increased empowerment and hope, increased

social functioning, more engagement in treatment, and an increased quality of life and life satisfaction. Peer support services also support efforts to address the behavioral health workforce shortage by supporting people in their paths to recovery.

4.2 Expand the availability of clubhouses

In 2017, the Legislature appropriated to HHSC \$1.7 million in GR to continue recovery-focused clubhouses across the state.⁶¹ The Legislature appropriated a similar amount in 2019 for use in the 2020-2021 biennium.⁶² The Clubhouse Model is an evidence-based, recovery-oriented program for adults diagnosed with a mental illness. Clubhouses are a cost-effective way to assist people with mental health challenges to stay out of hospitals while improving their ability to function successfully in the community through involvement in a peer-focused environment. Members are encouraged to participate in clubhouse operations, such as clerical duties, reception, food service, transportation, and financial services. By participating in the tasks necessary to operate the clubhouse, members develop confidence and skills in independent living and return to employment. Members are also encouraged to participate in activities to promote outside employment, education, meaningful relationships, housing, and an overall improved quality of life. HHSC has contracts with four clubhouses across the state including Austin Clubhouse, Concho Valley Clubhouse in San Angelo, Magnificat Clubhouse in Houston, and San Antonio Clubhouse. Outpatient Mental Health Services for People with IDD

4.3 Implement Community Outpatient Mental Health Services

HHSC received funding from the 86th Texas Legislature to establish new community outpatient mental health services for people with IDD. The project is in the development phase. The five LIDDAs participating in the project will provide collaborative care service delivery of physical and behavioral health services for individuals with IDD, preventing or reducing crisis situations through LIDDA-specific approaches. The pilot sites will offer the following services:

- cross-systems biopsychosocial approach;
- education and training to community mental health partners
- collaborative care case management; and
- skills training for parents and support systems

⁶¹ 2018-2019 General Appropriations Act, H.B. 1, 85th Legislature, Regular Session, 2017 (Article. II, at II-71, Health and Human Services, Rider 89).

⁶² 2020-2021 General Appropriations Act, 86th Leg., R.S., 2020 (art. II, at II-68, Health and Human Services, Health and Human Services Commission, Rider 65).

Strategy 4.4 Expand Mental Health Workforce Development and Training

Government Code Chapter 531, Subchapter M-1 establishes the Statewide Behavioral Health Coordinating Council (Coordinating Council). This council comprises representatives from state agencies receiving state funding for behavioral health services⁶³ and was tasked with creating and monitoring the implementation of a five-year *Statewide Behavioral Health Strategic Plan* and expenditure proposal.⁶⁴

The 2016-2017 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015, (Article IX, Section 10.04) created the Statewide Behavioral Health Coordinating Council (Coordinating Council). This council is comprised of state agencies receiving state funding for behavioral health services. The Coordinating Council identified the behavioral health workforce shortage as a gap in service. More than 80 percent of Texas counties are designated as Mental Health Professional Shortage Areas, which are defined as more than 30,000 residents per clinician. Many of the most experienced and skilled practitioners are approaching retirement, as more than one-third of Texas psychiatrists are over the age of 55. Texas higher education institutions have been unable to produce enough graduates to meet the predicted demand.⁶⁵ The Statewide Behavioral Health Strategic Plan addresses increasing the number of mental health professionals in an objective under Goal 2: Program and Service Delivery. Objective 2.4 aims to strengthen the behavioral health workforce by fiscal year 2021 with the following strategies:

- Expand opportunities to address behavioral health workforce shortages in rural and urban areas through such activities as residency programs, student loan forgiveness, paid internships, and collaborations with universities.
- Support and increase the competency of the workforce through joint training efforts, and continuing education in identified best, promising, and evidence-based practices.
- Enhance the recruitment and retention of a diverse workforce.

Since the beginning of fiscal year 2017, the Coordinating Council has worked on implementation of the Statewide Behavioral Health Strategic Plan by identifying short term opportunities toward implementation. As an example of a short-term opportunity, the participating agencies identified using The Centralized Training

⁶³ Tex. Gov't Code § 531.473(a).

⁶⁴ Tex. Gov't Code § 531.476.

⁶⁵ The Mental Health Workforce Shortage in Texas: As Required by H.B. 1023, 83rd Legislature, Regular Session, 2014.

Infrastructure for Evidence Based Practices (CTI-EBP) as a centralized platform for communicating about trainings related to behavioral health.

Strategy 4.5 Maintain Centralized Training Infrastructure for Evidence Based Practices

The CTI-EBP is designed to aid the development of a training infrastructure to support the delivery of mental health services in Texas for the adult and youth populations. The project was developed as a mechanism to ensure providers contracted by HHSC and delivering mental health services did so using evidence-based practices. The infrastructure promotes and supports the use of evidence-based and promising practices to facilitate resiliency and recovery and increase positive outcomes for individuals using behavioral health services in the Texas mental health system. HHSC contracted with the University of Texas Health Science Center, Department of Psychiatry, to coordinate and implement this project.

The training infrastructure includes evidence-based practices, including, but not limited to the following:

- Illness Management & Recovery
- Cognitive Adaptation Training (CAT)
- Cognitive Processing Training
- Social Skills and Aggression Replacement
- Nurturing Parent
- Motivational Interviewing
- Person Centered Recovery Planning

The CTI-EBP is free to those with HHSC funded contracts and through partnerships with other state agencies. As of December 1, 2016, the CTI-EBP E-Commerce charges non-subsidized (non-HHSC contracted providers) for web-based training offering continuing education units.

In June 2016, HHSC rolled out the six-module Mental Health Wellness for Individuals with an IDD (MHW-IDD) online training series for Direct Service Workers on the behavioral health needs of individuals with an IDD. Topics include:

- Trauma-informed care
- IDD and co-occurring MH needs
- Functional behavior assessment and behavior support
- Genetic syndromes associated with IDD
- Medical disorders associated with IDD, and
- Strategies and supports for direct support workers

The MHW-IDD training was developed to address a gap in workforce knowledge of behavioral health issues that affect individuals with IDD. It is available for free to the public and can be accessed at www.mhwidd.com. It is also offered on the CTI-EBP for HHSC contractors. The training series gained national recognition through the National Association of State Directors Developmental Disabilities Services Community Services Reporter. On average, about 500 users from across the country complete at least one module per week. In fiscal year 2018, HHSC developed additional modules for health care practitioners on best practices in treating individuals who have IDD and behavioral health needs. Topics include trauma-informed care, the importance of interdisciplinary team work, and communicating with people with IDD and co-occurring behavioral health needs. Continuing Nursing Education and Continuing Medical Education credits are offered to physicians and nurses who take the courses.

Strategy 4.6 Explore Hospital Step Down Models for Those in State Hospitals

In 2020, HHSC used MFPD rebalancing funds to develop a small Hospital Transition pilot program to divert psychiatrically and/or medically fragile individuals residing in state psychiatric institutions from nursing facilities or other restrictive settings into the community. This pilot was identified as a priority in HHSC's fiscal year 2020 business plan. These individuals no longer require acute inpatient care but have more intensive home and community support needs than persons typically discharged from these facilities. Community-based options that meet their needs and preferences do not currently exist, so these individuals are frequently recommended for nursing facility placement.

The pilot, a collaboration between HHSC and two LMHAs, provides intensive, home and community-based supports including pre-transition, transition, and supervised living services and employs evidence-based practices successfully tested in the state's Money Follows the Person Behavioral Health Pilot (BHP). Outcomes of the Pilot will be used to inform future diversion options for this population. Funds also enabled capital improvements to prepare for expansion of the pilot in 2021. Mental Health Block Grant funding has been identified to sustain the pilot in 2021-2023.

Strategy 4.7 Sustain the Home and Community-Based Services Adult Mental Health Program

The 2014-15 General Appropriations Act, S.B. 1, 83rd Legislature, Regular Session, 2013 (Article II, DSHS, Rider 81), required DSHS to establish home and community-based services for adults with serious mental illness (SMI) and a history of extended inpatient psychiatric hospital stays. The Legislature further directed

DSHS and HHSC to seek a Medicaid state plan amendment under Section 1915(i) of the Social Security Act. Texas received federal approval from CMS on October 13, 2015, for the HCBS-AMH program.⁶⁶

The 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, DSHS, Rider 61), subsequently required DSHS to expand the HCBS-AMH program to divert populations with SMI from jails and emergency departments into community treatment programs. HHSC formally submitted the state plan amendment to expand the 1915(i) to CMS on May 20, 2016. CMS approved amendments to the HCBS-AMH program on December 18, 2017.

The HCBS-AMH program provides home and community-based services and supports to help adults achieve stable tenure in their community of choice. HCBS-AMH services are provided in addition to traditional state plan benefits and include residential services, employment services, nursing, peer support, adaptive aids, minor home modifications, home delivered meals, non-medical transportation, psychosocial rehabilitation, substance use disorder services, and recovery management.

Between January 2018 and December 2019, the number of HCBS-AMH contracts increased from 36 to 41. As of August 2020, there were 51 executed provider contracts providing services across 26 counties, within the service areas of 17 LMHA/LBHAs. Since the inception of the program, a total of 367 individuals have participated in HCBS-AMH services. From August 2018 to August 2020, program enrollment increased by 124 percent, consistent with provider growth. As of August 2020, 81 individuals were enrolled in HCBS-AMH. Of those 281 individuals, 156 met long-term hospitalization criteria, 57 met jail diversion criteria, and 68 met emergency room diversion criteria. HHSC anticipates enrollments will continue to increase due to ongoing outreach and strategic partnerships with referring entities, such as other mental health entities, managed care organizations, and justice entities.

Strategy 4.5 Build upon the Money Follows the Person Demonstration Behavioral Health Pilot

Between 2008 and 2017, Texas implemented a BHP under the federal MFPD grant from CMS. The BHP operated in several central Texas counties, including Bexar and Travis. It was designed to help adult Medicaid clients with SMI and substance use disorders leave nursing facilities. Participants in the pilot were MFPD eligible, met a

⁶⁶ HHSC administers this program in accordance with S. B. 200, 84th Legislature, Regular Session, 2015.

nursing facility level of care, and were transitioning into the STAR+PLUS HCBS waiver. The pilot enabled Texas to test the efficacy of new services and techniques for this special population. The pilot served 454 individuals during its tenure.

Pilot participants ranged in age from 27 to 89 and had multiple health challenges, including chronic health conditions, physical disabilities, serious mental illness, and substance use disorders. Pilot services included community-based substance abuse treatment and Cognitive Adaptation Training (CAT), a rehabilitative service designed to help individuals establish daily routines, organize their environment, and build social skills. Services were provided up to six months before discharge (pre-transition) and up to one year after discharge. Services helped individuals acquire and improve their ability to engage in activities and instrumental activities of daily living, manage their medications, and social skills, which helped facilitate successful integration into the community. In addition, pilot participants received transition assistance, relocation assistance, and STAR+PLUS HCBS waiver services through their Medicaid MCO and other partners.

Outcomes for those who participated in the pilot include:

- 454 individuals have transitioned to the community;
- 70 percent successfully completed a year in the community and over 65 percent remained in the community at the end of the study, per independent evaluation;
- Cost of living in the community under the BHP was 71 percent of the cost of living in an NF; and
- For dual-eligible MFPD participants, it took 5.3 months of community residence to recover initial costs. For Medicaid-only MFPD participants, it took only 4.5 months of community residence to recover initial costs.

Pilot participants also experienced increased independence. Examples of increased independence include getting a paid job at competitive wages, driving to work, volunteering, getting a GED, teaching art classes, leading substance use peer support groups, and working toward a college degree.

To sustain the lessons learned from the MFPD BHP, the state is bringing evidence-based behavioral health practices piloted under MFPD to scale, systematically incorporating and sustaining them in STAR+PLUS. STAR+PLUS includes mental health rehabilitation, substance use treatment, relocation assistance and nursing facility care in its array of acute and LTSS services. Texas is using MFPD administrative funds to provide training and technical assistance in CAT and other evidence-based techniques to STAR+PLUS MCOs and their networks through a sustainable, university-based Center of Excellence.

Strategy 4.6 Expand Money Follows the Person Demonstration Self-directed Services Pilot Program for Individuals with Mental Illness

As part of MFPD Behavioral Health sustainability, Texas has piloted evidence-based self-direction for people with mental illness. Self-directed service options provide individuals with the ability to manage a flexible budget to purchase Medicaid services and supports. Self-directed care options empower individuals with tools designed to assist them in living the lives they choose in the communities they desire. Additionally, client choice promotes recovery and increases the likelihood that individuals will return to and remain in their communities.

Historically, in Texas, self-direction has been available to individuals receiving community-based personal attendant and HCBS waiver services, but not to individuals with a SMI who are receiving community-based mental health services and supports. A randomized trial of self-directed mental health services in a capitated behavioral health specialty program, which formerly existed in the Dallas service delivery area, demonstrated promising outcomes. These included better functioning, higher satisfaction, and lower institutional costs with no greater expenditure of funds than in the traditional system of care. To create sustainable mental health self-directed care options in STAR+PLUS, Texas developed and conducted a 2-year performance improvement project in one multi-county STAR+PLUS service delivery area. MFPD administrative funds supported planning, stakeholder involvement, and administration of the self-direction project.

Project interventions ended in April 2020. Evaluation will conclude in December 2020. The State is working with university partners and stakeholders to develop a toolkit, which includes person-centered planning, organizational readiness and fidelity instruments. The toolkit will support future potential adoption of mental health self-direction in the Medicaid managed care system.

Goal 5. Maintain and Improve Relocation Services

Relocation assistance includes outreach about community living, assessment of transition needs, and coordination of transition services. Housing assistance is provided if needed, as well as one-time funds to purchase household goods to assist in the transition from an institution to the community. Historically, Centers for Independent Living (CILs) and an ADRC provided relocation services for those transitioning from nursing facilities to the STAR+PLUS HCBS waiver. Since the nursing facility carve-in to managed care in March 2015, MCOs, through their service coordination activities, have played an increasing role in assessment and relocation assistance for their members in nursing facilities who wish to return to the community.

Effective September 1, 2017, HHSC changed relocation activities from a service, funded with GR and contracted through HHSC, to a component of service coordination administered by STAR+ PLUS MCOs. To ensure service continuity during the transition, the MCOs contracted with the existing relocation providers. Relocation assistance provided by the MCO includes one-time funds to purchase necessary household items not otherwise funded by the HCBS waiver. MCOs and relocation specialists coordinate with LIDDA staff when individuals with IDD in nursing facilities who wish to transition to the community and need relocation support. The relocation specialist conducts the relocation assessment and both the relocation specialist and the MCO SC participate as members of the service planning team. They both assist an individual with IDD to access:

- housing, transportation, medical, dental and prescriptions, depending on the program the individual chooses; and
- Supplemental Transition Support funding, if the individual qualifies.

Strategy 5.1 Continue to support relocation contractor capacity building.

To build capacity of organizations that traditionally provided relocation services, HHSC applied to participate in the National Association of State Units on Aging and Disability's Business Acumen Learning Collaborative. In August 2017, Texas was one of five states selected to join the collaborative. The goal is to assist community-based relocation providers in enhancing business skills that enable them to be successful in working in a managed care environment. The Texas team, comprised of disability advocacy organizations, MCOs, community-based organizations (CBOs) and facilitated by HHSC, continued through fiscal year 2019 to improve the contracting process and to develop pricing for relocation activities that adequately reflects the level of effort required.

The goal was to collaborate to create a sustainable relocation process that can efficiently serve people with disabilities seeking to live in the most integrated setting of their choice. In addition, it was anticipated CBOs and MCOs will collaborate to facilitate a transition from a cost reimbursement payment system to the most effective contracting and payment system under Medicaid managed care.

Significant accomplishments include:

- Greater understanding of each other's business practice and shared goals.
- Collaboration to revise the current contracts with MCOs.
- Made progress pricing the relocation function.

Goal 6: Continue to expand housing opportunities for individuals exiting institutions.

As noted in the 2001 Plan, one of the barriers to successful relocation from an institutional setting is the lack of affordable, accessible, and integrated housing. Integrated housing is defined as normal, ordinary living arrangements typical of the general population. Integrated housing is achieved when individuals with disabilities have the choice of ordinary, typical housing units located among individuals who do not have disabilities or other special needs

This section provides an update on accomplishments by HHSC in partnership with TDHCA and local public housing authorities.

Multi-Agency Collaboration

Collaboration between state agencies is the foundation for continued efforts to address housing barriers for those who desire to live in the most integrated setting. The Housing and Health Services Coordination Council role “is to increase state efforts to offer Service Enriched Housing through increased coordination of housing and health services.”⁶⁷ This council, created by S.B. 1878, 81st Legislature, Regular Session, 2009, is composed of 17 members: eight members appointed by the Governor and nine state agency representative members from HHSC, the Texas Department of Agriculture, Texas Veterans Commission and Texas State Affordable Housing Corporation.⁶⁸ While the scope of the Housing and Health Services Coordination Council is broader than issues related to those leaving institutions, it offers a forum for discussion and problem solving.

Strategy 6.1 Continue HHSC’s collaboration with the Texas Department of Housing and Community Affairs Section 811 Project Rental Assistance Program

The Section 811 Project Rental Assistance (PRA) Program is a project-based, federally-funded program that allows state Housing Finance Agencies (such as TDHCA) and state Medicaid Agency partners (such as Texas HHSC) to create rental assistance opportunities for persons with extremely low incomes who have a disability and are eligible to receive services and supports.

⁶⁷ See: <http://www.tdhca.state.tx.us/hhsc/>.

⁶⁸ The HHSCC 2016-2017 Biennial Plan and the Report of Findings and Recommendations of the Housing and Health Services Coordination Council are available on the TDHCA website at: <http://www.tdhca.state.tx.us/hhsc/biennial-plans.htm>

Section 811 PRA is administered by each state Housing Finance Agency. Properties elect to participate in the program. A project-based program requires a long-term obligation of an owner and many households will cycle in and out of eligible units over the lifetime of an agreement (usually 30-year agreements renewed for 1-5 years).

In contrast, the Section 8 program is administered by local Public Housing Authorities, and not the state Housing Finance Agency. While the Section 811 PRA Program is only available to individuals with certain disabilities, the Section 8 program is available to income-qualified households. Some Public Housing Authorities have set aside vouchers or created preferences for persons with disabilities or other groups.

The rental assistance covers the difference between the tenant payment (no more than 30 percent of the household's income) and the property's asking rent plus utilities. The program is a collaboration between TDHCA, HHSC, participating properties, and local disability service organizations. The Section 811 PRA creates the opportunity for persons with disabilities to live as independently as possible through the coordination of voluntary services and supports and subsidized, integrated rental housing. Individuals with disabilities, service providers, and state agency partners determined the target populations. As of August 2018, 72 households had moved into units and 946 were on a wait list. In contrast, two years later, September 2020, 445 households had moved into units and 2095 people are on the waiting list.

Based in part on Texas' efforts to create community-integrated housing options for persons with disabilities and TDHCA's ongoing collaboration with HHSC to jointly operate a housing voucher program (see Project Access, below), TDHCA was awarded funding from HUD fiscal year 2012 Section 811 PRA Program Demonstration round to support approximately 350 units of affordable, accessible, and integrated housing.

Due to complexities with 811 PRA, developers are not inclined to participate unless incentivized to do so. Therefore, starting in the 2015 Competitive Housing Tax Credit Application Cycle, Texas included in its *Housing Tax Credit Qualified Allocation Plan* (QAP) points for developers to participate in Section 811 PRA. Participation in the 811 PRA program has continued to be incentivized through points in the QAP and has expanded to include points under TDHCA's Multifamily Direct Loan Program.

PRA can be applied to new or existing multifamily developments owned by a nonprofit or private entity with at least five housing units if the developments

received funding or are in the process of applying for funding through TDHCA's multifamily housing programs and/or any federal agency or any state or local government program.

Only properties located in the following Metropolitan Statistical Areas are eligible to participate in the program:

- Austin-Round Rock
- Brownsville-Harlingen
- Corpus Christi
- Dallas-Fort Worth-Arlington
- El Paso
- Houston-The Woodlands-Sugar Land
- McAllen-Edinburg-Mission
- San Antonio-New Braunfels

Policy Considerations

The 811 workgroup realized there were additional barriers to exiting nursing facilities or other institutions that other target groups might not experience. When an apartment becomes available the individual in the nursing home may need a additional time for the assessment and service planning to be approved. TDHCA can help by using HUD funds to pay for the vacancy while eligibility is being determined or when no properties are available when someone is ready to leave a nursing facility. To mitigate these barriers, the eligibility criteria were changed to allow anyone who has exited a nursing facility within the past year to qualify. TDHCA also received board approval to give preference to those leaving an ICF/IID or a nursing facility. TDHCA along with HHSC implemented a risk mitigation fund to help those with criminal or bad credit histories. This fund is paid for through MFPD.

Strategy 6.2 Consider using the Barrier Busting Fund as a long-term strategy for locating housing for individual with past challenges.

With funding from the MFPD, TDHCA launched a new source of assistance designed specifically for 811 Program applicants and properties, the Section 811 Project Rental Assistance (PRA) Barrier Busting Fund. Barrier Busting Funds have been successful across the country in increasing access to affordable, accessible and integrated housing for individuals with disabilities, especially those who have trouble passing property screening criteria due to their credit, criminal and rental history.

This resource allows TDHCA to provide participating properties with a Barrier Busting payment (equivalent of one month's rent) when the person applying for housing would otherwise be denied because of the property screening criteria. Barrier Busting Funds can be accessed by Certified Referral Agents in support of households being referred to the 811 PRA participating properties.

Funds are available on a first-come, first-served basis; requests for payment will continue to be accepted through the earlier of the depletion of funds, or December 1, 2020. Individuals who qualify are eligible 811 Program applicants who are rejected by 811 PRA participating properties due to property-level screening criteria.⁶⁹

One staff member at TDHCA who assists in the administration of the 811 PRA Program is funded through the MFPD grant.

Strategy 6.3 Continue responding to HUD's expansions of 811 Mainstream Housing Choice Voucher Program

On September 4, 2018, HUD awarded \$98.5 million to 285 local public housing authorities across the country to provide permanent affordable housing to nearly 12,000 additional non-elderly persons with disabilities. In 2018, Texas was awarded \$5 million and 710 new vouchers across the state.

HUD released a second round of vouchers and awarded the Texas public housing authorities \$11,547,127 for 1546 new vouchers. This program helps to further the goals of the Americans with Disabilities Act by helping persons with disabilities live in the most integrated setting. The program also encourages partnerships with health and human service agencies with a demonstrated capacity to coordinate voluntary services and supports to enable individuals to live independently in the community. See Appendix E for the breakdown of vouchers by public housing authority

Strategy 6.4 Continue Project Access Vouchers (Section 8 Housing Choice Vouchers)

Project Access (PA) was originally a pilot program developed by HUD and the U.S. Department of Health and Human Services operated within the Section 8 Housing Choice Voucher Program. The goal of the pilot program was to assist low-income, non-elderly persons with disabilities to transition out of institutions into the

⁶⁹ To learn more: Visit the program website: <https://www.tdhca.state.tx.us/section-811-pra/referral-agents.htm> to review the Barrier Busting Fund Policy and Procedures.

community by providing access to affordable housing and necessary supportive services.

TDHCA applied for the pilot program and received 35 Section 8 housing vouchers from HUD in 2001. After the expiration of the HUD pilot program in 2003, the TDHCA governing board elected to continue the program out of a portion of its own traditional Section 8 vouchers in recognition of housing need and expressed public interest. TDHCA has continued to operate the program since then with periodic increases in the number of PA vouchers. In 2013, the TDHCA governing board elected to increase the voucher to 140. The TDHCA staff member who administers the PA Program is funded in part through the MFPD grant. Through the support of MFPD funds, TDHCA was able to administratively absorb the increase in vouchers.

The program is designed to “recycle” vouchers. A voucher is recycled when local housing authorities are able to absorb the cost of a PA voucher originally issued by TDHCA. When this occurs, the TDHCA voucher funds are freed up to be made available to offer a voucher to another individual on the PA wait list. As of July 31, 2018, over 1,388 households have used the voucher program.

TDHCA set a goal for the PA program to assist 145 households in 2018 and 145 households in 2019. Projections for 2018 and 2019 were reduced to 56 and 125 new vouchers, respectively, due to funding availability and higher rents impacting the program utilization.

Project Access Pilot Program

Since 2016, 18 of the 140 PA housing vouchers were reserved for persons exiting state psychiatric hospitals who are participating in a pilot program coordinated by TDHCA and HHSC. The PA Pilot Program uses Housing Choice Vouchers to help low-income people with disabilities transition from state-funded psychiatric hospital beds into the community by providing access to affordable housing. Eligible applicants must meet the disability criteria and either be a current resident of a state-funded psychiatric hospital or have been discharged from a state-funded psychiatric hospital within 60 days of the application date.

Since the program started, over 140 individuals have been referred and assisted with a PA voucher.⁷⁰

⁷⁰ DSHS, Project Access Pilot Program (March 21, 2016).

Strategy 6.5 Maintain HOME Investment Partnerships Program Tenant-Based Rental Assistance

HOME Tenant-Based Rental Assistance (TBRA) is funded by the federal HOME Investment Partnerships Program focusing on serving rural and special needs populations.

If a TDHCA local TBRA administrator is operating in the area, individuals exiting an institution can use this program to obtain rental assistance while waiting for a PA voucher (contingent upon eligibility and funding). Eligible individuals receive the PA voucher when their names come up on the PA wait list. TDHCA was recently awarded nearly \$400,000 from HUD under the Section 811 Mainstream Housing Choice Voucher Program to provide 50 vouchers to Project Access households.

While participating in the TDHCA TBRA program, an individual will not lose their place on the wait list for a PA voucher.

TDHCA does not set aside HOME TBRA rental assistance funds for this transition activity. MCOs, relocation contractors or other entities providing relocation assistance to individuals leaving nursing facilities can work with a local TBRA administrator to implement this process. The TDHCA TBRA administrator can choose to use existing TBRA resources to provide temporary rental assistance (potentially for up to five years, contingent upon funding availability) to individuals moving from an nursing facility to a community setting. The temporary rental assistance is made available until the individual's name comes up on the PA or a public housing authority wait list.

Since 2013 through August 2018, TDHCA's HOME TBRA program has assisted 31 households transition to the community using HOME TBRA funds while they waited to come up on the PA waiting list. Funding remains available to support this population. The average rental assistance amount provided under the TBRA Program to this population was \$5,292, and the average assistance term was about 9 months.

Strategy 6.6 Continue to support the Amy Young Barrier Removal Program

The Amy Young Barrier Removal (AYBR) program is a TDHCA program funded by the Texas Housing Trust Fund (HTF). HTF was established by the 72nd Legislature in 1991, to provide loans, grants, or other comparable forms of assistance to individuals and families with low- and very low-incomes to finance, acquire, rehabilitate, and develop decent, safe, and sanitary housing.

Funding sources consist of appropriations or transfers made to the fund, unencumbered fund balances, and public or private gifts or grants. HTF provides greater funding flexibility and has fewer regulatory restrictions than federally-funded programs. As a result, AYBR funds can be more easily tailored to meet the unique needs of Texans with low-incomes who have disabilities.

The AYBR program supports people with disabilities needing housing modifications. Launched in 2010, the program is named in honor of the late Amy Young, an advocate for Texans with disabilities. The program provides one-time grants up to \$20,000 for people with disabilities who need home modifications to increase accessibility and eliminate hazardous conditions. Program beneficiaries must include a person with a disability (any age), must have a household income not exceeding 80 percent of the Area Median Family Income, and may be tenants or homeowners. Of the \$20,000 total grant, at least 75 percent must be applied toward barrier removal, with no more than 25 percent applied to correction of life-threatening hazards and unsafe conditions. Common modifications include: installing handrails and ramps; widening doors; adjusting countertops and cabinets to appropriate heights; installing buzzing or flashing devices; installing accessible showers, toilets, and sinks; and customizing other modifications based on the participants' unique needs. People who participate in the AYBR program can remain in their communities, maintain existing social networks, and decrease dependence on institutional assistance.

AYBR administrators are Texas nonprofit organizations and local governments which process intake applications, verify eligibility, work with program beneficiaries to design modifications, and oversee construction.

For the 2018-2019 biennium, TDHCA allocated \$3,399,062 for the AYBR program. To promote equitable funds distribution across the state, HTF applies a geographic allocation formula to the program funds. Per this formula, both rural and urban regions of the state have a predetermined amount reserved only for their region for the initial period of funding availability. After this period, any remaining funds are rolled into one pool for use by any AYBR administrator across the state. This reservation system model expedites program approvals through an encrypted, paperless, online system which makes funds available on a first-come, first-served basis.

Since 2010, the AYBR Program has assisted Texans with disabilities in over 952 households increase their independence through creative design and barrier removal. In state fiscal year 2017 alone, HTF and AYBR program administrators modified 125 homes to become more accessible and safe.

Strategy 6.7 implement the Affordable Housing Project

The Affordable Housing Project is a collaboration between HHSC and the Texas State Affordable Housing Corporation to provide capital subsidies to developers that build or rehabilitate housing units as affordable, accessible and integrated housing units within Dallas and Travis Counties. The target population is people who receive or are eligible for community-based Medicaid long-term services and supports, with preference given to people exiting institutions and those with behavioral health needs. The project expects to fund 30 units.

The project is funded with approximately \$2M in enhanced match general revenue savings earned from participating in the MFPD. This project emerged from HHSC participation in a CMS Housing Innovator Accelerator Program.

Strategy 6.8 Continue to Fund Housing Navigators

Funded through MFPD, the ADRCs have been providing housing navigator services since 2015. Housing navigators develop and maintain relationships with key stakeholders, including housing authorities, property owners, developers, state and local lawmakers, with the goal of increasing accessible, integrated, and affordable housing options.

Navigation outreach increases the likelihood that property owners will accept vouchers and provides important housing information for those who wish to transition from an institution to home and community-based services.

Training on Housing Issues: Housing Summits

The housing summits signify important work connecting housing partners to improve affordable housing opportunities for individuals with disabilities.

In 2019-2020, HHSC sponsored three regional housing summits designed to gather input on the housing needs of local communities and strategies to address those needs.⁷¹ Summits were held in Houston, Temple and Schertz with 245 persons attending. Participants included state and local government agencies, nonprofit organizations, private developers, service providers and advocacy organizations. One positive outcome was the networking that occurred among participants, and the potential for new collaborations to create affordable housing for persons with disabilities. The summits also sparked renewed local interest in the issue of affordable housing and increased efforts to address this issue in some of the participating communities.

⁷¹ The remaining summits were cancelled due to COVID-19.

Regional summits involved representatives from multiple sectors:

- ADRCs;
- LMHAs/LBHAs;
- LIDDAs;
- MCOs;
- Relocation specialists;
- Federally Qualified Health Centers;
- Local Healthcare Districts;
- Homeless Continuums of Care;
- Homeless service providers;
- Veterans Administration;
- Non-profit housing providers;
- Public Housing Authorities;
- Local and County Municipalities; and
- Other organizations involved in the provision of tenancy support services.

Goal 7. Support Community – integrated Employment of Persons with Disabilities

Money Follows the Person Employment First Training across Texas

HHSC and the Texas Workforce Commission Vocational Rehabilitation Division (TWC-VRS) received MFPD administrative funds to provide cross training on Vocational Rehabilitation and the LTSS system. Vocational rehabilitation helps people with disabilities prepare for, find or retain employment and helps youth and students prepare for post-secondary opportunities. The program also helps businesses and employers recruit, retain and accommodate employees with disabilities.⁷² The target audience included: HCS and TxHmL service coordinators and providers; CLASS and DBMD providers and case managers; MCO service coordinators and providers for STAR+PLUS HCBS, STAR+PLUS, STAR Kids, MDCP; and Vocational Rehabilitation staff across the state.

Training topics include:

- Texas' Employment First policy;
- HCBS Settings Final Rule;

⁷² <https://www.twc.texas.gov/programs/vocational-rehabilitation-program-overview>

- Social Security Administration disability benefits programs: how to make working work for an individual on Social Security benefits, including Social Security Disability Insurance (SSDI)⁷³ and Military Survivor⁷⁴;
- Employment services and billing under HHSC waiver programs;
- Texas Workforce Solutions Vocational Rehabilitation Services overview and relationship to LTSS; and
- HHSC Employment Recruitment Coordinator statewide activities;
- Building Employer Relationships.

The Employment First training kicked off in July of 2018 and continued through the remainder of calendar year 2018. The training was again delivered in 2019 for the months of July through December of 2019. New and updated Employment Services Training has been created during the first seven months of 2020. The Employment Services Training was intended to be delivered in person, however due to challenges faced with COVID-19, in person delivery is not a feasible option. The team began converting the training to webinar-based platforms in August of 2020 with the goal of completing all webinar modules by the end of calendar year 2020. The purpose of Employment First and Employment Services training is to increase the successful placement of individuals using LTSS into competitive, integrated employment. The training provides increased knowledge and understanding of funding systems for TWS-VRS and Texas HHSC long term supports and services. The structure of the training walks registrants through how the employment process works and how to seamlessly sequence employment related services throughout individuals' work life. A total of 39 training events were delivered in 2019 to over 2,200 registrants. The 2019 training consisted of 11 training events delivered to over 1,000 registrants. It is anticipated that training being converted to webinar format during 2020 will be viewed by several thousand participants. .

Strategy 7.1 Expand Online Employment Services Training

The online Employment Services trainings provide an overview of waiver employment services and educational opportunities to enhance services pertaining to employment in Texas. Training initiatives are based on needs of service providers, people receiving services and supports, and emerging best practices. The trainings are a free resource on the HHSC Employment First webpage for professional staff, direct service workers, family, other caregivers and people with

⁷³ Social Security Disability Insurance pays benefits to individuals and certain family members individual worked long enough and paid Social Security taxes.

⁷⁴ The Survivor Benefit Plan (SBP) allows a retiree to ensure, after death, a continuous lifetime annuity for their dependents.

IDD who receive LTSS services. The data shows that the online training is being used daily across the state.

Strategy 7.2 Continue Money Follows the Person Employment Recruitment Coordinator Project

As one of several projects in Texas, MFPD is funding a project titled HHSC Employment Recruitment Coordinator (ERC) project. The project began in 2015 and is focused on education and relationship building with employers and businesses across the state. The goal of the project is to increase meaningful, integrated employment opportunities for individuals with disabilities.

The ERC project is a field-based approach to increase employer awareness around the state of why it is a good business decision to hire individuals with disabilities. The recruitment coordinator shares with employers the positive results for businesses of hiring individuals with disabilities, such as productivity, commitment, and reliability. While the ERC project does not focus on specific cases, staff work closely with partners at the Texas Workforce Commission, Texas Workforce Solutions Vocational Rehabilitation. The ERC project serves as a link between employers in communities across the state and employment assistance service providers to provide connections between the employers and the talent pool who have set employment as a goal. The ERC provides potential employer contacts to LIDDAs and providers once the initial groundwork and education has been conducted with a potential employer. The ERC staff also works closely with other HHSC and Texas Workforce Commission staff on mutual employment projects.

During the period of September 2018 through August 2020 the project reached approximately 3,000 people, per year with civic organization presentations, direct one to one meetings with businesses / employers, training delivery events, conference presentations and provider meetings.

The ERC completed each year:

- Average of 20 presentations civic and business organizations;
- Average of six large conference presentations;
- Average of 30 direct one to one meetings with employers; and
- Average of five disability job fairs where ERC was one of the multi-agency team members for planning and staffing.
- Approximately 2,200 professionals trained in CY 2018 and 1,100 professionals trained in CY 2019 where the ERC was part of the training delivery team for Employment First training delivery.

Goal 8. Improve Recruitment and Retention of Direct Service Workforce

An attendant is a person who assists people with their personal care and household tasks, also known as activities of daily living (ADLs)⁷⁵ and instrumental ADLs (IADLs)⁷⁶. Individuals receiving long-term care from attendants may have physical disabilities, chronic illness, cognitive impairment, or other complex needs and require assistance with activities such as preparing meals, bathing, dressing, and transferring, among others.

Community attendants, more specifically, help people remain active members of their local communities by assisting them with their ADLs and IADLs in home and community-based settings. Community attendants advocate for and assist hundreds of thousands of individuals in Medicaid and non-Medicaid programs across Texas. As such, community attendants play an important role in reducing more costly admissions to institutional care settings such as nursing facilities and state supported living centers and in reducing potentially preventable hospitalizations and emergency room visits.

A viable community-based LTSS system requires a stable and trained workforce. Nationally and in Texas there are significant concerns about attendant shortages and high turnover. Factors such as high rates of turnover are aggravated by an increasingly difficult marketplace in which to hire and retain quality community attendants. With demand for community attendant services expected to increase significantly over the next decade due to an aging population, the need to strengthen this workforce will also grow.

The 2014-2015 General Appropriations Act, 83rd Legislature, Regular Session, 2013 (Article II, Special Provision 61, Information on Funding Provided for Direct Care Workers and Attendant Wages) provided funds for an increase in the base wage of community attendants from the federal minimum wage to \$7.50 per hour in fiscal year 2014 and \$7.86 per hour in fiscal year 2015.

The 84th Legislature appropriated \$38.1 million GR and \$88.9 million All Funds to increase the base wage for attendants by \$0.14 to \$8.00 an hour. This represented a 1.7 percent increase. Even though a significant appropriation was made to raise the minimum wage of attendants over the federal minimum wage, cost of living

⁷⁵ Activities of Daily Living (ADLs) are activities essential to daily personal care including bathing or showering, dressing, getting in or out of bed or a chair, using a toilet, and eating.

⁷⁶ Instrumental Activities of Daily Living (IADLs) are activities essential to independent daily living including preparing meals, shopping for groceries or personal items, performing light housework, and using a telephone.

increases outpaces the increase in attendant wages. Therefore, providers had difficulty hiring and retaining qualified attendants.

With base wages near minimum wage, prospective employees often can earn higher wages in the fast food and other industries that hire low-wage workers. Without an increase to the minimum hourly wage, providers will continue to experience high turnover among community attendants.

HHSC sought additional funds for the 2020-21 biennium to increase the base wage from \$8.00 to \$8.50 per hour.

The 2018-19 General Appropriations Act, Senate Bill (S.B.) 1, 85th Legislature, Regular Session, 2017 (Article II, HHSC, Rider 207) is an expansion of the 2016-17 General Appropriations Act, House Bill (H.B.) 1, 84th Legislature, Regular Session, 2015 (Article II, HHSC, Rider 89). HHSC is required to submit a report annually, by August 31, to the Legislative Budget Board and the Governor on recruitment and retention strategies for community attendants that outlines actual expenditures, cost savings, and accomplishments implementing these strategies.

The August 2018 *Community Attendant Recruitment and Retention Strategies* report includes financial and non-financial strategy proposals that may potentially improve community attendant recruitment and retention in Texas.⁷⁷ The report provides data on employment and wages and strategies used by Medicaid agencies in other states. HHSC estimates that community attendant expenditures of at least \$7.9 billion on community attendant expenses during the 2020-21 biennium. HHSC outlined plans for further research to be conducted in the next fiscal year, including plans to revise questions on Medicaid cost reports to better capture data on attendant turnover and retention.

The 86th Legislature required HHSC to submit a community attendant workforce development strategic plan⁷⁸. The plan contains strategies and data relating to recruiting, retaining, and ensuring adequate access to the services of community attendants.

The 2018-19 General Appropriations Act, Senate Bill 1, 85th Legislature, Regular Session, 2017 (Article II, HHSC, Rider 207) required HHSC to submit annual reports on recruitment and retention strategies for community attendants during the 2018-19 biennium. Whereas Rider 207 gave HHSC the discretion to develop community

⁷⁷ <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/rider-207-community-recruitment-retention-strategies-aug-2018.pdf>

⁷⁸ 2020-21 General Appropriations Act, House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, Health and Human Services Commission [HHSC], Rider 157)

attendant recruitment and retention strategies, Rider 157 contains specific strategies that HHSC must pursue in its development of a strategic plan in addition to any other strategies the agency deems appropriate or necessary.

Strategy 8.1 Implement Rider 157 Community Attendant Development Strategic Plan.

Building off previous directives to develop strategies to recruit and retain community attendants, the 2020-21 General Appropriations Act directs HHSC to develop a Community Attendant Workforce Development Strategic Plan.

The strategic plan contains strategies to recruit, retain, and ensure adequate access to the services of community attendants as well as data to inform the decision-making of the Governor, the Legislature, and agency leadership. More specifically, the strategic plan includes information about the community attendant workforce in Texas, feedback collected from stakeholders during a cross-agency forum and through an online survey, and the HHSC's long-term goals and recommendations to address mounting challenges faced by individuals receiving or providing community attendant care. The agency's recommendations are intended to prevent the long-term consequences that an unstable community attendant workforce may create for the state and for the individuals needing direct care. The goals emerging from the stakeholder conversations at the forum include:

- Provide a living wage;
- Reduce administrative burden in the CDS hiring process;
- Workforce development;
- Improve data collection
- Pursue alternative sources of revenue

Activities and accomplishments related to each agency forum goal will be tracked as part of future Plan updates.

Strategy 8.2 Expand Money Follows the Person Demonstration Funded Direct Workforce Training

Increasingly, Texas is losing providers of direct services, direct service workers, physicians, licensed nurses and other professionals, who provide LTSS 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 competes with the private sector for contracts with specialists and providers who can serve these individuals. It is critical for LTSS provider agencies and managed care systems to have adequate numbers of direct service workers

and other network providers in place to serve all individuals in a community-based setting.

In 2016, the state used MFPD rebalancing funds to develop a computer-based training for staff who provide community-based services to individuals with complex behavioral and/or medical needs. The training was offered in response to direct service worker survey results indicating the need for additional training on this topic. In addition, MFPD funded five in-person workshops for providers on positive behavior outcomes.

In calendar years 2019 and 2020, prior to the COVID-19 Public Health Emergency (PHE), the state used MFPD funds to:

- Hold trainings on Medicaid and SSI for family members and providers;
- Launched a computer-based training on trauma informed care, crisis management for direct service workers;
- Provide statewide training and resources on caring for an individual with Alzheimer's disease;
- Offered Online training on Cognitive Adaptation Therapy (CATs);
- Prepared for in-person Mental Health First Aid Training until the PHE went into effect; and
- Developed a training on Person Centered Planning and the CDS option.

6. Conclusion

The state has made significant progress offering Texans community-based alternatives to institutional placement due to increasing legislative appropriations over the past six legislative sessions, as well as new policies and initiatives aimed at serving individuals in the community. Even with support through funding and policy changes, there is more work to be done to move the Plan forward by continuing to decrease the number of individuals in institutions and the interest list for Medicaid waiver services.

HHSC remains committed to continued progress through collaborative relationships with stakeholders. Stakeholders, including individuals and families, service providers, advocacy groups, and MCOs provide valuable input on the state's progress implementing the existing and previous plans and make recommendations to ensure community options for individuals with disabilities. Using the strategic plan framework, HHSC will continue to seek stakeholder input on progress, challenges, and recommendations for improvement in future biennial revisions of the Plan.

List of Acronyms

Acronym	Full Name
ADA	Americans with Disabilities Act of 1990
ADRC	Aging and Disability Resource Center
AYBR	Amy Young Barrier Removal
BHP	Behavioral health pilot
CAT	Cognitive Adaptation Training
CBA	Community Based Alternatives
CBO	Community Based Organization
CDS	Consumer Directed Services
CFC	Community First Choice
CIL	Center for independent living
CIS	Crisis Intervention Specialist
CLASS	Community Living Assistance and Support Services
CLO	Community Living Options for People with IDD in Nursing Facilities
CLOIP	Community Living Options and Information Process
CMS	Centers for Medicare and Medicaid Services
CPS	Child Protective Services
CR	Crisis Respite
CTI-EBP	Centralized training infrastructure for evidence-based practices
CY	Calendar Year
DADS	Department of Aging and Disabilities Services
DARS	Department of Assistive and Rehabilitative Services
DBMD	Deaf Blind with Multiple Disabilities
DFPS	Department of Family and Protective Services
DSHS	Department of State Health Services
ECC	Enhanced Community Coordination
ED	Emergency Department

Acronym	Full Name
EQRO	External Quality Review Organization
ERC	Employment Recruitment Coordinator
FFS	Fee-for-service
GR	General revenue
GRO	General residential operations
HCBS	Home and community based services
HCS	Home and Community-based Services program for individuals with an intellectual disability
HHS	Health and Human Services
HHSC	Health and Human Services Commission
H.B.	House Bill
HTF	Housing trust fund
HUD	Department of Housing and Urban Development
ICF/IID	Intermediate care facility for individuals with intellectual disabilities
IDD	Intellectual or developmental disability
IDD SRAC	Intellectual or Developmental Disability System Redesign Committee
ILS	Independent living services
IMD	Institutions for Mental Disease
Initiative	Promoting Independence Initiative
ISS	Individualized Skills and Socialization
JMC	Joint managing conservatorship
LAR	Legally authorized representative
LBHA	Local Behavioral Health Authority
LIDDA	Local intellectual and developmental disability authority
LMHA	Local mental health authority
LTSS	Long term services and supports
MCO	Managed care organization
MCOT	Mobile Crisis Outreach Team
MDCP	Medically Dependent Children Program

Acronym	Full Name
MFPD	Money Follows the Person Rebalancing Demonstration
MHSA	Mental Health and Substance Abuse
MHW-IDD	Mental Health Wellness for Individuals with Intellectual and Developmental Disabilities
NCAPPS	National Center on Advancement of Person-Centered Practices and Systems
NF	Nursing facility
PA	Project Access
PASRR	Pre-admission Screening and Resident Review
PCP	Person-centered Planning
PCSP	Parental Child Safety Placement
PCT	Person-centered Thinking
PHE	Public Health Emergency
PIAC	Promoting Independence Advisory Committee
PIW	Promoting Independence Workgroup
PPT	People Planning Together
PRA	Project Rental Assistance
QA	Quality assurance
QAP	Qualified Allocation Plan
RFP	Request for Proposals
S.B.	Senate Bill
SC	Service coordinator
SDA	Service Delivery Area
SMI	Serious mental illness
SRAC	System redesign advisory committee
SSI	Supplemental Security Income
SSDI	Social Security Disability Insurance
SSLC	State supported living center
STAR+PLUS	State of Texas Access Reform+ PLUS
STAR+PLUS HCBS	State of Texas Access Reform+ PLUS Home and Community Based Services program

Acronym	Full Name
TBRA	Tenant-Based Rental Assistance
TBI	Traumatic Brain Injury
TDHCA	Texas Department of Housing and Community Affairs
TIERS	Texas Integrated Eligibility Redesign System
TLCPCP	The Learning Community for Person-Centered Practices
TSAHC	Texas State Affordable Housing Corporation
TST	Transition Support Team
TWC	Texas Workforce Commission
TWS-VRS	Texas Workforce Commission Vocational Rehabilitation Division
TxHmL	Texas Home Living program
U.S.	United States
YES	Youth Empowerment Services

Appendix A. Executive Order GWB 99-2

EXECUTIVE ORDER

THE STATE OF TEXAS
EXECUTIVE DEPARTMENT
OFFICE OF THE GOVERNOR
AUSTIN, TEXAS
EXECUTIVE ORDER
GWB 99-2

Relating to Community-Based Alternatives for People with Disabilities

WHEREAS, The State of Texas is committed to providing community-based alternatives for people with disabilities and recognizes that such services advance the best interests of all Texans; and

WHEREAS, Texas seeks to ensure that Texas' community-based programs effectively foster independence and acceptance of people with disabilities; and

WHEREAS, programs such as Community Based Alternatives and Home and Community Services provide the opportunity for people to live productive lives in their home communities; and

WHEREAS, as Governor, I have been a consistent advocate for increasing funds to expand community-based services for the elderly and people with disabilities and, working with the Legislature, have increased funding for such programs by more than \$1.7 billion, a 72 percent increase, since taking office; and

WHEREAS, the 76th Legislature has provided funding to allow an additional 15,000 Texans to live outside of institutional settings through our Medicaid waiver and non-waiver community services; and

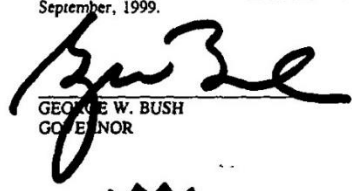
WHEREAS, Texas must build upon its success and undertake a broader review of our programs for people with disabilities and ensure services offered are in the most appropriate setting;

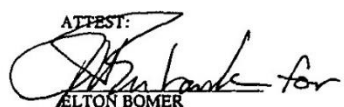
NOW, THEREFORE, I, GEORGE W. BUSH, GOVERNOR OF TEXAS, by virtue of the power vested in me, do hereby order the following directives:

1. The Texas Health and Human Services Commission (HHSC) shall conduct a comprehensive review of all services and support systems available to people with disabilities in Texas. This review shall analyze the availability, application, and efficacy of existing community-based alternatives for people with disabilities. The review shall focus on identifying affected populations, improving the flow of information about supports in the community, and removing barriers that impede opportunities for community placement. The review shall examine these issues in light of the recent United States Supreme Court decision in *Olmstead v. L.C.*
2. HHSC shall ensure the involvement of consumers, advocates, providers and relevant agency representatives in this review.
3. HHSC shall submit a comprehensive written report of its findings to the Governor, the Lieutenant Governor, the Speaker of the House, and the appropriate committees of the 77th Legislature no later than January 9, 2001. The report will include specific recommendations on how Texas can improve its community-based programs for people with disabilities by legislative or administrative action.
4. All affected agencies and other public entities shall cooperate fully with HHSC's research, analysis, and production of the report. This report should be made available electronically.

- 5. As opportunities for system improvements are identified, HHSC shall use its statutory authority to effect appropriate changes.

Given under my hand this the 28th day of September, 1999.


GEORGE W. BUSH
GOVERNOR

ATTEST:

ELTON BOMER
Secretary of State



Filed in the Office of
Secretary of State
SEP 28 1999
Statutory Filings Division
Statutory Documents

Appendix B. Executive Order RP-13

Executive Order

BY THE
GOVERNOR OF THE STATE OF TEXAS

Executive Department
Austin, Texas
April 18, 2002

EXECUTIVE ORDER
RP 13

Relating to community-based alternatives for people with disabilities.

WHEREAS, The State of Texas is committed to providing community-based alternatives for people with disabilities and recognizes that such services and supports advance the best interests of all Texans; and

WHEREAS, it is imperative that consumers and their families have a choice from among the broadest range of supports to most effectively meet their needs in their homes, community settings, state facilities or other residential settings; and

WHEREAS, as Governor, I am committed to ensuring that people with disabilities have the opportunity to enjoy full lives of independence, productivity and self-determination; and

WHEREAS, working with the Texas Legislature last session as Governor, I signed legislation totaling \$101.5 million dollars in general revenue to expand community waiver services; and

WHEREAS, also last session, I signed legislation promoting independence for people with disabilities and directing agencies to redesign service delivery to better support people with disabilities; and

WHEREAS, programs such as Community Based Alternatives, Home and Community-based Services, and other community support programs provide opportunities for people to live productive lives in their home communities; and

WHEREAS, accessible, affordable and integrated housing is an integral component of independence for people with disabilities; and

WHEREAS, Texas recognizes the importance of keeping children in families, regardless of a child's disability, and support services allow families to care for their children in home environments;

NOW, THEREFORE, I, Rick Perry, Governor of Texas, by virtue of the power and authority vested in me by the Constitution and laws of the State of Texas, do hereby order the following:

Review of State Policy. The Texas Health and Human Services Commission ("HHSC") shall review and amend state policies that impede moving children and adults from institutions when the individual desires the move, when the state's treatment professionals determine that such

placement is appropriate, and when such placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others who are receiving state-supported disability services.

Promoting Independence Plan. The Health and Human Services Commission shall ensure the Promoting Independence Plan is a comprehensive and effective working plan and thorough guide for increasing community services. HHSC shall regularly update the plan and shall evaluate and report on its implementation.

In the Promoting Independence Plan, HHSC shall report on the status of community-based services. In the plan, HHSC shall:

1. update the analysis of the availability of community-based services as a part of the continuum of care;
2. explore ways to increase the community care workforce;
3. promote the safety and integration of people receiving services in the community; and
4. review options to expand the availability of affordable, accessible and integrated housing.

Housing. The Health and Human Services Commission shall incorporate the efforts of the Texas Department of Housing and Community Affairs ("TDHCA") to assure accessible, affordable, and integrated housing in the recommendations of the Texas Promoting Independence Plan.

The Texas Department of Housing and Community Affairs shall provide in-house training of key staff on disability issues and technical assistance to local public housing authorities in order to prioritize accessible, affordable, and integrated housing for people with disabilities.

The Texas Department of Housing and Community Affairs and HHSC shall maximize federal funds for accessible, affordable, and integrated housing for people with disabilities. These agencies, along with appropriate health and human services agencies, shall identify, within existing resources, innovative funding mechanisms to develop additional housing assistance for people with disabilities.

Employment. The Health and Human Services Commission shall direct the Texas Rehabilitation Commission and the Texas Commission for the Blind to explore ways to employ people with disabilities as attendants and review agency policies so they promote the independence of people with disabilities in community settings.

The Health and Human Services Commission shall coordinate efforts with the Texas Workforce Commission to increase the pool of available community-based service workers and to promote the new franchise tax exemption for employers who hire certain people with disabilities.

Families. The Health and Human Services Commission shall work with health and human services agencies to ensure that permanency planning for children results in children receiving support services in the community when such a placement is determined to be desirable,

appropriate, and services are available.

The Health and Human Services Commission shall move forward with a pilot to develop and implement a system of family-based options to expand the continuum of care for families of children with disabilities.

Selected Essential Services Waiver. Dependent on its feasibility, HHSC shall direct the Texas Department of Mental Health and Mental Retardation to implement a selected essential services waiver, using existing general revenue, in order to provide community services for people who are waiting for the Home and Community-based Services waiver.

Submission of Plan. The Health and Human Services Commission shall submit the updated Texas Promoting Independence Plan to the Governor, the Lieutenant Governor, the Speaker of the House, and the appropriate legislative committees no later than December 1st each even numbered year, beginning with December 1, 2002.

All affected agencies and other public entities shall cooperate fully with the Health and Human Services Commission during the research, analysis, and production of this plan. The plan should be made available electronically.

This executive order complements GWB 99-2 and supersedes all previous executive orders on community-based alternatives for people with disabilities. This order shall remain in effect until modified, amended, rescinded, or superseded by me or by a succeeding Governor.



Given under my hand this the
18th day of April, 2002.

Rick Perry
RICK PERRY
Governor

ATTESTED BY:

FILED IN THE OFFICE OF THE
SECRETARY OF STATE
2:00 P. M., O'CLOCK

APR 18 2002

Gwyn Shea
GWYN SHEA
Secretary of State

Secretary of State

Appendix C. List of Promoting Independence Workgroup (PIW) Organizations

PIW Member Organizations

- Accessible Housing Austin, Inc
- ADAPT of Texas
- ARC of Texas
- Coalition of Texans with Disabilities
- D&S Community Services
- Disability Rights Texas
- EveryChild Texas
- Kindred at Home
- North Central Texas Council of Governments
- Private Providers Association of Texas
- Providers Alliance for Community Services of Texas
- Superior Health
- Texas Association for Home Care and Hospice
- Texas Council for Developmental Disabilities
- Texas Council of Community Centers
- Texas Department of Family and Protective Services
- Texas Department of Housing and Community Affairs
- Texas Healthcare Association
- Texas Parent to Parent
- Texas Workforce Commission
- University of Texas at Austin – Center for Disability Studies

Appendix D. Promoting Independence Accountability Benchmarks

The following chart portrays measures for strategies and goals by year. Certain columns contain numbers showing a certain time period for context.

Goal 1: Increase access to and strengthen the community-based service array

Strategy	2021 Measure	2022 Measure
Strategy 1.1 - Continue to offer slots for transitioning from institutions to community-based services either through seeking legislative appropriations to fund Promoting Independence (PI) slots or by attrition.	Number of slots filled: As of the second quarter of fiscal year 2020, 189 PI priority slots have been filled through attrition, with 256 pending enrollment.	Number of slots filled.
Strategy 1.4 Ensure Individuals Receive Existing Community-based Services to Meet Challenging Behavioral or Medical Needs	Number receiving existing services per fiscal year. Fiscal year 2019 Transition Support Teams: 1495 educational opportunities provided; 1551 technical assistance provided; 466 case consultations and peer review. Fiscal year 2019 Enhanced Community Coordination: 2900 services delivered. Fiscal year 2019 Crisis Intervention Services: 4023 served.	Ensuring individuals with challenging behavioral or medical support needs have access to community-based services to support their transitions and/or diversion from institutional settings (i.e., Crisis Services, Transition Support Teams, Enhanced Community Coordination).
Strategy 1.5 Continue Person-Centered Planning	Number trained in Person Centered Planning (PCP) each year. As of July 8, 2020, 7,678 people, including people from other states, had successfully completed the online PCP training that launched in February 2017.	Increased number of those trained each year.

Goal 2: Continue to transition children from institutions to family-based settings and enhance community-based supports for children with behavior challenges.

Strategy	2021 Measure	2022 Measure
Strategy 2.1 Transitioning Children to Family-Based Settings	<p>As of February 2020, 96 percent of children and young adults under age 22 living in congregate care had permanency plans in place each quarter of the biennium.</p> <p>From September 2019 to February 2020, 244 children transitioned to community-based family settings or were diverted from entering an institution.</p> <p>As of February 2020, 1,106 children were living in all types of institutions, including HCS residential settings, with the number of children residing in an institutional setting, excluding HCS, decreasing by 64% since 2002.</p>	<p>Of those living in institutions, 96 percent have a permanency plan in place each quarter of the biennium.</p> <p>The number of children in institutions who transitioned from or were diverted from admission to an institution increased from the previous biennium.</p> <p>Number of children in institutions decreased compared to the previous biennium.</p>
Strategy 2.2 Community-Based Supports for Children with Serious Emotional Disturbances	<p>Number served in the YES waiver per fiscal year.</p> <p>In fiscal year 2020, the YES waiver program served 2,751 participants, including approximately 151 children under DFPS conservatorship.</p>	<p>Increased number of YES participants</p>

Goal 3. Strengthen managed care support for transitions to and remaining in the community.

Strategy	2021 Measure	2022 Measure
Strategy 3.2 Continue Long Term Services and Supports Medicaid Managed Care Expansion	<p>Number of complaints to the Ombudsman's office regarding transitions from institutional services to HCBS in managed care.</p>	<p>Decreased number of complaints to the Ombudsman's office regarding transitions from institutional services to HCBS in managed care.</p>

Goal 4: Increase access to comprehensive behavioral health services to support individuals to transition to and remain in the community.

Strategy	2021 Measure	2022 Measure
Strategy 4.4 Expand Mental Health Workforce Development and Training	Increase the number of mental health training opportunities.	Increase the number of mental health training opportunities.
Strategy 4.5 Maintain Centralized Training Infrastructure for Evidence Based Practices	Number and types of training available each year; number who complete the on-line training modules: On average, about 500 users from across the country complete at least one module per week; number of LTSS trainings; number of non-traditional providers completing the training (e.g., caregivers)	Maintain number and types of training available each year; number who complete the on-line training modules; number of LTSS trainings; number of non-traditional providers completing the training (e.g., caregivers)
Strategy 4.7 Sustain the Home and Community-Based Services Adult Mental Health Program	As of August 2020, 281 individuals were enrolled in HCBS-AMH.	Increase number of individuals served.

Goal 5. Maintain and Improve Relocation Services

Strategy	2021 Measure	2022 Measure
Strategy 5.1 Continue to support relocation contracting capacity-building.	Fiscal year 2018 Number of individuals assessed: 2522 Fiscal year 2018 number transitions: 1497 Fiscal year 2018 length to complete transition: two-thirds transfer within three months of requesting to move Fiscal year 2018 number re-institutionalized: 10 percent	Maintain consistent number of individuals assessed and transitions, quarterly; length to complete transition, quarterly; number re-institutionalized, quarterly.

Goal 6: Continue to expand housing opportunities for individuals exiting institutions.

Strategy	2021 Measure	2022 Measure
Strategy 6.1 Continue HHSC's collaboration with the Texas Department of Housing and Community Affairs Section 811 Project Rental Assistance Program	As of October 2020, number moved into 811 properties: 445 Number on waiting list per biennium: 2095.	Increased number of people who are relocating/moving into 811 PRA properties.

Strategy	2021 Measure	2022 Measure
Strategy 6.4 Continue Project Access Vouchers (Section 8 Housing Choice Vouchers)	As of 2019, number of new vouchers added each fiscal year: 125.	Number of new vouchers added each fiscal year.
Strategy 6.7 Implement the Affordable Housing Project	The project expects to fund 30 units. Number of families housed in units; Number of owner agreements executed.	Implement and establish a baseline number of families housed in units; Number of owner agreements executed.
Strategy 6.8 Continue to Fund Housing Navigators	Calendar year 2019, number of local housing plans reviewed: 43	Maintain number of local housing plans reviewed.

Goal 7. Support Community-integrated Employment of Persons with Disabilities

Strategy	2021 Measure	2022 Measure
Strategy 7.1 Expand Online Employment Services Training	Calendar year 2019, the number of individuals completing the online trainings each fiscal year: 1100.	Increase the number of individuals completing the on-line training compared to the previous biennium.
Strategy 7.2 Continue Money Follows the Person Employment Recruitment Coordinator Project	Calendar year 2019, number of persons with disabilities engaged in seeking/gaining employment: 3000. Calendar year 2019, number of events attended: 60.	Increase the number of persons with disabilities engaged in seeking/gaining employment compared to the previous biennium. Increased number of events attended.

Goal 8. Improve Recruitment and Retention of Direct Service Workforce

Strategy	2021 Measure	2022 Measure
Strategy 8.2 Expand Money Follows the Person Demonstration Funded Direct Workforce Training	In calendar year 2019, expand awareness of training; increase the number of direct service workers completing training modules and type modules per year: 4 new modules.	Expand awareness of training; increase the number trained from the previous year.

Appendix E. Recommendations from the Promoting Independence Workgroup

The recommendations and narrative in Appendix D reflect the views and opinions of groups represented in the Promoting Independence Workgroup. The views and opinions expressed in these recommendations do not necessarily reflect the policy of HHSC. HHSC did not vet or approve data included in the recommendations.

Representatives of EveryChild, Inc., Texas Council for Developmental Disabilities, Coalition of Texans with Disabilities, The Arc of Texas, Disability Rights Texas, Texas Parent to Parent, Easterseals, Central Texas Coastal Bend Center for Independent Living, and Texas Association for Home Care and Hospice attend Promoting Independence Workgroup Meetings. Members of these groups contributed to the 39 workgroup recommendations in 2018.

For the 2020 report representatives from Disability Rights Texas, EveryChild and Center for Texans with Disabilities supported moving the 2018 recommendations forward for the 2020 report with certain modifications and additions noted throughout. The end result is 46 recommendations. The new recommendations from 2020 are included at the end. Recommendations are organized by general topic and include:

- Promoting independence
- Expanding community services
- Children
- Behavioral health
- Employment and meaningful day
- Relocation services
- Housing
- Workforce stabilization
- Improved process and quality
- State supported living centers

Promoting Independence

Recommendation #1

Continue Texas' commitment to Olmstead and Texans with disabilities by reinstating the Promoting Independence Advisory Committee and providing the data necessary to provide meaningful input to HHSC.

Rationale: 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 Promoting Independence Advisory Committee (PIAC) advocated for a more comprehensive system of long term services and supports (LTSS) responding to individual needs, regardless of age or diagnosis, and commends the Department of Aging and Disability Services (DADS) and HHSC for making policy changes supporting this goal, such as allowing children who qualify medically for nursing home care to access Home and Community-Based Services (HCS) nursing facility diversion slots. The Promoting Independence Advisory Committee was a key stakeholder committee that assisted HHSC to continue the work of the original Promoting Independence plan to help Texas reach its ultimate goals of individual choice and self-determination for people with disabilities. The success of the committee is evident by its many successfully adopted recommendations since 2001 and considerable expertise and analysis offered through stakeholder meetings and the Stakeholder reports. As new initiatives emerged, HHSC was able to utilize this group to serve in additional advisory capacities as required by innovative grant funding provided to Texas.

Expanding Community Services

Recommendation #2, Modified

Continue Texas' commitment to Olmstead and Texans with disabilities by funding waiver services for individuals on the home and community-based services interest lists at reasonable pace.

- Ensure access to Promoting Independence interest list waiver services continues through alternative means for assessments, service planning and authorizations and enrollments during the current public health emergency or other disasters.
- Fund at least 20 percent of the HCS, TxHmL, MDCP, STAR+PLUS and CLASS interest lists, taking into account the uptake rate, over the next biennium.
- Fully fund the DBMD interest list.
- Eliminate the interest list for individuals eligible for TxHmL waiver. Provide outreach and education to ensure awareness of TxHmL, especially for transition age public school students and their families, and no waiting for eligible individuals.
- Amend TxHmL financial eligibility to 300% SSI consistent with other waivers and base eligibility on the income of the individual.
- Provide funding for the most appropriate waiver when an individual is found to be ineligible for their current waiver (for instance: MDCP to HCS).
- Reduce the MDCP interest list by allowing children who have SSI and meet nursing facility level of care to receive Medically Dependent Children Program waiver

services with no wait like the policy in STAR+PLUS waiver. See Recommendation number 3.

Rationale: The current unduplicated interest list count is 165,227 as of August 31, 2020 and continues to increase at an alarming rate. Some individuals wait 14 - 15 years for critical services—waiting over a decade for services is not a reasonable pace. The limited funding for interest list reduction in the FY 2020 – FY 2021 biennium has already negatively impacted individuals and families with disabilities. Often, providing minimal support on the front end prevents more costly crisis situations. Private insurance does not cover long-term services and supports, such as, personal assistance services (attendant care), residential services, and employment supports. This makes Medicaid waivers a lifeline for Texans with disabilities.

Recommendation #3

Provide automatic access to adults and children who meet eligibility and are SSI recipients for those currently in a managed care model and when expanding managed care to the other long-term services and supports (mimic the STAR+PLUS Waiver model).

Rationale: When the STAR+PLUS waiver rolled out in Texas, adults who had SSI and qualified for the waiver received waiver services with no wait. This practice has significantly reduced the waiting list for the STAR + Plus waiver and has assisted individuals to stay in their homes and communities. When STAR Kids rolled out in November 2016, Texas had an opportunity to significantly reduce the MDCP interest list by allowing all children and young adults who receive SSI and meet waiver eligibility to automatically receive services with no wait. HHSC chose not to adopt the same policy for children in MDCP that it did for adults. Texas should provide automatic access to waiver level services to adults and children who meet waiver eligibility and who are SSI recipients for those currently enrolled in a managed care model and whenever a new waiver is carved into managed care.

2018 Recommendation #4, Modified

Prevent the unnecessary institutionalization of individuals with disabilities through transition, crisis diversion and PASRR diversion waiver services, known as Promoting Independence initiatives, by adequately funding PI waivers.

- Ensure that access to Promoting Independence waiver services continues through alternative means for assessments, service planning and authorizations and enrollments during the public health emergency or other disaster.
- Fund the following number of Promoting Independence waivers: o 500 HCS waivers for individuals to move from large or medium ICFs/IID

- ▶ 400 HCS waivers for individuals at imminent risk of institutionalization in an ICF, including SSLC
- ▶ 120 HCS waivers to assist individuals moving from state hospitals
- ▶ 216 HCS waivers for children aging out of DFPS foster care
- ▶ 600 HCS waivers for adults and children at imminent risk of admission to a nursing facility
- ▶ 700 HCS waivers for individuals to transition from nursing facilities
- ▶ 20 HCS waivers to assist children in moving from nursing facilities
- ▶ 35 HCS waivers dedicated for children living in DFPS licensed General Residential Operations
- Create a new target group in the HCS waiver for children aging out of DFPS foster care who have a related condition and do not have an intellectual disability and fund a sufficient number of HCS waivers to prevent the institutionalization of the children as they age out of the CPS system.

Rationale: Promoting Independence initiatives 1) allow individuals in institutions to access the critical services (habilitation, personal assistance services, residential support, etc.) needed to move from an institution into the community, and 2) prevent individuals at imminent risk of institutionalization. Aside from home and community-based services being the preferred choice of the majority of Texans with disabilities and their families, it is also the most cost effective and fiscally responsible option. When individuals are provided the appropriate home and community-based services, the state sees positive outcomes, such as decreased hospitalization, increased employment, and overall higher quality of life. However, the promoting independence waivers were not funded in the FY 2020 – FY 2021 biennium, no waivers were funded to prevent SSLC diversion and limited funding was provided for the lengthy waiver interest list, forcing more individuals into crisis and increasing the need for this funding.

2018 Recommendation #5, Modified

Prevent the unnecessary institutionalization of individuals with disabilities by funding facility diversion waivers for the following groups of individuals who have historically been left out of the Promoting Independence request.

- Ensure access to Promoting Independence diversion waiver services continues through alternative means for assessments, service planning and authorizations and enrollments during the current public health emergency or other disasters.
- Amend waivers to create a reserved capacity group of individuals at imminent risk of institutionalization and provide funding for the following:
 - MDCP waivers for children with developmental disabilities at imminent risk of nursing facility admission
 - ▶ CLASS waivers for children and adults at imminent risk of institutionalization

- ▶ STAR+PLUS waivers for adults without SSI at imminent risk of institutionalization
- Ensure individuals get the services that best meet their needs by creating a bridge between waivers and transfers to a more comprehensive waiver that best meets needs
- Create a system and a publicly available policy for individuals who find they are not eligible for a waiver only after waiting years on an interest list. Some waivers include provisions requiring that when this happens, the individual be placed on the appropriate interest list based on the date they were added to the list for the program for which they were found not eligible.
 - Include this language in all Texas HCBS waivers through waiver amendments.
 - ▶ In addition to waiver language, there should be a policy and a public awareness campaign to ensure that all parties (individuals, families, providers, service coordinators, case managers and MCOs, HHSC staff) know and share this policy and facilitate the transition to the other waiver(s) interest list.
 - ▶ For each population, study and provide data regarding when, why and how migrations between and among LTSS community and institutional programs and services occur with the purpose of getting individuals to the most integrated appropriate supports and services and prevent unnecessary institutionalization.
- Increase awareness of and accountability for providing Community First Choice (CFC) services.

Rationale: An individual may be eligible for multiple 1915 (c) waivers that are designed to help promote independence, protect health and safety, and prevent institutionalization. However, getting to the most appropriate waiver and service package when needed can mean a 14 to 15 year wait for many. Some individuals have learned after years of waiting that they were not placed on the correct interest list and have no recourse except to go on another list and begin the long wait again.

In addition, individuals with IDD, physical disabilities, aging Texans, and individuals with mental illness transition from settings and programs over the course of time and as their needs change. Some end up in more restrictive settings. Not enough information is known about the movement across service systems and how to use the information to better plan for and implement services that prevent unnecessary or long term stays in institutional settings.

Individuals with disabilities and their families regularly report they were not made aware of Community First Choice (CFC) or supported to access the service. There should be more effort to promote this service and hold MCOs, providers, service coordinators and case managers accountable for facilitating awareness, enrollment, and access to this service.

Recommendation #6

HHSC should fund, and continue to fund in future biennia, enhanced support including Enhanced Community Coordination for individuals with IDD, related conditions and mental health diagnosis transitioning out of institutions (SSLCs, ICFs, state hospitals and nursing facilities) and for individuals experiencing challenges in the community because of their complex/high support needs. This should cover physical, medical, behavioral and any other complex support need that puts the individual at risk of re-entering or entering an institution.

Rationale: Texas does not adequately support the transition of individuals out of institutions and has systemic issues obtaining the level of support needed or individuals with complex/high support needs. Additionally, there are not adequate crisis services or level of need adjustments that allow someone to receive enhanced support in a timely manner. It's been reported that a significant issue creating barriers to transition out of SSLCs is the community's ability to serve complex/high support needs—specifically behavioral needs.

Recommendation #7

Complex Needs and Access to General Revenue funds.

- Using the work of the DADS High Medical Needs Workgroup and HHSC's draft rules, seek stable, ongoing funding for targeted individuals with high needs related to medical and physical conditions, seek high medical/physical needs funding.
- Develop an LON for high medical and physical support needs in HCS with stakeholder input in order to identify needs and seek additional future funding.

Engage stakeholders and HHSC staff to develop publicly available policies and practices standards for access to General Revenue funding for individuals whose needs justify exceeding the cost cap of their waiver to remain in and be healthy and safe in the community. In addition, stakeholders and HHSC should identify any future modification that would further improve access to GR funds to promote independence, health and safety and keep individuals in the community.

Rationale:

Complex Medical and Physical Support Needs: Building a high medical needs support system with enhancements to the limited number of individuals with high complex needs is critical. Much of the previous work by HHSC and DADS on high medical needs service definitions, rates, and rules can serve as the foundation for a funding request and moving the process forward. Funding should take into account additional savings from individuals

who will be able to transition from SSLCs and other institutions based on these targeted enhancements. While funding was appropriated for the 2015-2016 biennium, it was not utilized to implement targeted modifications to the HCS program.

Assessment Tool: There is a high level of need in the HCS program for behavior supports and not for medical or physical support. Given the acuity of individuals who want to live in the community and could do so, the ability to provide equity between medical, physical and behavior supports is important and timely. Assessment tools and resource algorithms that account for high support needs, whether physical, medical, or behavioral should be appropriate and available.

Exceeding Cost Cap: General Revenue funding is available for qualified individuals to exceed the waiver cost cap for the waiver in which he or she is enrolled. There should be a clear, public process for policies and practices for access to this important option. While continuing the option is critical, when justified, HHSC and stakeholders should partner to establish, clarify or modify the policy and process and to identify funding sources to anticipate current and future needs.

Recommendation #8

HHSC should fund programs focused on moving individuals who use ventilators in nursing facilities to the community in a timely manner.

- Ensure the programs address individuals that have indicated they would like to transition to the community
- Direct STAR Plus MCOs to offer community-based services to people with vent assistance
- Provide training to MCOs and relocation specialists on relocating individuals who require ventilator care. Focus on those who serve areas in which facilities that provide ventilator care are located
- Create a "mentor" program, whereby individuals who utilize ventilators and/or their family members can provide advice and direction to transition teams

Rationale: Nursing home residents who require ventilator care face unique barriers in returning to the community. Although relocation specialists are asked to target nursing home residents with complex needs, they have not been provided training that's specific to working with this population. Providing training to relocation specialists and MCOs is essential to ensuring individuals who require ventilator care can be moved to the community in a timely manner.

Establish metrics to determine the degree of success that relocation contractors and managed care service coordinators have placing individuals on ventilators in the

community. The state needs to establish a public dashboard to ensure transparency and data sharing.

Recommendation #9

Add a Medicaid dental benefit for adults. Currently, there are little or no dental services for adults in Medicaid, resulting in poor oral health, poor nutrition and complications including heart disease, diabetes and hypertension. Severe dental pain is among the most common reasons for ER visits by adults in Medicaid and is a source for opioid prescriptions.

Rationale: Emergency rooms visits are costly to Medicaid, for patients who present with acute pain due to untreated dental problems and thus require opioids. These visits and costs could be converted into a more proactive approach, where regular dentistry would prevent rampant and painful decay.

Recommendation # 10

Restore funding for the In-Home and Family Support programs for individuals with physical disabilities, intellectual and developmental disabilities and individuals with a mental health diagnosis.

Rationale: In Home and Family Support (IHFS) provided flexible assistance to individuals with disabilities who need help with daily living activities. The program provided financial support to individuals enabling them to remain at home and prevent institutionalization. Around 6,000 Texans used this program to preserve their independence. The program was eliminated when it was not funded during the 85th Texas legislative session.

Children

Recommendation #11

Create set asides within the HCS, CLASS, and DBMD waivers for children who lose eligibility for MDCP waiver due to lack of medical necessity at their annual reassessment. Fund 50 set asides in CLASS, 50 in HCS and 5 in DBMD.

Rationale: Since the implementation of the STAR Kids program in November 2016, a significant number of children have lost MDCP eligibility upon reassessment. According to the MDCP denial data provided by HHSC for the number of denials based on the new STAR Kids Screening and Assessment Instrument is significantly higher than the denials for the previous four fiscal years.

Many of the children who have lost eligibility for Medicaid due to their loss of MDCP eligibility, continue to need the long-term services and supports offered in another 1915(c) waiver such as CLASS or HCS. Not only have children lost their waiver services, some have lost access to critical health care and long-term services and supports such as Personal Care Services. Without these services children are at risk of unnecessary institutionalization in Intermediate Care Facilities and Nursing Facilities at a high cost to the children, their families and the state.

Recommendation #12

Texas should include children with developmental disabilities living in Department of Family and Protective Services funded Residential Treatment Centers as a new priority population in the Texas Promoting Independence Plan.

- Require tracking of all children and youth with intellectual and developmental disabilities living in Residential Treatment Facilities for more than 12 months as part of the state's Promoting Independence initiative.
- Include children and youth with intellectual and developmental disabilities who are in the custody of the state and who have resided in a DFPS licensed Residential Treatment Facility for more than one year as a priority population in the Promoting Independence Plan.
- Provide these children the same expedited access to community waiver services as children residing in other long-term care facilities, such as SSLCs and ICFs/IID.
- Request and appropriate funding for 20 to 25 children living in RTCs for more than 12 months to receive the Home and Community-Based Services (HCS) waiver per biennium.
- Investigate the possibility of DFPS paying the state match required for the federal waiver funds through a transfer of general revenue from DFPS to HHSC.

Rationale: Children and youth with intellectual and developmental disabilities in state conservatorship are living in DFPS licensed Residential Treatment Centers for long periods of time, some for years.

In 2012, children and youth with intellectual and development disabilities residing in DFPS licensed long-term care facilities known as General Residential Operations were added to the Texas Promoting Independence Plan as a priority population. It was not well known then, that children with intellectual and developmental disabilities were also living in Residential Treatment Facilities. The facilities are designed to be short term psychiatric treatment facilities, not long term living arrangements. For these children to have the supports needed to successfully live with a family, they need access to the support of a long-term services and supports waiver. In addition, DFPS needs to identify and track these children to better understand and plan for their long-term needs. Access to long-

term services and supports will cost the state less than services in a Residential Treatment Center and will lead to an improved quality of life for the children and the ability for children to live in families.

Recommendation #13

Fund HCS waiver services for 35 young children with intellectual and developmental disabilities living in DFPS licensed General Residential Operations as part of the state's Promoting Independence Plan.

Rationale: Historically the state has granted HCS waiver services to approximately 10 to 13 young children under the age of 16 per year who are living in DFPS licensed General Residential Operations as part of Texas' Promoting Independence Plan. Access to the waivers resulted in children being able to move to families. Not only did the census in the facilities decrease by 45% because of the funding, but children successfully achieved permanence at an overall cost savings to the state. Historical funding of waivers:

- FY 2013, 10 children
- FY 2014 and 2015, 25 children
- FY 2016 and 2017, 25 children

The LAR for FY 2018 and FY 2019 included HCS waiver funding for 40 young children living in GROs which did not get funded. With the loss this biennium of access to the HCS waiver for children under the age of 16, there was a concern that not only would children be unable to leave the facilities and move to families, but that more children would be admitted and the census in the facilities would increase as well as the length of stay for children. It appears from the data below that the number of children living in the facilities as well as the length of stay in the facilities has increased. In addition, five children were discharged home with no or inadequate services which places them at imminent risk of removal from family at a higher cost to the state.

Recommendation #14

Encourage nurse delegation in Personal Care Services through education initiatives, rate enhancements, and value-based arrangements.

- Provide an increased rate of pay for Unlicensed Assistive Personnel who are trained to perform delegated tasks.
- Promote and educate providers, parents and recipients on what is considered "safe and appropriate" delegated services.
- Increase funding to home health agencies and nurses to train and supervise Unlicensed Assistive Personnel who performing nurse delegated tasks.

Rationale: The Texas Medicaid system for children does not fully support nurse delegation. The rate paid to direct service providers through PCS is low which results in high turnover and reluctance on the part of nurses to delegate. Families are reluctant to use nurse delegation because of their children's medical fragility and because PCS attendants are hard to find and do not remain on the job long. A higher rate should be paid for nurse delegation in PCS and passed through to the worker who provides the care. Also, home health agencies and nurses need a rate and payment mechanism that supports the training and supervision of unlicensed assistive personnel and supervision. Training should be provided to families, providers and members on nurse delegation and what is safe and appropriate.

Effectively working nurse delegated attendant services will result in overall cost savings to the state and will increase access to services by children with medical complexities.

Recommendation #15

We strongly urge HHSC to request ECI program funding that accounts for projected caseload growth for 2020 and 2021 in its base budget request. Projections should be calculated based on the number of children actually served by contractors, and not based on a target number of children served because contractors are required to serve all children who present as eligible and do not receive reimbursement for children beyond their assigned target number. The calculation should also include projected increases to caseload based on population growth.

Additionally, HHSC should request an exceptional item to increase the base amount of funding ECI contractors receive per child served.

Rationale: During the years the state decreased ECI funding the required hours per child per month increased significantly and the program implemented rigorous requirements for evaluating eligibility and assessing changes in children's function for measuring program impact. The increase in required hours is not fully covered by insurance and family payments for low and middle-income families, particularly those with no insurance coverage. ECI contractors are responsible for administering a system meeting Federal requirements including reaching out to and serving all eligible children without regard for their family's ability to pay and provide all required services. The demonstrated effectiveness of ECI is achieved by intensive training for staff in developing multi-faceted service plans and teaching family members to incorporate therapeutic activities into their everyday activities. ECI financing is complex: ECI contractors maximize State funding by public and private insurance, families, and contributing local funds. By increasing the per child allotment of contracted entities will be able to better cover the actual cost of providing effective interventions to children.

Behavioral Health

Recommendation #16

Improve access to crisis services for individuals with disabilities by expanding and fully funding crisis intervention services for Texans with IDD, related conditions, physical disabilities and mental health diagnoses. Expanded crisis intervention services should provide:

- Immediate access to crisis services, both in-home and out-of-home,
- Expedited access to crisis respite services. This includes separate out of home respite settings for children and adults,
- Expanded access to programs such as the START program for children and adults with disabilities at risk of out of home placement in a facility,
- Provider training and consultation services on mental health services for individuals with IDD and complex support needs,
- Training for individuals, families and providers on how to access and coordinate crisis intervention services,
- Enhanced service coordination with evaluations for services (diversion waivers, housing, mental health services) that will help divert institutional admissions,
- Ensure regional behavioral health hubs and other crisis intervention teams around the state are trained to recognize and handle mental health crisis in individuals with intellectual disabilities.
- Increased crisis intervention to individuals and families, including follow-along services to help prevent future crisis and promote recovery and resilience
- Increased access to appropriate Level of Need determinations, including expedited LON increases, and add-on rates to ensure providers can effectively support complex medical and behavioral health needs of people with IDD in community waiver services
- Criminal justice intervention teams to prevent Texans with IDD, related conditions and mental health diagnosis from entering the justice system, and
- Services that help individuals and families manage and recover from instances of crisis.

Rationale: Individuals with disabilities who have experienced trauma or who have behavioral health needs experience barriers to receiving community-based support. After exhausting all available resources, individuals end up in emergency rooms and institutions, at a much higher cost to the state. Texas must adequately fund a system of community-based support to help Texans with IDD, related conditions, physical disabilities, and mental health diagnoses identify, manage and recover from crisis. It is contrary to Texas' efforts

to support people in the community if emergency rooms and institutions are the only available option/choice for crisis services.

Recommendation #17

Improve access to trauma informed care and mental health supports and services for individuals with disabilities.

- Require trauma-informed care training throughout the IDD system.
- Develop contract requirements for MCOs that will ensure that appropriate mental health treatment is available to individuals with IDD.
- Develop training programs to build capacity in both the IDD workforce and the MH workforce to provide person-centered, trauma-informed support for individuals with IDD experiencing mental health conditions.
- Develop and administer provider training to improve mental health and wellness of individuals experiencing mental health conditions.
- Develop a cross-discipline unit in the consolidated HHSC to oversee initiatives to improve services to individuals with IDD and co-occurring mental health conditions.
- Begin collecting better data on prevalence, treatment, and recovery outcomes for this population.

Rationale: The mental health needs of children and adults with disabilities are often ignored, overlooked, or overshadowed by their disabilities. Consequently, instead of receiving appropriate mental health treatment and support, they typically receive a behavior management plan to control their behavior. Individuals with IDD experience mental illness at two to three times the rate of those without disabilities. Additionally, they experience abuse, neglect, isolation, institutionalization, bullying and other forms of trauma. All too often our mental health treatment plan is sedation to control behaviors. In the IDD services world, recovery from mental illness is not even considered a possibility. It is difficult to change values and cultures, but people with IDD deserve accurate mental health assessments, diagnosis, and treatment. Additionally, they should have access to quality crisis services, including crisis respite, when needed. They should have the opportunity to recover from their mental illness.

Despite beginning to recognize the mental health needs of individuals with IDD, we need to change the way we talk about them. When an individual without IDD experiences behavior changes due to a mental health condition, we call it mental illness. However, when it's an individual with IDD, we call it "behavior challenges," "problem behaviors," "behavior interventions," "behavior management," etc.

We have taken small steps to change the paradigm of control and compliance to respect and support, but we have a long way to go. DSHS and DADS developed online training

modules to provide information on the mental health needs of individuals with IDD and the impact of trauma. However, online webinars will not change the culture of how we support individuals with IDD and co-occurring mental health conditions.

We need to increase awareness, build workforce capacity, provide training and consultation, and demand quality mental health care for individuals with IDD. We need to require MCOs to ensure that their provider networks include mental health professionals who are willing to provide services to this population. Trauma-informed care should be the starting point in all our IDD programs – both community and institutional.

The Hogg Foundation for Mental Health in partnership with the National Child Traumatic Stress Network has developed a train-the-trainer toolkit/curriculum entitled Road to Recovery: Supporting Children with IDD Who Have Experienced Trauma. This toolkit can be used as a starting place, but in no way gets us to the finish line.

Recommendation #18

The Health and Human Services Commission should develop a pilot for self-directed mental health services in the integrated managed care system. The pilot should be developed with the goal of maximizing consumer choice and personal responsibility for achieving recovery.

Rationale: Self-directed services (SDS), sometimes referred to as consumer-directed services, is an alternative approach to the traditional delivery of community services for individuals with mental health conditions. Mental health treatment has traditionally been grounded in a medical model that primarily considers an individual's illness and accompanying debilities with treatment designed to eliminate their symptoms. With this model, participants receive services based on a limited menu of treatment options, services and supports with limited choice and control over their treatment plan. Self-directed services shift attention from eliminating symptoms to a focus on goals that use an individual's strengths to achieve recovery.

The SDS model used in a Texas pilot is based on four core values:

- Participant control
- Participant responsibility
- Participant choice, and
- Avoidance of conflict of interest.

In a self-directed service delivery model, a person-centered planning process helps an individual identify recovery goals and the specific services and supports needed to accomplish those goals.

After the treatment plan is developed, participants develop a budget for the purchase of goods and services to meet their goals. A self-directed individualized budget is typically a pre-determined amount calculated based on an average cost of care and the individual's assessed level of need. A portion of the individual's budget must be used on traditional treatment and services with a specified percentage available for non-traditional services identified in the recovery plan. This allows flexibility to purchase goods and services that the individual needs to reach their recovery goals (see example below). It also allows for consumers to select providers to whom they can therapeutically connect rather than having to settle for the provider to whom they are assigned. Purchased services and goods must be directly related to recovery plan goals. The individualized budget cannot exceed the amount that would have been spent in the traditional service delivery model.

Texas currently offers a consumer-directed service delivery model in all the physical disability/developmental disability waivers administered by the Department of Aging and Disability Services, as well as in Medicaid managed care programs that provide long term services and supports. Consumer-directed service delivery is available statewide in these programs. In the Texas mental health services system, the only self-directed service provision available is through a pilot implemented in 2005 in NorthStar, a carve-out managed care delivery system in seven north Texas counties. This will likely be going away with the termination of NorthStar. Although the pilot has achieved significant positive results, the state has not expanded self-direction in mental health services and has not tested the self-directed services option in the current integrated managed care system. This denies many individuals with serious mental illness access to treatment, goods, and services that can help them meet their recovery goals.

2018 Recommendation #19 Modified

HHSC should maintain a rider in the LAR to continue a Texas Statewide Intellectual and Developmental Disability (IDD) Strategic Plan as well as funding to implement the five-year strategic plan.

Rationale: The current system of support for Texans with IDD deserves a focused level of direction, coordination and prioritization necessary to create long-term, systemic advancements that improve the quality of life and increase self-determination for Texans with IDD. Using the existing structure and identified gaps of the Texas Statewide Behavioral Health Strategic Plan, the IDD Strategic Plan and the IDD Systems Redesign Advisory Committee, the state would benefit greatly from developing and implementing a strategic plan that focuses on quality, cost-effective services for Texans with IDD. In addition, Texas should continue to develop, fund and evaluate a managed care pilot program, envisioned by HB 4533 of the 86th Texas Legislature, for those with IDD and similar functional needs.

There are many avenues that cross multiple state agencies in which someone with IDD can seek services in Texas. Those services include (but are not limited to):

- Community-Based Services
- Medicaid Waivers: HCS, CLASS, TxHmL, DBMD, MDCP, STAR+PLUS and YES
- Intermediate Care Facilities
- State Supported Living Centers
- Nursing Facilities
- Residential Treatment Centers
- General Residential Organizations
- State Hospitals
- Criminal and Juvenile Justice
- Medicaid Managed Care
- HCBS Interest List
- Promoting Independence Initiatives
- Crisis Services
- Employment Services
- Foster Care
- Education

The wide array of services offered to individuals with IDD in Texas is complicated, disjointed and choppy. Texas would benefit from a purposeful look across the systems and services that support individuals with IDD.

Employment and Meaningful Day

Recommendation #20

HHSC should continue and expand the money follows the person (MFP) employment pilot. The pilot was conducted over a five-year period and provided funding to support employment providers with implementing systems change within their own agency, including Employment First policies and practices that improve competitive, integrated employment outcomes for individuals served. The organizations were required to produce changes within their systems to achieve successful competitive, integrated employment opportunities for people with IDD and other disabilities. Use the evaluation and recommendations from the UT Texas Center on Disability Studies of the original pilot to improve and advance the initiative.

Rationale: Nearly 85 percent of adults with IDD are not employed even though a majority of people with IDD report wanting to work. Texas' community-based employment assistance and supported employment services through the 1915c Medicaid waivers are

extremely underutilized compared to day habilitation services. Furthermore, Texas conducted interviews of individuals with IDD receiving both residential and nonresidential services through Texas' community-based Medicaid waivers and found individuals with IDD were not receiving the employment related assistance and support they wanted and needed to obtain competitive, integrated employment. This pilot will help providers implement employment first practices within their agency, understand how to utilize existing services to promote competitive, integrated employment outcomes for Texans with IDD, break the cycle of poverty for Texans with IDD, and help Texas comply with the Final HCBS Settings Rule.

Recommendation #21

Fund follow-along supported employment services for individuals who do not have a 1915c waiver.

Rationale: If an individual with IDD does not have a 1915c waiver, and they have exhausted their supported employment services through VR at TWC, there are not any services available to continue providing supported employment services—even if the individual still requires supported employment to maintain competitive, integrated employment. Additionally, if an individual has already closed their case with TWC, there are not any services available to provide long-term supported employment.

2018 Recommendation #22 Modified

HHSC should prioritize funding of an hourly Community Integration (CI) and Community Integration Support (CIS) in the FY 22 - 23 LAR.

- Provide funds to incentivize or reward creative service models that increase flexibility and support individualized, person- centered, lifespan goals to assist the state to come into compliance with HCBS requirements. (For instance: competitive/integrated employment, integrated retirement, community recreation, volunteering, or other activities identified as meaningful by the individual.)
- Incentivize waiver providers (DSAs-direct service providers) and day habilitation providers to become employment providers.
- Fully implement the ISS service proposed by the IDD SRAC workgroups to allow for choice of meaningful day providers and day activities across settings in order to comply with the federal HCBS regulations.
- Allow for flexibility of transportation services to support community participation activities.

Rationale: CI and CIS are required for compliance with the Home and Community-Based Services rules. Funding is necessary to effectively offer CI and CIS services, which would

move people out of segregated environments and into the community where they can lead self-directed, meaningful day activities. Without the addition of these services, individuals with IDD will continue to languish in day habilitation services that do not meet their needs, advance their independent living skills or help them achieve competitive, integrated employment.

Currently, individuals with IDD receiving day habilitation services do not have full access to the greater community through their HCBS services. Service delivery design and reimbursement rates are barriers to individualized, integrated community participation, making person centered plans and implementation plans hard to fully implement.

Individuals, regardless of where they live, who receive day habilitation services get the services primarily in facility settings with no or limited access to the community during day habilitation services.

Recommendation #23

Reinstate the Employment First Taskforce to support the Employment First practices established by Texas law.

Rationale: Individuals with disabilities experience a high rate of unemployment. Many individuals with disabilities who work are often in segregated settings and are paid sub-minimum wages.

Recommendation #24

Promote Texans with disabilities entering the workforce through entrepreneurship by including "a person with a disability" under the definition of Section 2161.001(3) of the government code as an "economically disadvantaged person" for the purpose of becoming a certified (HUB) Historically Underutilized Business in Texas.

Rationale: People with disabilities have been historically discriminated against in the workplace, which contributes to gaping disparities in unemployment rates between them and their non-disabled peers. Those currently eligible for HUB classification include women, minorities and service-disabled veterans, but the state should consider adding persons with disabilities to this category. According to the Texas Comptroller of Public Accounts, statewide HUB utilization has decreased from 12.58 percent in fiscal year 2014 to 11.97 percent in fiscal year 2017.

By adding people with disabilities, the state will expand the supply of qualified HUBs, a benefit to the state and to the disability community. In addition, the overall economy will

grow as individuals with disabilities enter higher tax brackets while concurrently reducing their dependence on government supports.

Recommendation #25

Establish training for individuals with disabilities and their families on work incentives and how income effects Medicaid and waiver eligibility. Ensure the material is accessible to all audiences including individuals with IDD, individuals with visual impairments, individuals with hearing impairments, etc.

Rationale: Despite the availability of Social Security Administration (SSA) initiatives, work incentives and the Ticket to Work program, employment services remain underutilized nationally and in Texas.

Supported employment through the Texas Workforce Commission and in Medicaid waivers are vastly underutilized. There is a significant disparity between the number of people who report a desire to work and the number employed.

Relocation Services

Recommendation #26

In the upcoming Legislative session, the Texas Legislature should initiate a review of the managed care model of providing Medicaid relocation services to determine whether resources for relocation are adequate and effectively providing the desired outcomes. The review should include determining the adequacy of funding established through managed care organizations to support relocation personnel and transition assistance services, as well as the solvency of a strong and high-performing consumer-centered long-term care system. HHSC staff should be directed to establish surveys of relocation contractors, consumers, and other stakeholders in the managed care process to identify barriers to consumer relocation or avoidance of institutionalization, as well as creative uses of partnerships and leveraged opportunities. HHSC should take steps as identified by surveys and through open and timely communications to implement appropriate measures that will achieve preferred person-centered transition services and supports.

Rationale: Historically in Texas, relocation from institutions to community is cost-effective and preferred by individuals with disabilities. Since September 1, 2017, assistance for individuals eligible for Medicaid to leave nursing facilities is provided through Texas' Medicaid Managed Care program with contracts held by organizations such as Centers for Independent Living. This is a change from previous years of service delivery under fee-for-service contracts between community-based organizations and the Health and Human Services Commission, a highly successful model recognized nationwide.

Housing

Recommendation #27

Funding to replicate the current Texas Department of State Health Services housing voucher program for individuals experiencing mental illness for persons with other disabilities.

Rationale: Lack of housing assistance is preventing many individuals with disabilities from successfully living in the community. Many individuals with disabilities have very low incomes that do not provide enough income to afford the rental amounts of most apartments. There are a very limited number of housing vouchers available in most communities in Texas. The current Texas Department of State Health Services housing voucher program for individuals experiencing mental illness has been very effective at addressing the housing needs of those individuals. A similar housing voucher program for individuals with other disabilities could help address the lack of affordable housing options.

Recommendation #28

Create Housing Navigator to assist people with IDD transition to the most integrated, appropriate housing for the individual.

Request appropriation and legislative approval to fund a Medicaid waiver benefit of Housing Navigator and assistance.

Address barriers for individuals with high needs that results in difficulty accessing housing.

Rationale: There is a lack of affordable housing options and no assistance for individuals with IDD to help them find the best housing solution. Assistance to find appropriate housing can be funded as a Medicaid waiver benefit. Funding for Housing Navigator to assist consumers and families, case managers, service coordinators and low-income individuals with intellectual and developmental disabilities transition and provide housing related services.

The Housing Navigator will educate a potential housing applicant on community living options, property availability, and the application process. The Housing Navigator assists prospective to apply for housing. The Housing Navigator maintains relationship with landlords and property managers, will assist with application process and monitoring of application process ensuring all documents are submitted to prospective landlord. The Housing Navigator works as a member of comprehensive service team to communicate changes in housing application progression and to ensure awareness and coordination necessary for supports and services and will assist with creative problem solving to resolve

landlord/tenant issues, referral to other community resources as need is identified. The Housing Navigator assists prospective and placed applicants to understand lease and tenant responsibilities, training for how to be a good neighbor, and to ensure the tenant understands how and when to communicate with a landlord.

Workforce Stabilization

Recommendation #29

Restore rate cuts made during the 85th Legislative Session for Community First Choice (CFC) in the HCS and TxHmL waivers

Rationale: Individuals with IDD rely on an adequate long-term service and supports system to lead independent, self-directed lives in the community. CFC provides critical personal attendant and habilitation care to support individuals in the community. Since the rate cut, there have been major barriers for individuals with IDD to access personal attendant care.

2018 Recommendation #30 Modified

- HHSC should seek an increase in legislative appropriations to increase the base wage for entry-level direct-support workers to \$15.00 in home and community-based services programs.
- Enhance training requirements and wages to attendants and direct support professionals to provide advanced supports to individuals with complex medical, physical, and behavioral support needs.
 - ▶ For medically fragile individuals in STAR+PLUS, increase wages and required training
 - ▶ For medically fragile individuals in HCS, increase wages, required training and create a new medically fragile Level of Need wages. The inability of providers to offer competitive wages and benefits results in high staff turnover, excessive overtime costs, and lack of continuity in the delivery of quality services and supports. Attendants and direct support professions should be provided advanced training and receive higher wages to provide high quality supports and services to individuals with complex medical, physical and behavior support needs and prevent unnecessary use of emergency rooms, hospitals and other institutional settings. Medically fragile individuals should have access to a medically fragile level of need or risk group to prevent institutionalization and protect health and safety.

Rationale: Providers of services to individuals with disabilities continue to experience significant challenges with attendant recruitment and retention due in large part to low Recommendation #30

HHSC should seek an increase in legislative appropriations to increase the base wage for entry-level direct-support workers to \$15.00 in home and community-based services programs.

Rationale: Providers of services to individuals with disabilities continue to experience significant challenges with attendant recruitment and retention due in large part to low wages. Additionally, the inability of providers to offer competitive wages and benefits results in high staff turnover, excessive overtime costs, and lack of continuity in the delivery of quality services and supports.

Improved Process and Quality

Recommendation #31

Implement a Medicaid eligibility policy that immediately ensures individuals with disabilities do not lose access to Medicaid.

Ensure providers receive 90-day retroactive Medicaid payments as allowed in Texas Medicaid.

Reinstate the Medicaid Eligibility Workgroup to examine current issues and develop solutions.

Rationale: Although legislation was passed during the 85th Legislative Session, Medicaid eligibility issues persist which causes undue hardships on families and individuals, the state and providers. An efficient process that ensures individuals do not wrongfully lose access to life saving Medicaid services does not exist.

Individuals will not be able to transition to the community or receive their Medicaid benefits unless the 90-day retroactive Medicaid billing and payments are effectively working.

Recommendation #32

HHSC should develop navigation tools to help families, individuals and providers understand the full system of supports available to individuals with disabilities, especially individuals experiencing crisis or are at risk of institutionalization.

Rationale: For the first time in decades, the Legislature did not allocate funding for interest reduction. Additionally, the Legislature made significant cuts to Promoting

Independence waiver slots. This has forced individuals with IDD into crisis at a higher rate than in previous biennium. In response to the lack of funding, HHSC developed a process to help mitigate the lack of interest list and promoting independence waivers through an attrition process.

Individuals, families, LIDDAS and providers remain unaware of the new diversion process and uninformed on how to navigate the new diversion process. Individuals experiencing crisis and who are at risk of institutionalization are not provided the support and resources necessary to remain in the community. For the first time in decades, the number of institutional admissions has outpaced institutional transitions.

Additionally, CFC was implemented to help provide relief to individuals waiting for Medicaid services. Individuals and families are unaware and uninformed of how CFC may help to provide needed person attendant and habilitation services.

Recommendation #33

Develop capability to electronically maintain health and life records for all individuals served in Long Term Services and Supports (LTSS) programs that are interoperable with related systems.

Require that all electronic health records are non-proprietary documents that seamlessly follow the person if they change Medicaid Managed Care Organizations.

Rationale: The implementation of Electronic Health Records (EHR) for individuals who receive Medicaid funded long term services and supports can significantly improve the health and community integration outcomes of individuals with disabilities as well as improve system and service coordination. As the state transitions, more individuals to Medicaid Managed Care the need for electronic records and integrated communication is critical.

Currently the system used by the state for billing and payment, service coordination and critical incident reporting is either outdated (Home and Community-based Services waiver CARE system) or paper-based (CLASS). Therefore, substantial administrative time is spent by service coordinators and providers in the exchange of information that should be seamlessly shared electronically. Systems currently operated in the fee-for-service program are also not interoperable with managed care organization systems, creating barriers to the vision of a more streamlined acute and long-term care service delivery system.

With the transition to managed care, MCOs would benefit from more seamless data sharing. It was incredibly burdensome on waiver providers when individuals with IDD

transitioned their acute care services to STAR+PLUS because of the amount of documentation MCOs requested on current medications and services. There was no streamlined way to share that information.

Recommendation #34

Make improvements to the long-term services and supports quality measures and data collection.

- Establish IDD population tracking codes within managed care that HHSC, MCOs and stakeholders can use to track LTSS quality measures.
- Continue to develop robust LTSS quality measures for all LTSS programs and populations, with stakeholder input.
- HHSC should provide and monitor IDD data on acute care and LTSS quality measures using encounter data from Medicaid managed care organizations and National Core Indicators to obtain participant experience. In addition to NCI-AD, measures should include sufficient NCI IDD measures.

Rationale: Currently, HHSC is not able to review and analyze quality metrics specific to the total population of individuals with IDD in the STAR Health, STAR Kids and STAR+PLUS programs. We strongly recommend HHSC and the MCOs work together to create a mechanism within relevant data systems to allow for tracking of quality and other metrics specific to individuals with IDD, not solely reliant on MCO self-reporting.

Recommendation #35

Make ombudsman programs independent of HHSC and add an ombudsman program for individuals in LTSS waiver services not included in managed care, including, but not limited to an independent managed care ombudsman, a new LTSS IID/ICF waiver ombudsman, and the State's long-term care ombudsman.

Rationale: Currently, as existing and new ombudsman programs work to assist individuals seeking or receiving services, these programs are embedded in HHSC. To increase autonomy and transparency, and better assist Texans with disabilities, Ombudsman services should be administratively and programmatically independent and outside of the agency. Also, while there is an ombudsman for SSLCs, it is important to create a separate ombudsman for individuals with IDD who are not in SSLCs. The reorganization of HHSC's complaints and inquiries system is more complicated and less user friendly now. It is hoped that, with an independent ombudsman, individuals get more help to make inquiries and complaints and get assistance or resolution of their concerns.

2018 Recommendation # 36 Modified

Consistent with the IDD System's Redesign Advisory Committee (SRAC), delay expanding LTSS managed care for individuals with IDD until implementation of a STAR+PLUS Pilot Program are completed and can be used to evaluate and determine whether and to what degree to add IDD LTSS to the current or a difference managed care model.

Rationale: The SRAC and a newly created STAR+PLUS Pilot Program Workgroup are collaborating and coordinating with HHSC to recommended pilot services and infrastructure needed to implement the pilot. The MCOs, providers and advocates are represented on both groups. Funding will be required in FY 2022 – FY 2023 and FY 2024- FY 2025 to fully implement and evaluate the pilot.

Recommendation # 36

Consistent with the System's Redesign Advisory Committee (SRAC), delay expanding LTSS managed care for individuals with IDD until issues identified as necessary by the committee are completed and can be used to evaluate and determine whether and to what degree to add IDD LTSS to the current or a difference managed care model.

Rationale: After significant review and consideration of whether all or part of the Texas Home Living Waiver should be incorporated into managed care, the SRAC recommended to HHSC a delay and further evaluation and review. This recommendation was supported by MCOs, providers and advocates and based on both the lack or readiness and the recent concerns with Star Kids and Star Health programs that also serve individuals with IDD.

Recommendation #37

Increase utilization of the consumer directed services (CDS) option.

- Expand the amount of services able to be self-directed in both fee for services and managed care programs.
- Integrate the CDS option in all trainings that involve the provider option.

Rationale: Despite the positive outcomes associated with the CDS option, many individuals do not choose to self-direct services. Frequently individuals are either not informed of the option at all or made to feel that it is too complicated. In addition, service coordinators, case managers, and MCO service coordinators are often unaware of the option and/or how it practically works. Although CDS is a service delivery option, many professionals still think that it is a separate program. Typically, service coordinators, case managers, and MCO service coordinators have a onetime separate training on CDS; CDS should be integrated into all trainings involving programs or services that can be self-directed.

Currently only the Texas Home Living Medicaid Waiver allows for all services to be self-directed. Expanding the amount of services that an individual can self-direct allows individuals more control over their lives and can simplify the processes for the employer.

State Supported Living Centers

Recommendation #38

Texas will evaluate and invest resources to ensure there is a robust system of community supports for individuals with disabilities, so they are not at risk of entering an institution. HHSC will examine the challenges faced by individuals with disabilities in the community, why individuals are entering institutions, where individuals are entering institutions, why transitions have been slow and provide a long-term plan to build up community supports and services.

Texas should create a new Promoting Independence category for individuals with IDD who are at risk of entering prison and/or a SSLC due to criminal justice issues. These diversion waivers should be used as a mechanism to provide support for individuals prior to institutionalization.

Rationale: According to HHSC's draft SSLC long-range plan, there has been an uptick in the number of admissions to the SSLCs. The admissions have outpaced the transitions for the first time in decades. The plan lists three major reasons for admissions:

Involuntary admissions: individuals with intellectual disabilities experience adverse outcomes when they come into contact with the criminal justice system. They are more likely to be convicted of a crime than individuals without disabilities. Individuals with IDD must have an alternative path for treatment and recovery without being unnecessarily admitted into prison and then a SSLC. Texas should consider reserving a small amount of Promoting Independence waivers to prevent individuals from entering the criminal justice system.

Community admissions: The SSLC long-range plan also details how individuals who were receiving services through an HCS Medicaid Waiver entered the SSLC. HCS is one of Texas' most robust waivers for individuals with IDD. HHSC must examine why individuals, even though they have access to the services through the HCS Waiver, have entered a SSLC and provide solutions to prevent future admissions. This demonstrates failure of Texas to offer a robust and comprehensive system of support to prevent individuals with disabilities from entering an institution.

Slow transitions: The draft plan also calls out slow transitions for one reason admissions have outpaced transitions. Again, this demonstrates that there is a lack of robust and comprehensive services in Texas' system of community supports.

Recommendation #39

HHSC will evaluate the quality of care, cost effectiveness and staffing issues at Texas' 13 state supported living centers (SSLCs). HHSC will examine ways that:

- The residents at the 13 SSLCs can receive an improved quality of care that improves the quality of life and health outcomes for the residents.
- Will bring Texas' 13 SSLCs to 100% compliance with the US Department of Justice Settlement Agreement. The monitoring reports continue to describe systemic failures of the SSLCs to provide their residents the quality of life and care they deserve.
- Utilize limited state resources in the most cost-effective way to ensure Texans with IDD receive the services they need to lead meaningful, self-directed lives, regardless of where they choose to live. HHSC's LAR should prioritize funding to support services for individuals where the majority of individuals choose to live, which is in the community with timely, high quality supports and services.

Rationale: Texas maintains a costly and overburdened system of state supported living centers. The census at the 13 SSLCs are historically low and the cost to maintain them are at a historic high. Staffing, quality and compliance with federal requirements continue to be system problems with Texas' SSLC system. Between September 2016 and October 2017, federal reports show, Medicaid officials threatened to halt the flow of federal money to the SSLCs a total of 25 times because of problems such as resident safety, substandard medical care, failure to address bedbugs and a lack of individual attention to residents.

While SSLCs continue to use almost half of the funding allocated to support individuals with IDD for just 3,000 people, 140,000 individuals languish on the interest list for community-based Medicaid waivers.

2020 PIW Recommendations

New Recommendation #40 Community Medicaid Waiver Enrollments

It is critical to use all methods possible to continue assessments for and enrollments in community programs during the pandemic and other disasters. Delays in processes to continue (through alternative methods like telehealth or telemedicine), assessments, service planning and authorizations and enrollments from interest lists and enrollments to avoid admission to an institution or transition from an institution to the community should

be vigorously implemented and not waived for long periods of time. At a time when congregate care environments pose a greater danger to health and safety due to difficulty managing infection controls, transitions to smaller settings or to one's own home are urgently needed. Diversion community services provided through Medicaid and Medicaid Waivers are extremely and timely needed to avoid nursing facility and intermediate care facility admissions, including state supported living center admissions. Diversion options should be expanded to additional Medicaid Waiver programs, not limited to but including, the home and community services (HCS) program, especially during a pandemic or other disaster to further avoid admissions to institutions.

New Recommendation #41 Nursing Facility PASRR Services

There has been an inappropriately extended COVID 19 waiver for completing of certain Pre-Admission Screening and Resident Review (PASRR) processes, such as completing of what is known as a PE Level II evaluation. This delay is extended beyond what CMS approved, in our view, and is resulting in individuals with intellectual and

developmental disabilities (IDD) not receiving specialized services they need and are entitled to while residing in a nursing facility. There are options for using telehealth, telemedicine and even telephonic options to provide for PASRR processes to restart without further delay. Without these services individuals may decline in health, independent functioning and emotionally during this time. With no end date known to the COVID 19 pandemic, HHSC should be required to immediately provide all PASRR assessments and services needed for eligible individuals residing in nursing facilities. We await further information regarding details on the recently announced webinar with nursing facilities and other stakeholders to see if this problem is going to be fully addressed through a new emergency rule.

New Recommendation #42

Prior Authorizations, Extensions of Individual Care Plans and Eligibility Determinations.

Extension of prior authorizations and extensions of individual plans of care (IPCs) for community programs and services have been very helpful and appreciated. It would be helpful to reduce the burdens of unnecessary prior authorizations for certain services by approving longer term authorizations and IPC extensions post-COVID unless there was a change in the individual's condition. Certain eligibility determination processes have used telehealth and telemedicine as a way to verify eligibility for community programs and should be reviewed and considered after this pandemic.

New Recommendation #43

Provide for telehealth payment parity throughout the pandemic and beyond as an effective method of delivering healthcare services to individuals throughout the state if agreed to by the individual and absent any contra-indications. Create a mechanism to determine when telehealth is indicated as a quality service delivery option.

New Recommendation #44

Apply the Family Opportunity Act's family income limit of 300% Federal Poverty Level after income disregards to the Texas Medicaid Buy-In for Children program and improve outreach so that more families can contribute to the cost of their children's care.

Rationale: In 2005, the federal government passed The Family Opportunity Act as part of the Deficit Reduction Act. The Act allowed states the opportunity to create a Medicaid buy-in program for families of children who meet the federal SSI disability criteria and whose family income is below 300% of the Federal Poverty Level (FPL). This option allows families of children with a disability determination to pay a premium to access Medicaid. Texas is one of only a few states that used this Act to create a Medicaid Buy-In option for children. Texas' program was passed by the Texas Legislature in 2009 and was estimated to initially support 2,000 children. The Texas legislation had bi-partisan support in both the house and the senate and is a program that has received positive attention on both a state and national level.

While the federal legislation allows states to set the financial eligibility at up to 300 percent of the FPL, Texas has chosen a lower financial eligibility of 150 percent. Texas could increase eligibility to 300 percent of adjusted gross income as have other states like Colorado. Eligibility for Colorado's program is 300 percent after income disregards.

In addition, when the Texas legislation was passed in 2009, the state and legislature estimated the program would initially support 2,000 families to contribute to the cost of their children's care by paying a premium for Medicaid. The fiscal note stated that the intent would be for the program to increase over time to approximately 6,000 to 7,000 families. The number of children served in 2020 remains at 2,000. Given the high percentage of uninsured children in Texas, improved outreach is warranted.

New Recommendation #45

Recommendation: Implement lessons from COVID-19 pandemic, including enhanced supports for high-risk individuals to avoid congregate settings and unnecessary ER/hospital visit, continuing extensions of authorizations and prescriptions and expanded telehealth. Strengthen community attendant reliability by increasing wages.

Rationale: People with disabilities and older adults are widely acknowledged to be at high risk for a bad outcome from COVID-19. Congregate settings are proven to elevate the risk of contracting the virus. For those in the community, it is critical they remain in the best possible health and avoid visits to a hospital, a dangerous place for a non-COVID patient. Telehealth and extensions of authorizations and prescriptions will reduce close interaction between persons. Keeping people healthy in their own homes should target the weak link in reliable attendant care: the very low wages.

New Recommendation # 46

Recommendation: Support critical community care providers by increasing the administrative rate for both the agency model and consumer director services option by \$1 per service hour.

Rationale: Medicaid rates cover services and administration. The services rate pays for the direct care worker/community attendant and has rightfully been identified as a priority need to increase. While less attention is directed to the administrative rate, adequate financial compensation for home health agencies and financial management services agencies is necessary for these essential services. The administrative rate has not changed in at least 14 years with the exception of a cut in the STAR Plus HCBS program.

Appendix F. 2019 Mainstream Voucher Awards by Texas Public Housing Authority

Public Housing Agency	Vouchers	Amount
Austin Housing Authority	125	\$1,203,300
Housing Authority of Fort Worth	200	\$1,399,488
Houston Housing Authority	272	\$2,231,565
San Antonio Housing Authority	59	\$381,981
Brownsville Housing Authority	13	\$60,739
Housing Authority of the City of Dallas, Texas	77	\$538,637
Housing Authority of the City of Waco	26	\$211,240
Housing Authority of the City of Laredo	50	\$312,276
Housing Authority of the City of Lubbock	25	\$175,872
McKinney Housing Authority	21	\$170,206
Housing Authority of Plano	30	\$277,521
Robstown Housing Authority	30	\$241,784
Housing Authority of the City of Abilene	100	\$541,224
Denton Housing Authority	50	\$425,328
Tarrant Co. Housing Assistance Office	38	\$396,388
Garland Housing Authority	25	\$210,237
Bexar Co. Housing Authority	60	\$449,784
Housing Authority of Odessa	25	\$234,444
San Angelo Housing Authority	20	\$122,734
City of Amarillo	150	\$726,048
Travis Co. Housing Authority	30	\$294,030
Central Texas Council of Governments	60	\$363,932
Dallas County Housing Assistance Program	60	\$578,369
Total:	1546	\$11,547,127