Policy Proposal Supplemental Materials

Please use this as a resource while we review the 89th Session Priorities. For each policy proposal, an attempt was made to provide all the information you may need to prioritize policies.

# Access

## 01.07

Require that a person or business that sells or provides a certificate, identification, tag, vest, leash, or harness for an emotional support animal must provide a written notice to the buyer or recipient on applicable laws and penalties for misrepresenting the animal as a service animal.

### Impact on Population

The emergence of ESAs has led to an increase in the fraudulent selling and subsequent misrepresenting of emotional support dogs as service dogs, including businesses now selling various misleading ESA-related certificates and merchandise that inaccurately imply that ESAs have the same legal rights and privileges as service dogs.

### Cost

There would be little cost to the state or taxpayers.

### Potential for Success

* How feasible is this policy proposal?
	+ Legislatively? This policy successfully became law in another state through the work of a coalition of stakeholders including all the different users of service animals and emotional support animals.
	+ Administratively? Potentially through the Texas Department of Licensing and Regulation FAQs.
* Has there been a successful Texas bill related to this proposal? [HB 5206](https://capitol.texas.gov/BillLookup/History.aspx?LegSess=88R&Bill=HB5206) was not fully successful but had parts that passed (fraudulently representing an animal as a service animal).
* Has this been done in other states successfully? [California Assembly Bill 468](file:///%5C%5Cgoliad%5CUsers%5Cmonica.villarreal%5CDownloads%5C20210AB468_92.pdf)

### Time

This is an ongoing issue but there is not a pressing time concern for solving it.

### GCPD Staff Recommendation

Staff is neutral on this recommendation. There are benefits but many challenges to enforcement. Staff will check on the California law and how they are enforcing it.

## 01.08

To tackle ESA fraud a person or business that sells or provides a dog for use as an emotional support dog will have to provide a written notice – in at least 12-point bold type, on the receipt or a separate paper – to the buyer or recipient of the dog stating that:

* the dog does not have the special training required to qualify as a guide, signal, or service dog;
* the handler of the dog is not entitled to the rights and privileges accorded by law to the handler of a guide, signal, or service dog; and
* knowingly and fraudulently representing oneself to be the owner or trainer of any canine licensed as, to be qualified as, or identified as, a guide, signal, or service dog is a misdemeanor.

### Impact on Population

The emergence of ESAs has led to an increase in the fraudulent selling and subsequent misrepresenting of emotional support dogs as service dogs, including businesses now selling various misleading ESA-related certificates and merchandise that inaccurately imply that ESAs have the same legal rights and privileges as service dogs.

### Cost

There would be little cost to the state or taxpayers.

### Potential for Success

* How feasible is this policy proposal?
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* Has there been a successful Texas bill related to this proposal? [HB 5206](https://capitol.texas.gov/BillLookup/History.aspx?LegSess=88R&Bill=HB5206) was not fully successful but had parts that passed (fraudulently representing an animal as a service animal).
* Has this been done in other states successfully? [California Assembly Bill 468](file:///%5C%5Cgoliad%5CUsers%5Cmonica.villarreal%5CDownloads%5C20210AB468_92.pdf), [California Civil Rights Emotional Support Animals and Fair Housing Law FAQ](https://calcivilrights.ca.gov/wp-content/uploads/sites/32/2022/12/Emotional-Support-Animals-and-Fair-Housing-Law-FAQ_ENG.pdf)

### Time

While this is an important issue, there is not a pressing need to solve this in the immediate future.

### GCPD Staff Recommendation

Staff recommend checking if TDLR could put this information into their FAQs. There is not a unified source of ESAs, so identifying providers that this potential law would impact would be difficult.

# Communications

## 02.05

Establish requirements for certified medical interpreters that are like those for certified court interpreters.

### Impact on Population

Effective communication is critical to the successful delivery of healthcare services. The Joint Commission on Accreditation of Healthcare Organizations—the nation’s oldest and largest standards-setting and accrediting body in healthcare—notes the importance of working to improve communication between healthcare professionals and patients.[[1]](#footnote-1) Successful communication with patients involves a strong interpersonal relationship, recognizing language needs, and an understanding of cultural issues. Effective communication happens when there is a joint understanding of meaning where patients and healthcare providers exchange information, and patients can participate actively in their care, ensuring the responsibilities of both patients and providers are clear. Successful communication takes place only when providers understand their patients, and patients receive accurate, timely, complete, and unambiguous messages from providers in enabling them to participate in their care.[[2]](#footnote-2)

Communication can become difficult for Deaf individuals requiring sign language interpreters. Federal guidance prohibits practices from requiring patients to bring their own interpreters to a healthcare setting, meaning these facilities must be able to provide patients qualified interpreters. It is important interpreters in all settings be proficient, but it is most crucial in a healthcare setting as any misunderstandings may have a direct impact on medical decision making and outcomes. Any sign language interpreters assisting a person who is Deaf or Hard of Hearing must be able to demonstrate essential knowledge, skills, and abilities so that communication is accurate, effective, and impartial. It is also important that specialized vocabulary or terminology or phrases are interpreted correctly to the patient. While [Texas Government Code Chapter 57](http://www.statutes.legis.state.tx.us/Docs/GV/htm/GV.57.htm) provides that court interpreters be certified in the legal field, there is currently no such requirement for interpreters in a medical setting. Establishing such a requirement would ensure better healthcare outcomes for people who are Deaf or Hard of Hearing.

### Cost

This proposal could be cost-saving to the community and revenue-generating for the State. Because the medical interpreting certification has already been created, requiring this certification would allow the State to generate revenue from the new applicants for the certificate. For the community, effective and accurate communication in a medical setting can lead to less medical errors that can be costly and dangerous.

### Potential for Success

* Has there been a successful Texas bill related to this proposal? The medical interpreting certification already exists in Texas; it just needs to become a requirement.
* Does this proposal have support from the disability community? There is support from both the Deaf community and the interpreting community.

### Time

Many Deaf and Hard of Hearing individuals report lack of qualified interpreters in the medical setting.

### GCPD Staff Recommendation

GCPD has carried this recommendation for multiple sessions without stakeholder response and a legislative sponsor. This is unlikely to progress. We further recommend that the committee members and staff identify stakeholders that are interested in this recommendation and that a bill be developed early enough to make it through legislative council. A small working group of stakeholders from TSID are re-evaluating and strengthening this proposal. Staff recommends updating the background to only apply to hospitals or ambulatory surgery center. States recommend a working group of SMEs continue to develop ideas, concepts, and support around the idea of medical interpreting.

# Education

## 03.01

TEA should allow teachers who want to teach children who use sign language to get their credentials by passing one of the following tests:

* The Texas Assessment of Sign Communications (TASC);
* The TASC American Sign Language (TASC-ASL);
* HHSC’s Texas Board for Evaluation of Interpreter certification at Basic, Advanced, Master, Level II, III, IV or V; or
* Sign Language Proficiency Interview, Advanced level or higher.

### Impact on Population

Testing options are limited for Deaf Education teachers who need credentialed by Texas Education Agency (TEA)/State Board of Educator Certification (SBEC) to work with children who use sign language.

Teachers certified prior to Sept 1, 1998 were grandfathered into the system with no test of their signing abilities. According to TEA, this provision was removed in 2009. TASC and TASC-ASL current version have been in use since 2010 and have been through the psychometric process.

According to TEA, TASC or TASC-ASL credential is not required for candidates seeking the Deaf or Hard of Hearing (DHOH) certification only for those who teach deaf education and work with students who use sign language.

If teachers hold deaf education certification from a teacher preparation program, they must have approval from that program to take the TEA/SBEC approved credential (TASC/TASC-ASL) to work with children who use sign language. If a teacher works with hard of hearing students for several years and then decides they want to work with students who sign, they must go back to their teacher preparation program for approval. This delays the process for teachers to work with students who sign.

### Cost

Teachers will have to pay to take the test, but they already do.

Changing the face of the certification will require IT work and include a fiscal impact, but unsure at this time what that would be.

### Potential for Success

Change of rule and procedure to allow teachers testing options. This lessens the workload for SBEC to test teachers in sign language and gives teachers more options to qualify to work with Deaf and Hard of Hearing students who use sign language. Some teachers may already hold one of these other credentials and be able to go straight from obtaining their DHOH certification to the classroom.

### Time

There is currently a special education teacher shortage, and this policy proposal could help alleviate the workforce shortage.

### GCPD Staff Recommendation

GCPD staff have reached out to the original proposer to get an update on the necessity of this proposal.

## 03.02

TEA should require itinerant teachers of the Deaf who work with students who use sign language to pass the TASC, TASC-ASL, or another test recognized by the agency. For teachers who are not credentialed, TEA should create a staff development plan with the State Board of Educator Certification.

### Impact on Population

Some teachers who hold Teacher of the Deaf certification have not tested for sign language competency (ie. Texas Assessment of Sign Communications (TASC), the TASC American Sign Language (ASL).

At the April 2019 GCPD meeting, the committee heard public testimony from a deaf student who claimed her itinerant Teacher of the Deaf could not communicate with her in sign language and had to use an interpreter to relay communications.

### Cost

Teachers will have to pay to take the test.

### Potential for Success

Change of rule and procedure to monitor for Deaf Education certified teachers for TASC or TASC-ASL certification, should require no additional cost to TEA, only rule and/or policy changes.

### Time

Some teachers of the Deaf are not able to provide direct instruction to their Deaf signing students.

### GCPD Staff Recommendation

GCPD staff have reached out to the original proposer to get an update on the necessity of this proposal.

## 03.03

Require a routine audit of teachers with Teacher of the Deaf certification currently working with students who use sign language to ensure teachers have passed the TASC, TASC-ASL, or other test recognized by TEA.

### Impact on Population

Some teachers who hold Teacher of the Deaf certification have not tested for sign language competency (ie. Texas Assessment of Sign Communications (TASC), the TASC American Sign Language (ASL).

At the April 2019 GCPD meeting, the committee heard public testimony from a deaf student who claimed her itinerant Teacher of the Deaf could not communicate with her in sign language and had to use an interpreter to relay communications.

### Cost

Teachers will have to pay to take the test.

### Potential for Success

Change of rule and procedure to monitor for Deaf Education certified teachers for TASC or TASC-ASL certification, should require no additional cost to TEA, only rule and/or policy changes.

### Time

There are some Teachers of the Deaf who currently cannot provide direct instruction to their Deaf signing students.

### GCPD Staff Recommendation

GCPD staff have reached out to the original proposer to get an update on the necessity of this proposal.

# Health

## 06.03.01 – 06.03.05

***Recommendation 6.3.1***: To ensure that the information captured on the STAR-Kids Screening Assessment Instrument (SK-SAI) is both accurate and complete, the beneficiary and his or her parents or guardians should be involved in completing and reviewing the assessment instrument together with the managed care organizations before it is submitted to Texas Medicaid Healthcare Partnership (TMHP).

Denial notice forms do not explain why the beneficiary does not need the level of care provided in a nursing facility or why the beneficiary is no longer eligible for MDCP, despite being eligible in the past, and no change in the medical necessity criteria. 42 CFR 431.210(b) requires that denial notices explain the specific reason for the decision. Also, 42 CFR 431.210(c) requires denial notices include the “specific regulations that support, or the change in federal or state law, that requires the action.” TMHP’s notices failed to cite any regulations. Such non-specific denial notices encourage arbitrary denial decisions. This process was modified by HHSC on January 1, 2019.

***Recommendation 6.3.2***: HHSC should require TMHP to issue non-form letter denials that (1) provide specific reasons for the denial, including reasons why the beneficiary does not need the level of nursing care that would be provided in a nursing facility and why the individual beneficiary no longer meets medical necessity for Medically Dependent Children Program (MDCP); and (2) include the “specific regulations that support, or the change in federal or state law, that requires the action.”

***Recommendation 6.3.3***: HHSC should issue ascertainable standards (i.e., written guidance) on the meaning of the medical necessity criteria and train Texas Medicaid Healthcare Partnership (TMHP) reviewers on these standards.

***Recommendation 6.3.4***: HHSC should instruct Texas Medicaid Healthcare Partnership (TMHP) to follow the guidance on parents and guardians in assessing medical necessity and increase transparency on testing of SK-SAI.

***Recommendation 6.3.5***: HHSC should release all information, subject to any restrictions under state and federal law (such as HIPAA), related to how the STAR-Kids Screening Assessment Instrument (SK-SAI) was tested for inter-rater reliability and validity, and all statistics for the denial rate on renewals.

### Impact on Population

The eligibility process used by Texas Medicaid to determine continued medical necessity/eligibility for the Medically Dependent Children Program (MDCP) has several key problems that has resulted in skyrocketing denial rates for the program during the renewal process: 2.6% in 2014-2015 to 10.7% in July 2017, the last known date for which HHSC released statistics on MDCP denials. The stated goal of MDCP is “to provide support services that help prevent unnecessary placement of an individual in a long-term care facility and to support de-institutionalization of individuals who reside in nursing facilities.” Under Texas Rule 19.2401, to meet medical necessity, the child or young adult must (1) have a medical condition of sufficient seriousness that exceeds the routine care which may be given by an untrained person; and (2) require licensed nurses’ supervision, assessment, planning, and intervention that are available only in an institution.

MDCP and nursing facility admissions have the same eligibility/ medical necessity criteria. Yet, while nursing facility populations are not reassessed annually and permanent medical necessity for nursing facility admission is deemed after six (6) months, the majority of children and young adults on MDCP who have chronic disabilities and health conditions are assessed annually for continued eligibility for MDCP.

The Managed Care Organization (MCO) assessing MDCP eligibility began using a new assessment instrument, the STAR-Kids Screening Assessment Instrument (SK-SAI), which includes a Nursing Care Assessment Module (NCAM), used to identify a beneficiary’s need for skilled nursing services. Once completed, the SK-SAI is forwarded to the Texas Medicaid Healthcare Partnership (TMHP) where TMHP nurse reviewers and medical directors use portions of the SK-SAI—primarily the NCAM—to determine eligibility for MDCP. If a TMHP medical director determines that the beneficiary no longer meets eligibility for MDCP, TMHP notifies the beneficiary that he or she has 14 business days to submit additional information supporting continued eligibility. If no additional information is submitted, or TMHP deems that the additional information does not support continued eligibility, TMHP issues a notice denying eligibility for MDCP. It appears that deficiencies within the process used by Texas Medicaid that appears responsible for the rise in denials for MDCP at renewal.

Prior to the transition to STAR-Kids and the use of the new assessment instrument (SK-SAI), renewal denial rates for children and young adults on MDCP during their annual reassessments was 2.6% (2014-2015) and 3.13% (2015-2016). In 2017, following the transition of MDCP beneficiaries to STAR-Kids, the percentage of beneficiaries being denied renewal for MDCP skyrocketed to 11.58% for February 2017 through May 2017. For June 2017, the denial rate was 14.1%, and for July 2017, the denial rate was 10.7%.

### Cost

Unknown.

### Potential for Success

There has not been a bill related to this proposal in recent sessions. HHSC has also not indicated they will be addressing this proposal.

### Time

Families are being denied and are not provided with information to help them understand their denial or the process.

### GCPD Staff Recommendation

Staff recommend a different path be identified to solve this issue.

## 06.04

Support the establishment of a Family Licensed Health Aide (FLHA) program by removing the prohibitive language, permitting families/parents to become paid caregivers for their children under the Texas home health benefit. This would be supported through legislative action. GCPD further recommends that legislation that include a statement that participation in this model is up to the family and the MCO cannot pressure a family to participate.

### Impact on Population

* ***Improved access to care***–The nursing shortage crisis has created an access-to-care barrier, and unfortunately the nursing shortage has no end in sight.  Allowing family members to be trained, certified caregivers for their loved ones helps solve the staffing crisis that often has families receiving partial care or experiencing extended facility/NICU stays pending arrangement of home nursing.
* ***Improved quality of care***–No one can bring the same level of passion and attention to caregiving as a parent or family member can for their own child. Parents, family members, and legal guardians not only provide the highest quality of support, but also ensure an on-going continuity of care. The current Private Duty Nursing model yields inconsistent care, recurring missed shifts, perpetual staff turnover, and increased re-hospitalizations which cost the state on average $4,264 per day.[[3]](#footnote-3)[1]

The Family Licensed Health Aide (FLHA) program will add another nurse-staffing option to the existing Texas benefit structure. With Board of Nursing approved principles of delegation, home care agencies would allow a parent, family member or legal guardian to become paid Certified Nursing Assistants (CNA’s). This allows these groups to provide skilled services for their loved one directed by a Physician and operating under the supervision and guidance of a Registered Nurse.

In addition to the improved access to care, the improved quality of care, and the reduction in costs to the state, this program provides a level of stability and empowerment to these families that often end up living on the edge. With inconsistent nursing care, family members are frequently tasked with taking on the duties of their child’s unfulfilled care, which causes the need to constantly leave their job or call in with last-minute emergencies. This essentially makes these parents un-hirable or unemployable because they are viewed as unreliable workers. This forces families to become single-income-households or parents to leave the workforce altogether, which inevitably leads to these families requiring greater support from state programs. With inconsistent care, a lack of resources, and stress caused by instability in the household, it is unfortunate that the child is the one who is left with the most suffering.

### Cost

It would save the state money by using a CNA for Private Duty Nursing instead of a nurse. A reimbursement for a nurse is higher than it is for a CNA. For example, a CNA visit rate is $46.09 a visit or $23.05 an hour. Private Duty Hourly Nursing rates depending on acuity of care and discipline range from $33.16 an hour to $52.12 an hour.

### Potential for Success

This model offers cost savings to the state, not only from decreased costs associated with hourly compensation, but also with more consistent staffing. Additionally, evidence shows significant impact on decreased hospitalization rates. For families with medically fragile children, 80% end in divorce. One of the parents ends up on government assistance since they must quit their job to care for their child, often due to lack of nurse staffing. By training the parent and employing the parent as a can, the parent can come off government assistance. The agency provides a livable wage and full benefits package to the parent as an employee. This model also adds more CNAs to the workforce in Texas. A CNA is entry level nursing position, which also establishes a career ladder for these parents. In CO and NH, we have seen Family CNAs pursue more advanced nurse and therapist degrees once they are introduced to the healthcare field. Also, the Family CNAs can work for other facilities or homecare agencies. This program offers a solution for the nationwide aide and nursing shortage we are facing.

Some agencies oppose this model because they are worried it will affect their revenue. It will decrease their revenue but increase their gross margin. They will be able to staff more cases, have greater consistency in care, promote better patient outcomes, and see a significant decrease in missed shifts. Some parents are worried that Managed Care Organizations (MCOs) will make all PDN children go to this model. To combat this fear, we suggest putting in a legislation statement that says participation in this model is up to the family and the MCO cannot pressure a family to participate. It will have tremendous positive impact on the Private Duty Nursing (PDN) community, just as we’ve seen in CO, as it will add more caregivers, offering parents more choice. Ultimately, this legislation would be adding more CNAs to the labor market, which benefits the entire healthcare system.

### Time

Many families experience job los and poverty because they cannot find or afford adequate care for their loved ones. This proposal would allow those families to meaningfully contribute to the workforce, learn a new skill, and take care of their loved ones.

### GCPD Staff Recommendation

Staff recommend continuing support for this initiative.

## 06.05

The HHSC Rate Analysis Division should proactively engage with audiologists and other stakeholders to review the Medicaid rates for hearing aid fitting and related procedures to ensure the rate is sufficient:

* evaluate the reimbursement process to implement timely payment and reimbursement to providers; and
* compare Medicaid rates to other state agency rates for hearing aid dispensing, fitting, maintenance, evaluation, etc. including Texas Workforce Commission Vocational Rehabilitation Services rates.

### Impact on Population

Prior to 2006, adult Medicaid recipients could receive hearing aids (HAs) every six years and children Medicaid recipients received HAs through PACT, the Program for Amplification for Children in Texas. After 2006, HAs adult benefits were terminated. Between 2009 and 2013, both adults and children were able to receive 2 HAs, accessories, and replacement devices.

The Office of the Inspector General (OIG) issues a rule requiring HAs billing at the lowest actual acquisition cost, invoice, or published fee. Providers bill according to the HHSC fee schedule, many times higher than acquisition cost. The OIG sought to recoup the difference or disallow payments.

In 2013, difficulties began with delayed and denied reimbursement, recouped reimbursement, and rate reductions in other services (including fitting, evaluations, etc.). TAA surveyed providers that year (126 responses) and results showing 73% of audiologists accepting Medicaid are unlikely/definitely not to continue accepting Medicaid if reimbursement drops below $400. The reimbursement fee includes all the appointments necessary to see and follow up with patients for the length they have the HAs.

The 2014 TAA survey resulted in 37% of providers discontinue dispensing HAs through Medicaid, 20% have limited or are considering limiting the number of Medicaid patients they can accept per month. Providers reported the numbers of children and infants served yielded a 92% and 91% decrease respectively. The 2017 survey indicated 43% of providers no longer see Medicaid patients, 38% discontinued dispensing HAs through Medicaid, 5% are still enrolled in Medicaid but will not accept new patients, and 6% froze provision of services to established patients. This has resulted in an 80-83% decrease in patients receiving services.

A lengthy approval process involving audiologist, ENT, and primary care physician, and significant staff resources are required for pre-approval process. Even with proper approval, denials are constant. Limited access to adequate providers leads to limited access to services for individuals with disabilities.

The cost for 1 child with hearing aids and proper follow-up care for 3 years = $3,500. The Medicaid Reimbursement Rate for the same services over 3 years = $1,750.

This does not include the staff cost to receive pre-authorization and reimbursement.

### Cost

Unknown budget costs.

### Potential for Success

Requires rule change and revaluation of reimbursement rates. HHSC has the technical expertise to take on the project. Will help with meeting the needs of Medicaid eligible constituents.

### Time

There is a dearth of providers in Texas. There are some areas where people must travel 200 miles to see a provider.

### GCPD Staff Recommendation

Staff recommend continuing support for this initiative.

## 06.06

HHSC should evaluate the adequacy of its Medicaid provider network throughout the state to ensure sufficient geographical coverage and timeliness of audiological services.

### Impact on Population

Prior to 2006, adult Medicaid recipients could receive hearing aids (HAs) every six years and children Medicaid recipients received HAs through PACT, the Program for Amplification for Children in Texas. After 2006, HAs adult benefits were terminated. Between 2009 and 2013, both adults and children were able to receive 2 HAs, accessories, and replacement devices.

The Office of the Inspector General (OIG) issues a rule requiring HAs billing at the lowest actual acquisition cost, invoice, or published fee. Providers bill according to the HHSC fee schedule, many times higher than acquisition cost. The OIG sought to recoup the difference or disallow payments.

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This does not include the staff cost to receive pre-authorization and reimbursement.

### Cost

Unknown budget costs.

### Potential for Success

Requires rule change and revaluation of reimbursement rates. HHSC has the technical expertise to take on the project. Will help with meeting the needs of Medicaid eligible constituents.

### Time

There is a dearth of providers in Texas. There are some areas where people must travel 200 miles to see a provider.

### GCPD Staff Recommendation

Staff recommend continuing support for this initiative.

## 06.07

Form an advisory coalition with subject matter experts from HHSC’s Early Childhood Intervention Program (ECI), the Texas Workforce Commission (TWC), and the Texas Education Agency (TEA) to study and make recommendations on pre-service and annual professional development opportunities for providers on supporting children with developmental delays and disabilities, supporting early childhood mental health, and other related topics.

### Impact on Population

An advisory coalition could provide sustainable solutions to the shortages and gaps in these services.

### Cost

Unknown.

### Potential for Success

There has not been a bill in recent session on this proposal, but it may be accomplished voluntarily by the identified agencies.

### Time

Children with disabilities are not being identified or properly supported in the early childhood setting, which can cause significant delays in development.

### GCPD Staff Recommendation

GCPD staff recommend inviting TWC staff to present at a future GCPD quarterly meeting on their childcare grants and explore the possibility to align grant requirements with these policy objectives.

## 06.08

Strengthen relationships between ECI and childcare providers to improve referrals to critical early interventions for babies and toddlers with disabilities.

### Impact on Population

Parents of children with disabilities face significant barriers to obtaining and maintaining high quality, reliable, inclusive child care; resulting in parents dropping out of the workforce, family isolation, turning to unregulated care, and a missed opportunity to connect with other programs like Early Childhood Intervention (ECI). Currently child care providers only account for 2 percent of referrals to ECI, and many ECI providers across the state report challenges being able to serve children in their natural environment because they are denied opportunities to work with children who are in child care settings during the day.

Babies and toddlers are missing out on the safe, inclusive, early opportunities that they deserve, largely because child caregivers are not aware of the requirements under the Americans with Disabilities Act (ADA) or how to support children with disabilities in care. Child caregivers would benefit from training on working with children with disabilities and supporting early childhood mental health. There is a wealth of free training opportunities available in Texas.

### Cost

No known cost.

### Potential for Success

These recommendations reiterate what has already been established under federal law. All resources and/or requirements cited in the above recommendations already exist and are available at no cost to child care providers. Additionally, inclusive child care programs are thriving across the state and can serve as successful models.

### Time

Early childhood is a critical time period and referrals to early interventions are key to development.

### GCPD Staff Recommendation

Recommendation 6.8 - 6.11 are all related and receive the same staff recommendation. Staff recommends retaining this recommendation while working toward administrative solutions that do not require legislation to implement the goals of this policy.

## 06.09

Ensure child caregivers are aware of ECI services and know how to refer children for an ECI screening.

### Impact on Population

Parents of children with disabilities face significant barriers to obtaining and maintaining high quality, reliable, inclusive child care; resulting in parents dropping out of the workforce, family isolation, turning to unregulated care, and a missed opportunity to connect with other programs like Early Childhood Intervention (ECI). Currently child care providers only account for 2 percent of referrals to ECI, and many ECI providers across the state report challenges being able to serve children in their natural environment because they are denied opportunities to work with children who are in child care settings during the day.

Babies and toddlers are missing out on the safe, inclusive, early opportunities that they deserve, largely because child caregivers are not aware of the requirements under the Americans with Disabilities Act (ADA) or how to support children with disabilities in care. Child caregivers would benefit from training on working with children with disabilities and supporting early childhood mental health. There is a wealth of free training opportunities available in Texas.

### Cost

No known cost.

### Potential for Success

These recommendations reiterate what has already been established under federal law. All resources and/or requirements cited in the above recommendations already exist and are available at no cost to child care providers. Additionally, inclusive child care programs are thriving across the state and can serve as successful models.

86th - [HB 4450](https://capitol.texas.gov/tlodocs/86R/billtext/pdf/HB04450I.pdf#navpanes=0) (Gonzalez, Mary) /SB1817 (Zaffarini) - Ensure child care providers are well educated on Early Childhood Intervention (including what ECI is, how to identify missed milestones, how to refer, and clarify that ECI can take place in child care centers). The bill also reiterates that childcare providers cannot discriminate against children with disabilities.

### Time

Early childhood is a critical period and referrals to early interventions are key to development.

### GCPD Staff Recommendation

Recommendation 6.8 - 6.11 are all related and receive the same staff recommendation. Staff recommends retaining this recommendation while working toward administrative solutions that do not require legislation to implement the goals of this policy.

## 06.10

Require childcare providers to develop a discipline policy that is made available to all families.

### Impact on Population

Families often report that their children with a disability have been suspended or expelled from childcare, however there is no reporting requirement for these discipline practices, making it difficult to articulate the true extent of the problem.

Families of children with disabilities regularly report challenges finding and maintaining care. Analyses also show that the childcare crisis disproportionately affects children with disabilities. Furthermore, childcare providers in Texas are currently permitted to elect whether they provide care to children with disabilities, or report that they would like more consultation/training on mental health and working with children with disabilities.

### Cost

No known cost.

### Potential for Success

These recommendations reiterate what has already been established under federal law. All resources and/or requirements cited in the above recommendations already exist and are available at no cost to childcare providers. Additionally, inclusive childcare programs are thriving across the state and can serve as successful models.

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### Time

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### GCPD Staff Recommendation

Recommendation 6.8 - 6.11 are all related and receive the same staff recommendation. Staff recommends retaining this recommendation while working toward administrative solutions that do not require legislation to implement the goals of this policy.

## 06.12

Amend HHSC Medicaid Managed Care contracts to require that should the MCO be unable to provide access to the appropriate specialist within 30 days, then the member will be allowed to go out of network with the MCO covering all costs incurred. If the primary care physician (PCP) cannot provide routine care in 14 days, then the member will be allowed to go out of network with the MCO covering all costs incurred. If the PCP cannot provide urgent care in 1 day, then the member will be allowed to go out of network with the MCO covering all costs incurred.

This would enhance the feasibility for the MCOs to provide timely and quality healthcare to Texans with Disabilities and provide relief to the already stressed provider network. No additional costs shall be incurred to the state, as TMPH would pay the physician and related hospital or DME costs, after which time TMHP would be reimbursed by the specific MCO. This would greatly improve working relationships with providers.

### Impact on Population

There has been increased difficulty with MCOs providing an adequate provider base, especially for specialists and sub-specialists. For example, an adult with a 70-degree spinal curvature was not given referral to a specialist that accepted Medicaid for over three years. This proposal would mean fewer critical hospitalizations, patients with disabilities can return to work more quickly, 1115 providers will find financial relief; and public education will experience fewer critical care situations.

### Cost

No additional costs incurred, as TMPH would pay the physician and related hospital or DME costs, after which time TMHP would be reimbursed by the specific MCO. This would greatly improve working relationships with providers.

### Potential for Success

This would enhance the feasibility for the MCOs to provide timely and quality healthcare to Texans with Disabilities. This would provide relief to the already stressed provider network.

### Time

There is a serious shortage in coverage the impacts individuals needing acute or specialized care.

### GCPD Staff Recommendation

Staff considers these sound policy recommendations but recommend building a large coalition of advocates to ensure this is successful next session.

## 06.13

Texas and HHSC should explore ways to enhance opportunities for mental health professionals to access training to increase the number of evidence-based practitioners in the state.

### Impact on Population

Texas is home to several populations who historically have high rates of PTSD—it ranks second in the nation for the number of human-trafficking victims; resettles more refugees than any other state; has a high population of unaccompanied child migrants; and has one of the largest populations of military service members and is the second most populated state of military veterans. These populations experience high rates of trauma, and in a state with an already critical shortage of mental health professionals, their ability to find appropriate treatment is low.

### Cost

Unknown.

### Potential for Success

It may be difficult to do something that could be considered expanding Medicaid; however, it is also an issue that greatly impacts all Texans. This proposal would require a change in the Medicaid state plan. It would also support the creation of policy to provide evidence-based PTSD treatment training statewide.

### Time

This issue is currently affecting individuals with PTSD who cannot access evidence-based care.

### GCPD Staff Recommendation

Staff recommends doing more research on this recommendation. Staff are in communication with HHSC about this recommendation.

## 06.18.01 – 06.18.03

***Recommendation 6.18.1:*** To protect the best interests of children parented by people with disabilities or children who could be parented by people with disabilities Texas must use procedural safeguards adhering to the ADA and respect the due process and equal protection rights of parents by ensuring:

1. a parent’s disability is not a basis for denial or restriction of visitation or custody in family or dependency law cases when the visitation or custody is determined to be otherwise in the best interest of the child.
2. a prospective parent’s disability is not a basis for the denial of participation in public or private adoption when the adoption is determined to be otherwise in the best interest of the child.
3. an individual’s disability is not a basis for denial of foster care or guardianship when the appointment is determined to be otherwise in the best interest of the child.

***Recommendation 6.18.2:*** Where a parent or prospective parent’s disability is alleged to have a detrimental impact on a child, the party raising the allegation should bear the burden of proving by clear and convincing evidence that the behaviors are endangering or will likely endanger the health, safety, or welfare of the child. If this burden is met, the parent or prospective parent must have the opportunity to demonstrate how supportive parenting services can alleviate any concerns that have been raised. The court may require that such supportive parenting services be put in place, with an opportunity to review the need for continuation of such services within a reasonable period.

***Recommendation 6.18.3:*** If a court determines that a disabled parent’s right to custody, visitation, foster care, guardianship, or adoption is to be denied or limited, the court must make specific written findings stating the basis for such a determination and why the provision of supportive parenting services is not a reasonable accommodation that must be made to prevent such denial or limitation.

### Impact on Population

Approximately 4.8 million families in the United States (based on average 5-year 2010-14 estimates) have a parent or grandparent with a disability with children under the age of 18.

### Cost

Unknown.

### Potential for Success

There are 20 states in the country that have passed similar legislation. However, no bill was filed during the last session, and no efforts appeared to be made by the organization that brought this recommendation to GCPD.

### Time

This is model parents’ rights legislation and has been done in many other states.

### GCPD Staff Recommendation

GCPD staff are neutral on this recommendation.

## 06.19

Support the growth in independent living services for Texans with vision loss age 55 and older through targeted investments in caseworkers. To strengthen training through community providers for the blind, Texas should establish and fund five to six senior vision loss training center pilot programs in major cities throughout the state to offer day-time classes teaching independent living skills in an apartment-style setting to older adults diagnosed with severe vision loss. This program will allow them to travel each day from their homes to the classes, promoting their learning of how to live with vision loss. These programs’ curriculum content shall include:

* orientation and mobility – in and out of the home;
* personal care and grooming;
* cooking and house cleaning;
* communication skills: reading, writing, telephone, computer;
* home safety: lighting, organizing, labeling, and marking;
* shopping and managing money;
* library services; and
* adaptive aids.

### Impact on Population

The prevalence of blindness and visual impairment among people 65 years of age and older, according to the U.S. Census, (American Community Survey), is estimated to be about 7.6%. This means that there are currently more than 288,000 Texans, aged 65 and older, who experience some level of severe vision loss, and this number will increase by the same 60% over the next 15 years – to over 460,000 individuals by 2035.

### Cost

The average annual cost for nursing home care is about $47,000 for a semiprivate room, according to North Texas Aging and Disability Center and Genworth Financial Inc.

By comparison, providing in-home independent living services and adaptive aids to an older adult losing their vision costs less than one tenth that amount.

### Potential for Success

Through a proposed shift in funding realignment the TWC will add 23 more independent living (IL) specialist to its OIB program by 2025. This expanded funding will make it possible for TWC to serve some 2500 additional older Texans each year who are experiencing vision loss.

However, the reality is that even a staff of 39 IL specialists simply cannot provide needed direct service to a quarter million visually impaired older adults in 254 counties throughout the state.

### Time

Unavoidably, everyone is getting older. And, unavoidably, many people will experience a loss of vision.

### GCPD Staff Recommendation

There has been great progress on this policy proposal through the Older Individuals who are Blind program, but it can still use more support to expand to the levels recommended.

## 06.20

HHSC should task the Statewide Behavioral Health Coordinating Task Force with studying ways to increase the availability and awareness of high-quality, comprehensive care for people with mental health (MH) diagnosis and IDD. This should include:

* examining how to increase workforce capacity through training and other incentives;
* increasing cross-agency collaboration and developing a more wholly integrated system of care for people with IDD;
* expanding trauma-informed care training; and
* evaluating the impact of using intelligence quotient (I.Q.) thresholds as exclusionary criteria for access to MH and/or IDD services.

### Impact on Population

There are several possible explanations about why people with IDD suffer disproportionately with mental health conditions. They might experience more stress related to frustrating social challenges. Limited language abilities could make it difficult to communicate feelings and needs. People with IDD are also at a higher risk of experiencing trauma such as physical, emotional and sexual abuse, neglect, bullying, and unnecessary restraints. These inherent challenges and high incidents of trauma create a unique susceptibility for the development of mental health conditions.

Access to quality treatment continues to be a problem. Significant workforce shortages of MH/IDD specialists, as well as limited knowledge and training for MH and IDD professionals creates a substantial barrier. We need stronger efforts to capitalize on the expertise in both fields and establish a seamless, comprehensive, and integrated system of care for this population.

Without this integrated, expert care, uninformed providers and caregivers often attribute challenging behaviors to disability and fail to adequately evaluate for underlying medical or mental health conditions. There is a lack of cross agency and department coordination because of limited knowledge and training. Local mental health centers and the local authorities for IDD services are typically co-located, but service coordination and provision are siloed making it difficult for individuals with IDD to access mental health services.

To make matters worse, our overall research about people at the intersection of MH and IDD is sorely lacking. This sparse data leads to confusing or inappropriate assessments and evaluations, which make the standard criteria for mental illness difficult to obtain. Important too, may be the necessity of modifying current mental health diagnostic criteria for this population.

Another important factor in providing quality treatment is understanding the significance of trauma. Attention has recently been given to the impact of trauma and the need for trauma- informed care for both child welfare/juvenile systems as well as adult criminal justice systems. The legislature has mandated trauma training in both these systems, but despite the fact that people with IDD experience high rates of trauma and institutionalization, Texas has not yet prioritized trauma-informed care for this vulnerable population.

### Cost

No known cost.

### Potential for Success

These recommendations are feasible because the framework already exists. Gaps in care can be easily resolved through better community outreach, improving internal policies at State agencies, and strengthening collaboration between providers, both public and private. Training resources could be made at no additional costs, and creative workforce incentives would encourage medical professionals to specialize in MH/IDD care.

[HB 4183](https://capitol.texas.gov/BillLookup/history.aspx?LegSess=86R&Bill=HB4183)- Relating to addressing adverse childhood experiences and developing a strategic plan to address those experiences. *(left pending)*

[SB 239](https://capitol.texas.gov/BillLookup/History.aspx?LegSess=84R&Bill=SB239)-Relating to student loan repayment assistance for certain mental health professionals.

[HB 3116](https://capitol.texas.gov/BillLookup/History.aspx?LegSess=86R&Bill=HB3116)-Relating to the establishment of a task force to conduct a comprehensive study on best practice standards for the detention of persons with intellectual and developmental disabilities.

[SB 292](https://capitol.texas.gov/BillLookup/History.aspx?LegSess=85R&Bill=SB292)- Relating to the creation of matching funds grant program for a community collaborative to reduce recidivism, arrest, and incarceration of individuals with mental illness. **(Does not include measures for individuals with intellectual disabilities.)**

[HB-906](https://capitol.texas.gov/BillLookup/history.aspx?LegSess=86R&Bill=HB906)-Relating to the establishment of a collaborative task force to study certain public school mental health services.

### Time

“The rate of mental health conditions for those with IDD is two to three times higher than that of the general population. Approximately 30-50% of children with IDD might also have mental health conditions, according to research in the Journal of Intellectual and Developmental Disability. That’s more than the average for all other children.” (navigatelifetexas.org)

### GCPD Staff Recommendation

Staff are neutral on this policy recommendation.

## 06.21

HHSC should work with the leads of each state hospital redesign to create a specialty services unit for people with intellectual and developmental disabilities (IDD) to divert people from hospital emergency departments and jails.

### Impact on Population

People with intellectual and developmental disabilities (IDD) experiencing mental health crises are extremely limited in terms of accessing psychiatric hospitalization and treatment. Creating a dedicated IDD Specialty Services Unit as a part of the statewide State Hospital Redesign that could be replicated across the state hospital system would provide a strong start to creating a robust network of appropriate treatment options for people with IDD and mental health diagnoses.

### Cost

Unknown.

### Potential for Success

This proposal was made when the state hospital redesign was still ongoing. Now that the redesign has ended, GCPD staff is in communication with HHSC on other ways to meet the spirit of this proposal.

### Time

There is a dearth of culturally competent treatment facilities available for people with IDD experiencing serious mental health crises. Anecdotally, law enforcement and other crisis mental health professionals report being unable to find private psychiatric hospitals that will accept people with IDD experiencing a mental health crisis. This means individuals often wind up remaining in emergency department beds or being transferred to jail- both inappropriate settings for an individual experiencing a mental health crisis. Additionally, Austin State Hospital (ASH) and North Texas State Hospital (NTSH) appear to be the only two state hospitals out of ten that have a specialty services unit that mentions treating people with IDD.

### GCPD Staff Recommendation

Staff are waiting on a response from HHSC.

## 06.22

* Revise TAC §260.203, §259.307, §259.355, TxHmL Billing Requirements 3410(b)(c)(d), and HCS Billing Requirements 3420(b)(c)(d) to remove the prohibition on allowing family members, including spouses and parents, to be the paid personal care attendant.
* Make the PHE flexibility currently set to end on August 31, 2024 that allows family members, including spouses and parents, to be the paid personal care attendant permanent.

### Impact on Population

The US is experiencing an attendant shortage that is becoming a crisis. Starting during the COVID-19 pandemic, families have been unable to find reliable, well-trained personal care attendants to care for their family member. Families report struggling to find attendants willing to work for the rate set by Medicaid. When families are able to find someone, the attendant is unreliable and does not show up on time or at all. Due to this, family members often lose their jobs as they are unable to leave their family member unattended.

### Cost

This should be cost-generating for the state as family members will be able to contribute to the Texas economy.

### Potential for Success

According to CMS, Texas implements a 1915(k) Community First Choice state plan program that provides personal care and similar services, which are most often provided by family members. There is no prohibition on the use of parents or other legally responsible individuals in the CFC program. It is state choice to recognize parents in this way and something Texas can decide to change.

Difficulties: Some members of the Texas Legislature disagree with allowing family members to be paid. Some legislators believe the family members should just do the work for free.

Successes: Many stakeholder groups have advocated for this allowance, including PPAT, Texas P2P, and EveryChild, Inc. The solution itself is a practical one that responds to the current crisis creatively. This would keep families together and can potentially reduce a family’s reliance on other state programs.

In addition to the improved access and quality of care, and the reduction in costs to the state, this program provides a level of stability and empowerment to these families that often end up living on the edge of poverty. With inconsistent attendant care, family members are frequently tasked with taking on the duties of their child’s unfulfilled care, which causes the need to constantly leave their job or call in with last-minute emergencies. This essentially makes these parents un-hirable or unemployable because they are viewed as unreliable workers. This forces families to become single-income-households or parents to leave the workforce altogether, which inevitably leads to these families requiring greater support from state programs. The inconsistent care, a lack of resources, and stress caused by instability in the household, results in greater adverse health impacts on these medically fragile children.

### Time

Many families are struggling with finding quality, reliable caregivers for heir family members.

## 06.23

Change “Interest List” to “Wait List” in Government Code for Medicaid Waiver Programs under Texas Health & Human Services Commission.

### Impact on Population

The 1915(c) Medicaid waivers call the wait list an interest list. This is does not comply with plain language best practices and can cause confusion.

### Cost

No known cost.

### Potential for Success

HCBS waiver programs were introduced in the 1980s as an optional Medicaid benefit allowing states to choose to provide long-term services and supports (LTSS) in community-based settings. Throughout the country, the demand for these services often outweighs the availability. If it is necessary to defer the entrance of individuals to a waiver, the state must have policies that govern the selection of individuals for entrance to the waiver when capacity becomes available. Page 6 While the Centers for Medicare and Medicaid Services (CMS) provides states guidance, states have autonomy to manage their waiting or interest lists. \*Texas uses the term interest list because qualification and eligibility statuses are unknown at the time the individual is placed on a list. However, most reports used the term wait list. CMS indicates these policies should be based on objective criteria and applied consistently in all geographic areas served. CMS is careful to limit their guidance to the way states establish criteria for selection of entrants into the waiver and does not dictate state strategies for managing a wait list. This flexibility allows states to design an interest list management system targeted for their states unique populations and geographic areas.

<https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/medicaid-waiver-programs-interest-list-study-sept-2020.pdf>

### Time

This is not a time sensitive issue.

## 06.24

Allow intervener services for individuals in the 1915(c) waivers while the individual is hospitalized.

### Impact on Population

Currently, an individual on a 1915(c) waiver who enters the hospital loses access to their intervener services. An intervener is a service provider with specialized training and skills in deafblindness who, working with one individual at a time, serves as a facilitator to involve an individual in home and community services and activities, and who is classified as an Intervener, Intervener I, Intervener II, or Intervener III in accordance with Texas Government Code §531.0973. An intervener provides services tailored to the unique needs of the individual. Because the services are so tailored to the individual, they cannot be performed by an unfamiliar service provider. In a setting like a hospital, the individual may not be used to the environment and need a lot of support from their intervener, especially considering how many service providers come in and out of a hospital room in each visit. It is important for the health, wellbeing, and safety of the individual that they are able to use their intervener services.

If an individual is able to keep using their intervener services while hospitalized, it could:

* prevent medical errors due to miscommunication.
* reduce the anxiety and fear an individual may be experiencing because they are hospitalized. This could reduce aggressive behaviors and protect the individual and the service providers.

### Cost

This could save money for members of the community by reducing medical errors and trauma.

### Potential for Success

[CFR §441.301(c)(5)](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.ecfr.gov%2Fcurrent%2Ftitle-42%2Fchapter-IV%2Fsubchapter-C%2Fpart-441%2Fsubpart-G&data=05%7C02%7Crebecca.lopez%40gov.texas.gov%7Cc90dbe3bc7534988a94d08dc183cad23%7C54cb5da6c7344242bbc25c947e85fb2c%7C0%7C0%7C638411896107660256%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=yk9OturOORPuYSZDrME3x4D1LNJwACQJ4UdMPZzwXKo%3D&reserved=0)is the federal law that prohibits receiving waiver services while a person is hospitalized.

CMS currently has proposed rules on allowing certain services while an individual is hospitalized.

### Time

This is not a time sensitive issue.

## 06.25

When payment rates for specific services within the 1915(c) waivers are raised, such as rates for personal care attendants, the total budget for the waiver should also be raised.

### Impact on Population

Rates for specific services have increased while the total allowed budget has stayed the same which forces individuals to cut the amount of each service they receive. For the Deaf-Blind with Multiple Disabilities Waiver, the total budget (or cost cap) for someone in the waiver is $114,736.07. The payment rate to receive personal attendant services rose from $8.11 to $10.60. If an individual was receiving 20 hours of personal attendant services at $8.11, it would cost $162.20 per week. With the new rate, the individual would only be able to receive 15 hours and 18 minutes for the same cost. To continue to receive 20 hours, the cost would be $212.00 each week. The individual must decide whether to lose almost 5 hours of services per week or pay $50 more per week on that service. If the individual chooses to continue to receive 20 hours of personal attendant services, they will need to adjust the other services they receive to stay within the total budget.

Texas, along with the rest of the country, has seen costs of living and inflation steadily rising. To continue to attract the best providers to provide services to individuals in the Medicaid waivers, the payment rates for these services need to reflect the rising costs of living. To truly make meaningful adjustments to the payment rates for services provided through the waivers, the total budget for the waivers needs to be adjusted in tandem.

This impacts individuals in the waivers, especially those who are already using the majority of their allowed budget prior to the rate increases.

### Cost

Unknown.

### Potential for Success

If a total budget is not raised, only specific rates are increased, the net increase is 0. By raising the budget total, the intent of the payment rate increases can be realized**.**

### Time

Many individuals are now having to cut services because of this issue.

## 06.26

HHSC shall explore the feasibility of using the 3% that Managed Care Organizations return back to GR to fund this benefit: A Medicaid dental benefit for any adult with a disability receiving Medicaid that covers preventive as well as urgent dental care needs in a manner appropriate to an individual’s specific disability.

### Impact on Population

A Texas Health Institute study issued October 2018 reports that “the American Dental Association estimates the average cost of a regular, preventive dental visit is between $180 and $211. They further estimate the annual cost of providing dental coverage in Medicaid is between $822 and $856 per member.” In comparing preventive versus emergency room costs the study offers the following data: there were 122,096 emergency room visits in Texas for non-traumatic dental conditions in 2016. 25,647 of these visits were made by Medicaid recipients (21% of total ER visits) with an average charge of $1,692.25 per individual and a total charge of $43.4 million. 700 of these visits (15% of total ER visits) required inpatient admissions with an average charge of $42,726.27 and a total charge of $29.9 million. Total costs in 2016 for emergency room visits for Medicaid recipients was more than $73.3 million. “This describes significant differences in costs based upon the treatment setting.”

Source: Ankit Sanghavi, BDS, MPH, Gourav Patil, MPH, MBBS, Sean Boynes, DMD, MS, Eric Tranby, PhD, Avery Bow, Vu Diep (2018). *Emergency Department and Inpatient Hospitalization for Non-Traumatic Dental Conditions in Texas*. Accessed on October 19, 2018: <https://www.texashealthinstitute.org/oral-health.html>

A 2015 University of Washington study of 20–29 year-olds, who account for more emergency room (ER) toothache visits than other age group, revealed that toothache was the fifth most common reason for all ER visits by this group. Researchers cited a 6.1% average annual increase in ER visit rates for toothache among 20-29 year olds during 2001-2010, compared to 0.3% for back pain and 0.8% for all causes of ER visits. During 2009-2019, an estimated 3.02 million total ER visits were for toothache (2.8% of ER visits) where 42% of the visits were made by 20-29 year olds. While it was the third most common reason for ER visits for those individuals with no insurance, it was the fifth most common reason among Medicaid patients.

Source: Charlotte W. Lewis, MD, MPH, Christy M. McKinney, PhD, MPH, Helen H. Lee, MD, MPH, Molly L. Melbye, DDS, MPH & Tessa C. Rue, MS (2015). *Visits to US Emergency Departments by 20 to 29 Year-olds with Chief Complaint of Toothache during 2001–2010*. Accessed from PMC US National Library of Medicine, National Institutes of Health on October 18, 2018: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4418214/>

An analysis commissioned by the [National Association of Dental Plans (NADP)](https://www.nadp.org/PressReleases/PressReleasesArchive/2017/11/23/nadp-analysis-shows-adults-with-medicaid-preventive-dental-benefits-have-lower-medical-costs-for-chronic-conditions) disclosed that preventive dental care was shown to reduce overall medical costs 31 to 67 percent for patients diagnosed with seven chronic health conditions as follows:

* Coronary heart disease: 67% lower
* Diabetes: 36% lower
* High Blood Pressure: 31% lower
* Angina: 45% lower
* Other Heart Disease: 45% lower
* High Cholesterol: 43% lower
* Asthma: 37% lower

Thus, analysis results “suggest that policies and programs within Medicaid that encourage recipients to receive preventive dental care have the potential to dramatically reduce the health care costs associated with these conditions” and that “without preventive dental services provided as a benefit to adult Medicaid recipients, there is a potential for higher health costs as patients lack an important component of their health care needs.” The analysis also points out that in addition to increased health costs for chronic conditions, Medicaid patients who do not have dental care coverage “are more likely to visit hospital emergency rooms rather than lower cost community health centers or private offices” for their dental needs. This is reflected in the doubling or emergency room visits for dental issues during the years 2000-2010.

In consideration of the above, an Adult Medicaid dental care benefit targeting adults with disabilities is proposed for the following reasons: (1) Many adults with disabilities are typically unable to fully take care of their dental needs without expert care. For instance, some adults with physical disabilities may not have the fine motor skills to hold a toothbrush properly or manage their routine oral hygiene, thus allowing cavities or dental disease to develop. An individual with IDD who is unable to articulate pain associated with dental issues may manifest behavioral issues in reaction to dental pain or be unable to eat foods necessary for nutritional adequacy, thus creating a risk to their overall health. (2) Dental health impacts the whole person. The effects of limited access to routine dental care may impair an adult's overall physical health (increased risk of heart disease/ stroke, dementia, respiratory problems, diabetes, obesity, infertility, pregnancy complications, or cancer), psychological and social functioning (loss of self-esteem and communication by avoiding conversations or laughing/smiling due to tooth loss), and employability. (3) Preventive dental care can save money in the long run. Dental visits to emergency rooms made by adult Medicaid recipients are typically for a chronic dental condition. Preventive care will not only help reduce the average cost per person for adult dental care (now covered only under emergency room visits averaging over $400 per visit), it will allow for a cost effective proactive approach to adult dentistry in general. A program of adult preventive dentistry will enable more individuals to receive routine basic services such as **regular checkups, regular cleanings, x-rays, and general oral health management that helps deter more serious dental problems that develop because of delays in treatment that end up requiring costlier treatment protocols. (4) Dental treatment received from emergency rooms are contributing to the current public health crisis: an opioid epidemic.** Because emergency room staff tend to lack expertise in dental care, most treatment they provide is limited to palliative care. [An Oregon Health and Science University Report](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4386544/) **disclosed that opioid analgesics (painkillers) were the most frequently dispensed medication for emergency room dental visits. Opioids were found to have been dispensed for 56% of the dental visits made to the emergency room.**

### Cost

FY 23 program costs and offsets are based on LBB assumptions of 450,000 enrollees with 39% of beneficiaries visiting the dentist annually.

Total Potential Program Offsets = $95,402,233 (money saved)

Program Costs Total = $26,676,000

Federal Share = $16,219,008; State Share = $10,456,992

### Potential for Success

This has already passed the 87th Legislature ([SB 1648](https://capitol.texas.gov/BillLookup/History.aspx?LegSess=87R&Bill=SB1648)), but it is not funded.

### Time

Unaddressed dental issues can lead to severe and life-threatening health conditions.

# Housing

## 07.01

Promote adoption of accessible, affordable, and transit-oriented housing in Texas communities through the sharing of information on local visitability ordinances and best practices for the development of accessible single-family homes and duplexes.

### Impact on Population

* People with disabilities: Disability prevalence statistics can range anywhere from 10 to 20 percent of the overall population.[[4]](#endnote-1) Reduced structural barriers in housing will help people with disabilities lead more independent lives and more fully participate in their communities.
* Older adults: Visitability would provide the basic accessibility features needed by older individuals with mobility impairments to stay in their communities. By 2030, one in five Americans will be age 65 or older, a doubling of this population age group from 35 million to over 72 million people in the 20 year period from 2010 to 2030.[[5]](#endnote-2) Surveys have consistently shown that older adults have an overwhelming desire to age-in-place where they have established community ties and memories over the years.[[6]](#endnote-3) According to a 2014 AARP survey, almost 80% of adults 45 and older state would like to stay in their homes for as long as possible as they age.[[7]](#endnote-4)
* Young families: Young families with babies in strollers can enter and leave their homes easily and visit friends without the worry of lifting a stroller up and down steps.
* Growing families: Hauling bags of groceries up the front steps and into the house is no problem for large or growing families.
* Families with elderly family members or relatives: Elderly family members or visiting relatives don’t have to worry about those challenging front porch steps leading up to the front door or maybe having no access to a downstairs bathroom when they visit.
* People Re-locating/ Movers: Less hassle in moving boxes and house-hold belongings.
* Delivery Drivers or Couriers: Large items can easily be left on the front entryway.

### Cost

This could be cost-saving because it would allow more people to age in place.

### Potential for Success

* How feasible is this policy proposal?
	+ Legislatively? This is not likely to be successful in the Texas Legislature.
	+ Administratively? This could be accomplished by municipalities.

### Time

Affordable and accessible housing is an ongoing crisis.

### GCPD Staff Recommendation

Staff feel this is a very important issue, but not one that the Texas Legislature is supportive of. GCPD Staff should continue to promote this to municipalities.

## 07.02

GCPD will study strategies and “solutions that work” from other states or local communities that have expanded community-based housing options for people with disabilities and ensures long-term housing affordability.

### Impact on Population

Low-income people with disabilities wishing to live independently may have the potential for more opportunities for securing affordable accessible housing.

Individuals with disabilities whose sole source of income is SSI/SSDI are competing with the general public for low-income affordable housing. Sometimes individuals with disabilities cannot compete successfully with the general population in first come-first serve situations due to disadvantages resulting from a lack of English proficiency, mobility issues or inaccessible websites so that affordable housing locations becomes saturated with general low-income individuals rather than those who are disabled.

### Cost

Unknown.

### Potential for Success

* Has there been a successful Texas bill related to this proposal? The city of Houston has seen success with “Housing First.”
* Has this been done in other states successfully? Utah, along with other states, have successfully implemented “Housing First” policies.

### Time

Accessible and affordable housing is an ongoing crisis.

### GCPD Staff Recommendation

This recommendation needs to be improved to be more specific, actionable, measurable. This recommendation would benefit from interagency input.

## 07.03

TDHCA should create a public awareness campaign to ensure people with disabilities looking for accessible housing are able to find what they need, including individuals that assist the public in locating housing (e.g., apartment locator services, real estate agents, etc.).

### Impact on Population

Even though both the FHA and TDHCA require multi-family complexes to meet accessibility standards people with disabilities have difficulty finding accessible units. Individuals with disabilities are not aware of the TDHCA search engine and those who are find those who do have found it not accessible.

### Cost

Unknown.

### Potential for Success

* How feasible is this policy proposal?
	+ Administratively? Because this does not need to be done through the Texas Legislature, TDLR may choose to do this.
* Has there been a successful Texas bill related to this proposal? No.

### Time

Accessible and affordable housing is an ongoing crisis.

### GCPD Staff Recommendation

Staff recommend keeping this as a low priority.

# Transportation

## 09.01

Strengthen enforcement of accessible parking laws as follows:

* Strengthen language in Texas Transportation Code, Title 7. Vehicles and Traffic, Subtitle H. Parking, Towing, and Storage of Vehicles - Chapter 681, Privileged Parking, Section 681.010 – Enforcement so that it is unequivocal in its mandate for all individuals with enforcement responsibilities to enforce accessible parking laws (i.e., change “may” to “shall” or “must”).
* Bolster language in enforcement responsibilities as they apply to accessible parking on private property or areas of public accommodation.

### Impact on Population

The Committee found that enforcement of current accessible parking laws was a leading concern to Texans with disabilities. This theme was common in comments received at a public hearing on accessible parking as well as from survey responses from individuals with disabilities. In an open-ended question where survey respondents could share information on any concern they had about accessible parking, enforcement was the topic that generated the most responses for this question (13.7% or 269 responses of 1959 responses received for this question). In addition to conveying an overall general need for enforcement of current accessible parking laws, survey responses shared a perception of general reluctance by both law enforcement officers and/or private property owners/managers to enforce accessible parking laws including those times when they tried to report real-time violations to local authorities. More information can be found in the [GCPD Review of Accessible Parking for Persons with Disabilities](https://gov.texas.gov/uploads/files/organization/disabilities/GCPD_Report_85th_TxAccessibleParking__final_110116.pdf).

### Cost

This proposal could increase state revenue by enforcing violations and fines.

### Potential for Success

There have been no successful Texas bills on this topic, but it has been accomplished in other states:

* [Alabama Code § 32-6-233.1(b)](http://alisondb.legislature.state.al.us/alison/codeofalabama/1975/32-6-233.1.htm) - Any authorized municipal, county, or state law enforcement officer may go on private property to enforce this section.
* [Missouri Revised Statute § 301.143.7](http://www.moga.mo.gov/mostatutes/stathtml/30100001431.html) - Law enforcement officials may enter upon private property open to public use to enforce the provisions of this section and section 301.142, including private property designated by the owner of such property for the exclusive use of vehicles which display a distinguishing license plate or card issued pursuant to section 301.071 or 301.142.
* 625 Ill. Comp. Statute 5/11-1301.3(c-1) - Any person found guilty of violating the provisions of subsection (a-1) a first time **shall** be fined $600. Any person found guilty of violating subsection (a-1) a second or subsequent time **shall** be fined $1,000
* [Kansas Statute § 8-1,130a(a](http://rvpolicy.kdor.ks.gov/Pilots/Ntrntpil/IPILv1x0.NSF/698490e1288fdf7086256524007f6168/774935b28cc205f686257868005c9aca)) - Any person who utilizes any accessible parking identification device issued to another person . . . shall be guilty of an unclassified misdemeanor punishable by a fine of not less than $100 nor more than $300.

### Time

This is not a time sensitive issue.

### GCPD Staff Recommendation

Staff recommendation retiring this recommendation.

## 09.02

Control accessible parking placard fraud and abuse through administrative remedies, such as:

* coordinating with the Department of Motor Vehicles, county tax assessor collectors, and the Department of State Health Services cross-checking of current disability placard holder lists against the state registry for death records and cancelling any placard for an individual identified as deceased and explore tracking of parking placards by the Department of Motor Vehicles with a unique identifier (Texas driver license or state identification number); and
* coordinating with local law enforcement to enforce accessible parking placard fraud and abuse.

### Impact on Population

Disabled parking placard fraud and abuse is a prevalent problem nationwide. It not only denies legitimate placard holders’ access to needed accessible parking spaces, it also costs our towns and cities millions of dollars in lost parking revenues each year.

### Cost

Potential for substantial increase in revenues for local jurisdictions from uncollected parking meter fees and fines from placard violators**.**

### Potential for Success

This has not been implemented by any state agencies on a voluntary basis. This has also not been included in a bill in the 88th session.

### Time

This is not a time sensitive issue.

### GCPD Staff Recommendation

Staff recommends giving this a low priority or recommend that it be retired. Staff will reach out to impacted state agencies and ask one final time if it would be possible to implement administratively.

## 09.03

In coordination with the Texas Department of Motor Vehicles and county tax assessor-collector offices, develop statewide public awareness on accessible parking and its impact on Texans with disabilities through public awareness campaigns.

### Impact on Population

Surveys conducted by GCPD reflect that the public perceives there is a shortage of accessible parking spaces at both local businesses and medical facilities. News reports and audits from around the country show that parking fraud and abuse not only denies access to accessible parking spaces by legitimate placard holders but adds to the growing shortage of current accessible parking spaces as our population ages and more people acquire or are diagnosed with mobility disabilities.

### Cost

There will be costs associated with developing a public awareness campaign.

### Potential for Success

Public education and awareness will help reduce accessible parking fraud and abuse. Examples of successful public awareness campaigns including an accessible parking campaign from another state:

* ["Think of Me, Keep it Free"](http://coloradodisabilitycouncil.org/thinkofmekeepitfree/) - accessible parking campaign (Colorado)
* ["Don't Mess with Texas"](http://dontmesswithtexas.org/the-campaign/) - anti-litter campaign (Texas)
* ["Click It or Ticket"](http://www.nhtsa.gov/nhtsa/ciot/index.html) – seat belt campaign (National)

### Time

This is not a time sensitive issue.

### GCPD Staff Recommendation

Staff will implement this as time and resources allow and further recommend that this policy proposal be retired.

## 09.04

Change the language in the Transportation Code from “Handicapped Parking” to “Accessible Parking” to align with the spirit of Texas Government Code, Chapter 392, Person First Respectful Language Initiative.

### Impact on Population

Person first language focuses on the individual not the disability. The Committee believes the term “accessible parking” better describes the function of the parking space rather than using the outdated statutory term “handicapped parking.” Using the term accessible parking will serve as a reminder to the public that the parking is intended as an accommodation for people with disabilities. It eliminates generalizations and stereotypes.

### Cost

No known cost.

### Potential for Success

There has not been recent legislation on this proposal.

### Time

This is not a time sensitive issue.

### GCPD Staff Recommendation

Staff recommend retaining this policy proposal with a low priority. Staff recommend changing the word "Disabled Parking" to "Accessible Parking."

## 09.05

Amend [Transportation Code § 681.011 Offenses; Presumption](http://www.statutes.legis.state.tx.us/Docs/TN/htm/TN.681.htm) to permit alternative sentencing which includes:

* required education classes on disability awareness and accessible parking with a reduced fine upon completion of said education;
* community service/restitution requirements at a nonprofit organization that serves persons with disabilities or any other community restitution that may sensitize the violator to the needs and obstacles faced by persons with disabilities; and
* the development of standardized required education classes on disability awareness and accessible parking by the Texas Department of Motor Vehicles to fulfill the requirements of recommendation 9.5(a).

### Impact on Population

Education and sensitivity training may reduce repeat violations.

### Cost

Exact costs are unknown, but there may be costs associated with developing the training and education classes.

### Potential for Success

Example of state that provides alternative sentencing:

* [Washington Rev. Code § 46.19.050(12) Community restitution](http://apps.leg.wa.gov/RCW/default.aspx?cite=46.19.050). For second or subsequent violations of this section, in addition to a monetary penalty, the violator must complete a minimum of forty hours of: (a) Community restitution for a nonprofit organization that serves persons with disabilities or disabling diseases; or (b) Any other community restitution that may sensitize the violator to the needs and obstacles faced by persons with disabilities.

### Time

This is not a time sensitive issue.

### GCPD Staff Recommendation

Staff recommend retaining this recommendation and reserving it for a future transportation subcommittee project to develop a standardized sensitivity training course that may be used by courts for alternative sentencing. GCPD will explore partnerships with other agencies on this goal.

## 09.06

Redefine the van accessible requirements in the Texas Accessibility Standards (TAS) for medical and rehabilitation facilities to significantly increase the number of van accessible spaces.

* Optimal placement shall include a mix of van accessible and accessible spaces for equitable access to the closest accessible path of travel.
* Changes shall be implemented in the manner of the least cost.

Pending approval of this recommendation TDLR shall add an ADVISORY MEMO into the TAS to update this requirement.

### Impact on Population

Hospital Outpatient, Rehabilitation Facility, and Outpatient Physical Therapy Facilities already require between 10-20% more accessible parking spaces due to the nature of business. Angled parking and shared access aisles will assist in making this goal possible.

### Cost

Unknown.

### Potential for Success

There has not been recent legislation on this policy proposal.

### Time

This is not a time sensitive issue.

### GCPD Staff Recommendation

Staff recommend retaining this at a moderate level of priority and be clarified that this shall only implemented with new construction or reconstruction.

## 09.07

Consider expanded statutory authority in Human Resources Code, Title 7, Chapter 115.009 to grant additional authority to the GCPD to:

* provide education, training, and assistance to law enforcement agencies on accessible parking enforcement; and
* work with other state agencies to provide public education and awareness on accessible parking issues and compliance with accessible parking laws.

### Impact on Population

The education function is in keeping with current responsibilities of GCPD.

### Cost

No known cost.

### Potential for Success

There have been no bills filed in recent sessions to address this proposal.

### Time

This is not a time sensitive issue.

### GCPD Staff Recommendation

Staff recommend retiring this policy proposal.

## 09.08

Amend Section 681.0032 of the Texas Transportation Code to include Texas Centers for Independent Living, day habilitation, and senior activity centers or other organizations that provide independent living services.

### Impact on Population

The 27 Texas Centers for Independently Living and other organizations that provide individuals with disabilities accessible transportation are currently unauthorized to obtain and use an accessible parking placard. This creates logistical and safety concerns for individuals with disabilities when a closer space is necessary to fulfill work or personal obligations. This issue has been highlighted over several years with many failed administrative solution attempts.

Organizations that provide accessible transportation for individuals with disabilities to live independently and thrive in their community of choice do not have access to accessible parking placards. The Texas Transportation Code provides for accessible parking placards to:

1. Individuals with a disability (Driver License or Identification Card number required);
2. Individuals who are applying on behalf of an individual with a disability and who regularly assist individuals with a disability (Driver License or Identification Card number of assisting driver required); or
3. The administrator or manager of an institution licensed to transport individuals with a disability defined under Section 681.0032 of the Transportation Code (which is a license for residential facilities).

The current law only allows for a van or bus operated by residential institutions, facilities, and residential retirement communities licensed under the Health and Safety Code where individuals with a disability or seniors live to obtain an accessible parking placard. Current law does not allow Centers for Independent Living or other nonprofits who regularly provide accessible transportation for individuals with a disability to obtain an accessible parking placard so that they may work, thrive, and play in the community independently. It is a third degree felony for non-residential institutions or persons not authorized to use an accessible parking placard.

### Cost

The recommendation may provide a positive fiscal impact to the State of Texas. While accessible parking placards are no cost to individuals with permanent disabilities, individuals with temporary disabilities and institutions may be charged five dollars. Hence, Centers for Independently Living would pay the required accessible parking placard fee. Additionally, individuals with disabilities would more likely be able to receive the necessary supports and services to live independently and out of State-supported institutions (i.e. Diversion).

### Potential for Success

The implementation of this recommendation is feasible. While an amendment of administrative rule or policy may be typically more feasible, amending the necessary transportation statutes and rules may be the most feasible through the Texas Legislature.

Other legislative history and general information regarding accessible parking occurred in the 81st Texas Legislative Session, 2009, with the creation of the Texas Department of Motor Vehicles and include:

* House Bill 400 allows a grace period for a person cited for illegally parking a vehicle with an expired disabled parking placard by obtaining a valid placard within 20 working days or before your first court date to have the citation dismissed House Bill 618 exempts a vehicle with a specialty license plate for recipients of the Air Force Cross or Distinguished Service Cross, the Army Distinguished Service Cross, the Navy Cross, the Medal of Honor, or the Legion of Merit medal from parking fees collected through a meter charged by a governmental authority other than the federal government, when the vehicle is being driven by or for the transportation of the person who registered the vehicle.
* House Bill 965 entitles a veteran to register, for the person's own use, any number of motor vehicles for which the registrant may be issued specialty license plates for disabled veterans and disabled parking placards.
* House Bill 2020 authorizes a vehicle to be parked for an unlimited period in a parking space or area designated for the disabled if the vehicle displays license plates issued by another state of the United States indicating that the owner or operator of the vehicle is a disabled veteran of the United States armed forces.
* House Bill 3095 simplifies enforcement and increases the fines for illegally parking in disabled parking spaces from $250 minimum to $500 maximum, to a minimum of $500 and a maximum of $750. With each offense the fines increase and community service is added.
* House Bill 3593 authorizes a person entitled to license plates for disabled veterans to elect to receive standard license plates at the same cost as the disabled veteran license plates.

### Time

This is not a time sensitive issue.

### GCPD Staff Recommendation

Staff recommend retaining this policy proposal with a moderate to high level priority. Matt will research the language of the policy proposal for ways to prevent unintended fraud.

## 09.09

Transportation Network Companies (TNCs) and the Texas Legislature should further study how public and private driver incentives can lower the cost of owning and operating a WAV to provide expanded access to passengers who use fixed-frame wheelchairs.

### Impact on Population

Since 2010, a number of private TNCs have entered the transportation services market by offering on-demand travel options that use an application on a person’s mobile phone using technology to “order” transportation services, and highly automated private ride service. The most recognized TNCs are Uber and Lyft.

The vehicles used by TNCs are commonly personal cars or sedans owned by the drivers or are leased from the TNC. This transportation service model has several levels of service with different prices, however, there is no option for an accessible vehicle for customers who use fixed-framed wheelchairs.

There are few, if any, Wheelchair Accessible Vehicle (WAV) that can transport customers who use fixed-framed wheelchairs. During the 85th Legislative Session (2017), H.B.100 recommended a study by which the TNCs would develop pilot projects with accessible services in one of the top four cities with the largest market share over a two-year period and report to the Legislature by January 2020. TNCs have expanded rapidly without required accessibility standards. HB 100 removed all local/municipal regulation of TNCs and elevated to state level and the Texas Department of Licensing and Regulation (TDLR).

This has led to complaints of discrimination, such as refusing service based on disability, and a reduction in WAVs, largely because taxi companies that previously were required to provide this service have had their fleets shrink.

### Cost

Unknown.

### Potential for Success

There has not been a bill related to this policy proposal since the 85th session.

### Time

This issue has become exacerbated with the expansion of TNCs.

### GCPD Staff Recommendation

Staff recommend retaining this proposal with one of the highest priorities addressing an unsolved transportation issue.

## 09.10

Amend Texas Transportation Code Sec. 502.061(a) by adding the following health professions as allowable verifiers: Speech Language Pathologist, Occupational Therapists, Audiologists, School Psychologists, and Diagnosticians. Amend Texas Transportation Code Sec. 502.061(b) by removing “The department may not provide to the Department of Public Safety information that shows the type of health condition or disability a person has.”

### Impact on Population

By allowing those professionals to verify an individual’s disability, more people with disabilities will be able to access this program. Striking the sentence from (b) will allow peace officers who pull over a vehicle registered under this program to know the specific type of communication impediment and therefore which are the best strategies to use when communicating with the individuals in the vehicle. Currently, it will only show “communication impediment” which could vary from Deafness to Autism.

This is a systemic issue as it affects everyone enrolled in this program.

### Cost

There are no expected costs to these amendments.

### Potential for Success

* Samuel Allen Law ([SB 976](https://capitol.texas.gov/BillLookup/History.aspx?LegSess=86R&Bill=SB976)) passed in the 86th Session. This established the Driving with Disability program.
* [SB 2304](https://capitol.texas.gov/BillLookup/History.aspx?LegSess=88R&Bill=SB2304), passed in the 88th Session, requires public and open-enrollment charter schools to give information to students with disabilities on this program.

### Time

This is not a time sensitive issue.

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