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A CRS Review of 10 States: Home and Community-Based Services States Seek to Change the Face of Long-Term Care: Texas

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Abstract. The Congressional Research Service undertook a study of ten states in 2002. The research looked at state policies on long-term care as well as trends in both institutional and home and community-based care for persons with disabilities. It included a review of state documents and data on long-term care, as well as national data sources on spending. Interviews were held with state officials. The 10 states included in the study are: Arizona, Florida, Illinois, Indiana, Louisiana, Maine, Oklahoma, Oregon, Pennsylvania, and Texas. This report presents background and analysis about long-term care in Texas. Reports on the other nine states and an overview report will be available during 2003.

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A CRS Review of 10 States: Home and Community-Based Services – States Seek to Change the Face of Long-Term Care: Texas

May 1, 2003

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Home and Community-Based Services – States Seek to Change the Face of Long-Term Care: Texas

Summary

Demographic challenges posed by the growing elderly population and demands for greater public commitment to home and community-based care by persons with disabilities of all ages have drawn the attention of federal and state policymakers for some time. Spending on long-term care by both the public and private sectors is significant. In 2001, spending for long-term care services for persons of all ages represented 12.2% of all personal health care spending (almost \$152 billion of \$1.24 trillion). Federal and state governments accounted for almost two-thirds of all spending. By far, the primary payor for long-term care is the federal-state Medicaid program, which paid for almost half of all long-term care spending in 2001.

Many states have devoted significant efforts to respond to the desire for home and community-based care for persons with disabilities and their families. Nevertheless, financing of nursing home care, chiefly by Medicaid, still dominates most states' spending for long-term care today. To assist Congress understand issues that states face in providing long-term care services, the Congressional Research Service (CRS) undertook a study of 10 states in 2002. This report, one in a series of ten state reports, presents background and analysis about long-term care in Texas.

Ten percent of the Texas population is 65 and older. The state has a large, rapidly growing elderly population, estimated to reach 4.4 million, or 16.1% of the state's total population in 2025. Medicaid spending for long-term care in FY2001 was \$3.3 billion – 28.5% of all Medicaid spending. Medicaid spending for institutions was more than 70% of Medicaid long-term care spending and more than 20% of all Medicaid spending in FY2001. Spending for home and community-based services has increased rapidly in recent years and represented 29.2% of Texas long-term care spending in FY2001, primarily due to increased use of the Medicaid Section 1915(c) home and community based waiver program. From FY1990 to FY2001 spending for this program increased from less than 1% to over 21% of all Medicaid long-term care spending in Texas.

Texas provides a wide range of services in the home and community to about 100,000 adults with disabilities. Despite this, the state has significant overcapacity in its nursing home industry. As a result, the nursing home occupancy rate is quite low – 68.5% in 2000. The state continues to serve many persons with developmental disabilities in large state institutions and has no plans to close any facilities in the foreseeable future.

Interviews with state officials and a review of state reports highlighted a number of issues including: an imbalance in Medicaid financing favoring institutional care, rather than home and community-based care; a shortage of frontline long-term care workers; and waiting lists for home and community-based services.

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Preface

Demographic challenges posed by the growing elderly population and demands for greater public commitment to home and community-based care by persons with disabilities of all ages have drawn the attention of federal and state policymakers for some time. Spending on long-term care by both the public and private sectors is significant. In 2001, spending for long-term care services for persons of all ages represented 12.2% of all personal health care spending (almost \$152 billion of \$1.24 trillion). Federal and state governments accounted for almost two-thirds of all spending. By far, the primary payor for long-term care is the federal-state Medicaid program, which paid for almost half of all U.S. long-term care spending in 2001.

Federal and state Medicaid spending for long-term care was about \$75 billion, representing over one-third of all Medicaid spending, in FY2001. Over 70% of Medicaid long-term care spending was for institutions – nursing homes and intermediate care facilities for the mentally retarded (ICFs/MR). Many believe that the current federal financing system paid through Medicaid is biased toward institutional care. State governments face significant challenges in refocusing care systems, given the structure of current federal financing. Many states have devoted significant efforts to change their long-term care systems to expand home and community-based services for persons with disabilities and their families. Nevertheless, financing of nursing home care – primarily through the Medicaid program – still dominates most states' spending in long-term care today.

While advocates believe that the federal government should play a larger role in providing support for home and community-based care, Congress has not yet reached consensus on whether or how to change current federal policy. Congress may continue an incremental approach to long-term care, without major federal involvement, leaving to state governments the responsibility for developing strategies that support home and community-based care within existing federal funding constraints and program rules.

To help Congress review various policy alternatives and to assist policymakers understand issues that states face in development of long-term care services, the Congressional Research Service (CRS) undertook a study of ten states in 2002. The research was undertaken to look at state policies on long-term care as well as trends in both institutional and home and community-based care for persons with disabilities (the elderly, persons with mental retardation, and other adults with disabilities). The research included a review of state documents and data on long-term care, as well as national data sources on spending. Interviews were held with state officials responsible for long-term care, a wide range of stakeholders and, in some cases, members or staff of state legislatures.

The 10 states included in the study are: Arizona, Florida, Illinois, Indiana, Louisiana, Maine, Oklahoma, Oregon, Pennsylvania, and Texas. States were chosen according to a number of variables, including geographic distribution, demographic trends, and approaches to financing, administration and delivery of long-term care services.

This report presents background and analysis about long-term care in Texas. Reports on the other nine states and an overview report will be available during 2003.

Home and Community-Based Services – States Seek to Change the Face of Long-Term Care: Texas

Introduction: Federal Legislative Perspective

States choosing to modify their programs for long-term care face significant challenges. Financing of nursing home care has dominated long-term care spending for decades. The federal financing structure that created incentives to support institutional care reaches back to 1965. A number of converging factors have supported reliance on nursing home spending. Prior to enactment of Medicaid, homes for the aged and other public institutions were

The Social Security Amendments of 1965, which created the Medicaid program, required states to provide skilled nursing facility services under their state Medicaid plans, and gave nursing home care the same level of priority as hospital and physician services.

“Section 1902 (a) A State plan for medical assistance must provide for inclusion of some institutional and some noninstitutional care and services, and, effective July 1, 1967, provide (A) for inclusion of at least . . . (1) inpatient hospital services . . . ; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing home services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older; (5) physicians’ services” P.L. 89-97, July 30, 1965.

financed by a combination of direct payments made by individuals with their Social Security Old Age Assistance (OAA) benefits, and vendor payments made by states with federal matching payments on behalf of individuals. The Kerr-Mills Medical Assistance to the Aged (MAA) program, enacted in 1960, a predecessor to Medicaid, allowed states to provide medical services, including skilled nursing home services, to persons who were not eligible for OAA cash payments, thereby expanding the eligible population.¹

In 1965, when Kerr-Mills was transformed into the federal-state Medicaid program, Congress created an *entitlement* to skilled nursing facility care under the expanded program. The Social Security Amendments of 1965 required that states provide skilled nursing facility services and gave nursing home care the same level of priority as hospital and physician services. Amendments in 1967 allowed states to provide care in “intermediate care facilities” (ICFs) for persons who did not need skilled nursing home care, but needed more than room and board. In 1987, Congress eliminated the distinction between skilled nursing facilities and intermediate care

¹CRS Report 83-181, *Nursing Home Legislation: Issues and Policies*, by Maureen Baltay.

facilities (effective in 1990). As a result of these various amendments, people eligible under the state's Medicaid plan are *entitled* to nursing home facility care; that is, if a person meets the state's income and asset requirements, as well as the state's functional eligibility requirements for entry into a nursing home, he or she is entitled to the benefit.

These early legislative developments were the basis for the beginnings of the modern day nursing home industry. Significant growth in the number of nursing homes occurred during the 1960s – from 1960 to 1970, the number of homes more than doubled, from 9,582 to almost 23,000, and the number of beds more than tripled, from 331,000 to more than one million.² (Today there are about 17,000 nursing homes with 1.8 million beds.³)

During the latter part of the 1960s and the 1970s, nursing home care attracted a great deal of congressional oversight as a result of concern about increasing federal expenditures, and a pattern of instances of fraud and abuse that was becoming evident. Between 1969 and 1976, Senator Frank Moss, then-Chairman of the Subcommittee on Long-Term Care of the Senate Special Committee on Aging, held 30 hearings on problems in the nursing home industry.⁴

Since its inception, Medicaid has been the predominant payor for nursing home care. In 1970, over \$1 billion was spent on nursing home care through Medicaid and Medicare. Federal and state Medicaid payments accounted for almost all of this spending – 87%. Medicaid spending for nursing home care grew by 50% in the three-year period beginning in 1967.

In FY2001, Medicaid spent \$53.1 billion on institutional care (for nursing homes and care in intermediate care facilities for the mentally retarded).

Home care services received some congressional attention in the authorizing statute – home health care services were one of the optional services that states could provide under the 1965 law. Three years later in 1968, Congress amended the law to require states to provide home health care services to persons entitled to skilled nursing facility care as part of their state Medicaid plans (effective in 1970). During the 1970s, the Department of Health, Education and Welfare (now Health and Human Services, DHHS) devoted attention to “alternatives to nursing home care” through a variety of federal research and demonstration efforts. These efforts were undertaken not only to find ways to offset the high costs of nursing facility care, but

²U.S. Congress, Senate Special Committee on Aging, *Developments in Aging, 1970*, Report 92-46, Feb. 16, 1970, Washington, cited from the *American Nursing Home Association Fact Book, 1969-1970*.

³American Health Care Association, *Facts and Trends 2001, The Nursing Facility Sourcebook*, 2001, Washington. The number of nursing homes is for 1999-2000 and number of beds is for 1998. (Hereafter referred to as American Health Care Association. *The Nursing Facility Sourcebook*.)

⁴U.S. Congress, Senate Special Committee on Aging, *Nursing Home Care in the United States: Failure of Public Policy*, Washington, 1974, and supporting papers published in succeeding years.

also to respond to the desires of persons with disabilities to remain in their homes and in community settings, rather than in institutions. However, it was not until 1981 that Congress took significant legislative action to expand home and community-based services through Medicaid when it authorized the Medicaid Section 1915(c) home and community-based waiver program.

Under that authority (known then as the Section 2176 waiver program), the Secretary of DHHS may waive certain Medicaid state plan requirements to allow states to cover a wide range of home and community-based services to persons who otherwise meet the state's eligibility requirements for institutional care. The waiver provision was designed to alter the bias in the Medicaid program that favored institutional care over care in home and community-based settings. Services include: case management, personal care, homemaker, home health aide, adult day care, habilitation, environmental modifications, among many others.⁵ These services are covered as an *option* of states, and under the law, persons are not entitled to these services as they are to nursing facility care. Moreover, states are allowed to set cost caps and limits on the numbers and types of persons to be served under their waiver programs.

Notwithstanding wide use of the Section 1915(c) waiver authority by states over the last two decades, total spending for Medicaid home and community-based services waivers is significantly less than institutional care – about \$14.4 billion in 2001, compared to \$53.1 billion for nursing facility care services and care for persons with mental retardation in intermediate care facilities (ICFs/MR). Despite this disparity in spending, in many states the Section 1915(c) waiver program is the primary source of financial support for a wide range of home and community-based services, and funding has been increasing steadily. Federal and state Medicaid support for the waiver programs increased by over 807% from FY1990 to FY2001 (in constant 2001 dollars).

The home and community-based waiver program has been a significant source of support to care for persons with mental retardation and developmental disabilities as states have closed large state institutions for these persons over the last two decades. Nationally, in FY2001, almost 75% of Section 1915(c) waiver funding was devoted to providing services to these persons.

States administer their long-term care programs against this backdrop of federal legislative initiatives – first, the *entitlement* to nursing home care, and requirement to provide home health services to persons entitled to nursing home care, and, second, the *option* to provide a wide range of home and community-based services

⁵States may waive the following Medicaid requirements: (1) statewideness – states may cover services in only a portion of the state, rather than in all geographic jurisdictions; (2) comparability of services – states may cover state-selected groups of persons, rather than all persons otherwise eligible; and (3) financial eligibility requirements – states may use more liberal income requirements for persons needing home and community-based waiver services than would otherwise apply to persons living in the community. For further information, see CRS Report RL31163, *Long-Term Care: A Profile of Medicaid 1915(c) Home and Community-based Services Waivers*, by Carol O'Shaughnessy and Rachel Kelly.

through waiver of federal law, within state-defined eligibility requirements, service availability, and limits on numbers of persons served.

A CRS Review of Ten States: Report on Texas

Summary Overview⁶

Overview

- Long-term care issues for the elderly and persons with disabilities have been a challenge for Texas policymakers for some time. Institutional spending dominates public long-term care financing and the Texas population is rapidly aging. Among the state's responses to these challenges are efforts to expand home and community services over time, integrate delivery of these services, and develop a comprehensive response to the Supreme Court's decision in *Olmstead v. L.C.*⁷
- In September 1999, then-Governor George W. Bush issued an executive order requiring the Texas Health and Human Services Commission (HHSC) to review all services and supports available to persons with disabilities in Texas and make recommendations for improvement to them.⁸ The Commissioner appointed a 12-member advisory board to help the state formulate its plan which resulted in a blueprint that the state has been following to improve its long-term care system for persons with disabilities.

Demographic Trends

- Texas is a large state with a relatively young population; persons aged 65 and over represent about 10% of the population. However, the state has a large, rapidly growing elderly population, estimated to reach 4.4 million in 2025.
- Persons aged 85 and over with two or more limitations in activities of daily living (ADLs) are estimated to increase 31% by 2010 to a total of 31,270. The number of persons aged 18 to 64 with the same level of disability will increase by 10.7%, reaching 60,290 in that year.

⁶Information based on Texas data and documents, national data, and interviews with state officials. This report does not discuss programs for persons with mental illness. It also generally excludes discussion of programs for infants and children with disabilities, other than those serving persons with mental retardation and developmental disabilities.

⁷The Supreme Court ruled in *Olmstead v. L.C.* that Title II of the Americans with Disabilities Act (ADA) requires states to transfer individuals with mental disabilities into community settings, rather than remaining in institutions, when a state treatment professional has determined the appropriateness of such an environment, the community placement is not opposed by the individual with a disability, and the placement can be reasonably accommodated.

⁸Texas Health and Human Services Commission, *Texas Promoting Independence Plan, In Response to Executive Order GWB99-2 and the Olmstead Decision*, Jan. 9, 2001, Austin Texas.

Administration of Long-Term Care Program

- Texas has four major state-level departments that administer home and community services to persons with disabilities and operate under the umbrella of the HHSC. Over time, Texas has struggled with coordinating the activities of these departments and has created several innovative programs to attempt to integrate their activities at the state and local levels.

Trends in Institutional Care

- Texas has a large number of nursing home beds; the occupancy rate is quite low – 68.5% in 2000. This implies that the state has significant excess capacity in its nursing home industry. The supply of licensed assisted living facility beds has grown from 21,628 in 1997 to 40,259 in 2001. Like nursing homes, the occupancy rate in assisted living facilities is also quite low – only 59% in 2001.
- Unlike many other states, Texas has not eliminated many of its large state facilities for persons with developmental disabilities. The state closed two of its 15 facilities in 1996; the remainder, some of which began operation in the 1960s, remain open. The state has no plans to close any facilities in the foreseeable future. Persons living in large institutions with 16 or more residents declined from 74.6% of all persons living in group residences in 1990 to 57.7% in 2000. Nevertheless, Texas retains a relatively large proportion of persons with developmental disabilities in institutions compared to many states, ranking 48th in the Nation in its use of smaller community facilities.

Trends in Home and Community-Based Care

- Texas supports a wide range of services for older and younger adults with physical disabilities through its: Medicaid personal care and day activity and health services programs; a Medicaid Section 1915(c) home and community-based services waiver for adults with disabilities (excluding persons with developmental disabilities); and eight small programs funded by state funds and federal Social Service Block Grant (Title XX of the Social Security Act) funds.
- Texas has three Medicaid Section 1915(c) home and community-based services waivers for persons with developmental disabilities. The largest waiver– the Home and Community-Based Waiver – served 6,731 people of any age with a diagnosis of mental retardation at a cost of \$263 million in SFY2002. The waiver offers a wide range of services including home modifications, group residential options, case management habilitation, nursing, therapies, and supported employment. No state-funded programs are specifically designed to serve persons with developmental disabilities, other than mental retardation.

Long-Term Care Spending

- Spending for nursing home care decreased as a percentage of Medicaid long-term care spending from 55.2% in FY1990 to 48.8% in FY2001. During the same period, the portion spent on (intermediate care facilities for the mentally retarded (ICFs/MR)) decreased from 34.4% to 22%. While the proportion of Medicaid long-term care funds spent on institutional care decreased during the 1990s, there was a slow but steady increase in the spending for home and community-based services, primarily due to increased spending on the Medicaid Section 1915(c) home and community-based waiver program. However, less than one of every three Medicaid dollars spent on long-term care in Texas is for home and community-based services.
- Almost half of waiver spending in Texas is devoted to the aged and disabled populations; waiver spending for persons with developmental disabilities accounted for almost 40% of spending in FY2001, with the remainder for other populations with disabilities. (In many other states, funding for waiver programs for persons with developmental disabilities account for the largest portion of waiver spending.)

Issues in Financing and Delivery of Long-Term Care

- Among the challenges Texas faces are an institutional bias in financing long-term care services; a crisis in nursing home liability insurance; large waiting lists for community services; need for increased access to housing with services the community; and a long-term care labor shortage.
- There has been pressure from consumers for expanded opportunities to direct the course of their own care. As a result, Texas sought and received approval from the Centers for Medicare and Medicaid Services (CMS) to provide consumer-directed services in all home and community-based programs; in 2003, more than 100,000 Medicaid beneficiaries may be eligible to direct their personal attendant and respite care services.

Demographic Trends

Texas was the second most populous state in the country in 2000 with a population of 20.9 million. It also is one of the younger states. Its population aged 65 and older – 2.1 million persons in 2000 – represents only 9.9% of its total population ranking it 47th in the Nation. (**Table 1**).

Despite being a young state, Texas has a large population of older persons that is growing rapidly. From 1990 to 2000, the state's elderly population grew by 20.7%, and those most in need of long-term care – the population age 85 and older – grew by 42.8%. (**Table 1**).

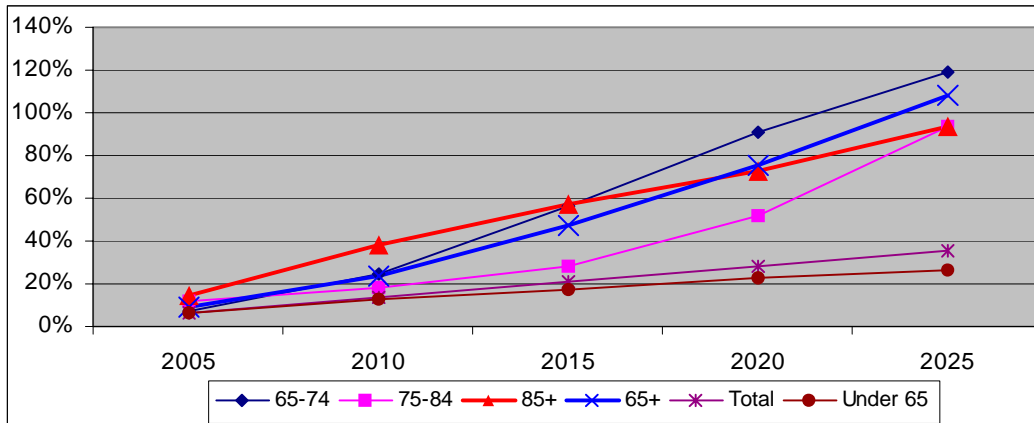
Table 1. Texas Population Age 65 and Older, 1990 and 2000

Age	1990		2000		Percent change, 1990-2000	2000 population rank in U.S. (based on percent)
	Number	Percent of total population	Number	Percent of total population		
65+	1,716,576	10.1	2,072,532	9.9	20.7	47
65-74	998,239	5.9	1,142,608	5.5	14.5	47
75-84	551,732	3.2	691,984	3.3	25.4	47
85+	166,605	1	237,940	1.1	42.8	46
Under 65	15,269,934	89.9	18,779,288	90.1	23	5
Total	16,986,510	100	20,851,820	100	22.8	2

Source: U.S. Census Bureau. Profile of General Demographics for Texas: 1990. 2000: [http://www.census.gov/census2000/states/tx.html]. Percentages may not sum to 100% due to rounding.

Texas, along with the rest of the country, will experience large increases in its older population over the next 25 years. By 2025, its elderly population will increase by 107.8% (See **Figure 1**). In 2025, 16.1% of the Texas population will be aged 65 years or older, compared to 18.5% for the Nation (**Table 2**). While older persons will represent a smaller proportion of the Texas total population compared to the United States as a whole in 2025, Texas will have to address the long-term care needs of 4.4 million elderly then, nearly 500,000 of whom will be aged 85 or older.

Figure 1. Percentage Increase Over 2000 Population in Texas, 2005-2025



Source: CRS calculations based on data from the U.S. Census Bureau. Projections: [http://www.census.gov/population/www/projections/st_yrby5.html]; analyzed data from State Populations Projections: Every Fifth Year.

Table 2. Elderly Population as a Percent of Total Population, Texas and the United States, 2025

Age	Proportion of total population in Texas	Proportion of total population in United States
65+	16.1%	18.5%
65-74	9.3%	10.5%
75-84	5.0%	5.8%
85+	1.7%	2.2%
Under 65 population	83.9%	81.5%

Source: CRS calculations based on data from the U.S. Census Bureau. Projections: [http://www.census.gov/population/www/projections/st_yrby5.html]; analyzed data from State Populations Projections: Every Fifth Year. See **Appendix 3** for information on projection assumptions.

Need for Long-Term Care

Table 3 presents estimates of the number of persons aged 18 and over in Texas who have limitations in two or more activities of daily living (ADLs) and thus may need long-term care services. These estimates were derived from data generated by The Lewin Group, Inc., and combine national level data on persons with disabilities with state-level data from the U.S. Census Bureau on age, income, and broad measures of disability.

Persons aged 85 and over with two or more limitations in ADLs are estimated to increase 31% by 2010 to a total of 31,270; the number of persons aged 18 to 64 with the same level of disability will increase by almost 11% reaching 60,290. Growth in the number of adults of all ages with disabilities will place pressure on public and private long-term care resources.

Table 3. Estimated Number of Persons with Two or More Limitations in Activities of Daily Living (ADLs), By Poverty Status, in Texas

	2002			2005			2010		
Percent of Poverty	Persons with 2+ ADLs by age and income								
	18-64	65+	85+	18-64	65+	85+	18-64	65+	85+
Up to 100%	15983	20316	6089	16672	21643	6618	17689	24618	7982
Up to 150%	24175	39610	10938	25215	42175	11887	26758	47827	14339
Up to 200%	30743	52271	14222	32064	55651	15456	34030	63071	18644
All income	54470	93257	23853	56812	99260	25923	60290	112211	31270

Source: CRS analysis based on projections generated by The Lewin Group, Inc., through the HCBS State-by-State Population Tool available on-line from: [<http://www.lewin.com/cltc>]. *The Lewin Group Center on Long-Term Care HCBS Population Tool*, by Lisa M.B. Alexih, and Ryan Foreman.

Administration of Long-Term Care Programs

State and Local Administration

Texas has four major departments that administer institutional and home and community services to persons with disabilities, which now operate under the umbrella of the Texas Health and Human Services Commission (HHSC). Over time, Texas has struggled with coordinating the activities of these departments and has created several innovative programs to attempt to integrate their activities at the state and local levels.

The Texas Health and Human Services Commission (HHSC) oversees the activities of the Texas Department of Human Services, Texas Department of Mental Health and Mental Retardation, Texas Department on Aging, Texas Rehabilitation Commission, and other human service agencies. The Health and Human Services Commission is also the single state agency for Medicaid and operates the program through memoranda of understanding with its subordinate departments.

Each of the state agencies under the HHSC umbrella has a citizens' oversight board appointed by the Governor and an agency head (commissioner or executive director) who reports to the HHSC commissioner. The citizen boards provide input into a department's operations through approval of agency rules.

The Texas Department of Human Services (DHS) has an Assistant Deputy Commissioner for Long-Term Care who oversees client eligibility for services, program policies, community care (i.e., most home and community services), and education. The program policy unit regulates nursing facilities, intermediate care facilities for the mentally retarded (ICFs/MR), and hospices.

Ten regional offices carry out most of DHS' work through administration of a number of programs, collectively called Community Care. These programs provide home and community services to a wide range of people with disabilities. The 10 regional offices determine functional and financial eligibility as well as provide case management for the majority of Community Care programs. The Department contracts out functional assessment and case management for two Medicaid Section 1915(c) home and community-based services waivers that serve persons with developmental disabilities.

The Texas Department of Mental Health and Mental Retardation (TDMHMR) confines its services for persons with developmental disabilities to those with mental retardation; services for those with other types of developmental disabilities remain with DHS. TDMHMR has local authorities in each county in the state that provide services to persons with mental retardation directly, or through a network of local providers. These traditional local authorities do functional assessment and case management.

In eight regions of Texas, TDMHMR has implemented a new design for the local authorities. Under this model, local authorities are the single entry point for services; they assess the need for services and perform case management that

incorporates person-directed planning to support the participant in decision-making regarding their services. These local authorities provide quality assurance, they do not provide services.

The *Texas Department on Aging (TDOA)* administers the Older Americans Act program which supports nutrition services, family caregiver support services, information and referral, in-home and respite services, and the nursing home ombudsman program, among others. Twenty-eight area agencies on aging administer the Older Americans Act services. In 1999, the legislature proposed merging TDOA with the other long-term care units in DHS; this step toward integration was delayed until 2006 due to concerns expressed by some advocacy groups.

The *Texas Rehabilitation Commission (TRC)* administers vocational rehabilitation programs and funds ten Independent Living Centers, which served 21 counties and 3,260 people in 1999.⁹ The Commission also operates a Comprehensive Rehabilitation Services program for people with traumatic brain or spinal cord injuries; the program served 489 people in FY1999.¹⁰

Integration and Coordination Efforts

Texas has undertaken four major efforts to integrate and coordinate health and long-term care services at the state and local levels. In 1991, the Health and Human Services Commission (HHSC) was created to oversee the state's health and human services departments. Until recently, the Commission had to rely primarily on coordination efforts to persuade the departments to work together at the state and local levels, the Commission acquired the power to transfer funds among the departments and thus now has more tools to ensure coordination of departmental activities.

In 1987, legislation established the Community Resource Coordination Groups (CRCGs) of Texas. This county-based interagency forum coordinates health, long-term care, and social services for persons needing services from more than one state agency. In 2001, legislation expanded the CRCG program to adults (prior to that time only children were covered). Seventeen state-level agencies under the purview of the HHSC have signed a memorandum of understanding to support the development of CRCGs around the state. The state has a CRCG team for adults, and another for children, which oversee the development of the county units. According to state officials, all 254 Texas counties have units devoted to children, and 95 counties have units for adults.

In yet another coordination effort, the 76th Texas Legislature permitted communities to submit local access plans for long-term care services and required the state to support these efforts. The plans describe barriers to access to services and request assistance from HHSC in surmounting those barriers. Only about 23

⁹Texas Council on Developmental Disabilities and Texas Office for Prevention of Developmental Disabilities, *Texas Services Supplement to 2000 Biennial Report*. Hereafter referred to as *Texas Services Supplement to 2000 Biennial Report*.

¹⁰*Texas Services Supplement to 2000 Biennial Report*.

communities had submitted plans by August 2000, and one-third of these communities were aggressively pursuing local access systems. The legislature did not appropriate any funding to support these planning efforts, but the HHSC and TDOA received a \$1.4 million Real Choice Systems Change Grant from the U.S. Department of Health and Human Services to assist with these efforts in SFY2003.¹¹ The Texas grant, entitled *Texas Real Choice Grant: Creating a More Accessible System for Real Choices in Long-Term Care Services* is designed to test the concept of a “systems navigator program,” which is intended to help people of all ages with disabilities avoid institutionalization. Two communities have been selected to evaluate the program’s effectiveness in diverting people from institutions or transitioning them from institutions into the community. Future plans are dependent upon the results of the evaluation.

One of Texas’ most ambitious integration efforts is development of a small “consolidated Medicaid waiver” project in Bexar County. The project is intended to merge Medicaid Section 1915(c) home and community-based services waivers for adults and children with disabilities that are ordinarily separately administered. Taking this step allows for one set of providers, one comprehensive service array, one consistent set of rates, and one administrative agency. This project serves 100 individuals who qualify for nursing facility care (50 adults and 50 children) and 100 individuals who qualify for ICFs/MR care (50 adults and 50 children), regardless of age or type of disability.

Another innovative project is the development of a single assessment instrument that could be used in all long-term care programs, with an emphasis on predicting resource (service or dollar) use. The Texas Instrument of Functional Assessment (TIFA) may be used for broad budget prediction/planning purposes, or at the program level to determine eligibility for a program or to set limits on individual resource use. The TIFA is currently being administered to over 6,000 persons receiving publicly-funded long-term care services to determine if there is a correlation between the TIFA and service utilization. Final results are expected by January 2004.

¹¹ Texas Health and Human Services Commission, *Enhancing Community Access for Long-Term Care*, Progress Update on SB374, Aug. 11, 2000.
[www.hcbs.org/compendium/web/texas_rc.htm] (accessed on Apr. 3, 2003)

Texas Long-Term Care Services for the Elderly and Persons with Disabilities

Trends in Institutional Care

Since 1997, the number of nursing home beds and facilities in Texas has been steadily declining.¹² By 2000, Texas had 1,251 nursing facilities with 127,525 beds, with an occupancy rate of 68.5% in 2000 (**Table 4**). At 61.5 beds per 1,000 older Texans aged 65 and older, the state's rate is higher than the national rate of 52.7. The ratio of 536 beds per 1,000 persons aged 85 and over is much higher than the national average of 434.8 per 1,000. The low occupancy rate combined with the high ratio of nursing home beds to older persons implies that the state has significant excess capacity in its nursing home industry.

While the nursing home supply has dropped over the last several years, the supply of licensed assisted living facilities has grown from 794 in 1997 to 1,298 in 2001. During the same time period the number of licensed beds almost doubled from 21,628 to 40,259.¹³ Significant excess capacity exists among assisted living facilities as well; the occupancy rate in these facilities was only 59% in 2001.¹⁴ The state does not control the supply of assisted living facility beds.

Table 4. Nursing Home Characteristics in Texas and the United States

(data are for 1999-2000)

Characteristic	Texas	United States
Number of facilities	1,251	170,023
Number of residents	87,299	1,490,155
Number of beds	127,525	1,843,522
Number of Medicaid beds	34,768	841,458
Number of beds per 1,000 pop aged 65 and older	61.5	52.7
Number of beds per 1,000 pop aged 75 and older	137.1	111.1
Number of beds per 1,000 pop aged 85 and older	536.0	434.8
Occupancy rate	68.5%	80.8%

Source: American Health Care Association, Facts and Trends: The Nursing Facility Source book. *For the U.S.*, Ibid., American Health Care Association.

As in most states, a large portion of Medicaid long-term care spending in Texas is devoted to nursing home care. In FY2001, of total long-term care spending under Medicaid (\$3.3 billion), 48.8% was spent on care in nursing homes. Texas state

¹² Texas Department of Human Services, *FY2001 Long Term Care Regulatory Annual Report*, Oct. 2001. Hereafter referred to as *FY2001 Long Term Care Regulatory Annual Report*, Oct. 2001.

¹³ *FY2001 Long Term Care Regulatory Annual Report*, Oct. 2001.

¹⁴ *FY2001 Long Term Care Regulatory Annual Report*, Oct. 2001.

officials generally believe that Medicaid's financial incentives help promote an institutional bias in the program.

Trends in Home and Community-Based Care

Texas supports a relatively wide range of home and community-based services for adults with physical disabilities. These include two Medicaid state plan services provided at the option of the state – personal care and adult day care; one Medicaid Section 1915(c) home and community-based waiver program; and eight small programs funded by state and Social Service Block Grant (SSBG) funds authorized under Title XX of the Social Security Act.

Texas employs two features that make its financial eligibility standards for home care services provided *under its state Medicaid plan* different from those used by other states. The first is its use of a Special Income Rule to determine eligibility for home care services. In the early 1980s, the state received approval from the U.S. Department of Health and Human Services (DHHS) to conduct a Section 1115 demonstration project¹⁵ designed to eliminate custodial care in nursing homes and to serve people needing that level of care in the community. Under the demonstration, Texas was allowed to use a Special Income Rule, known as the “300% rule” when determining eligibility for a Medicaid state plan service known as *Primary Home Care*. Under the rule, persons may have income up to 300% of the federal SSI level and qualify for Medicaid. Ordinarily, states are allowed to use this more liberal income standard to determine financial eligibility *only* for institutional care, or for Section 1915(c) home and community-based waiver services. States are not allowed to use the 300% rule for Medicaid *state plan services*. Since Texas does not have a medically needy program (which allows persons with high medical expenses to deplete their income and then establish Medicaid eligibility), the use of the 300% rule for home care in Texas was intended to establish a more liberal standard for home care *only*. When the Texas demonstration project ended, Congress amended the Medicaid statute¹⁶ to allow Texas to continue to use the more liberal 300% rule to determine eligibility for home care services offered under the state Medicaid plan, thus creating eligibility for home care for persons who have higher income than would otherwise be eligible.

In addition to its use of the 300% Special Income rule, Texas allows persons who qualify for nursing home care and whose income exceeds 300% of the SSI level to place income into special trusts, called “Miller trusts,” and still qualify for Medicaid coverage. Medicaid law requires states that use only the 300% rule (and

¹⁵Section 1115 of the Social Security Act allows the Secretary of the Department of Health and Human Services (DHHS) to conduct research and demonstration programs authorized under the Social Security Act, including Medicaid. Under this authority, states may experiment with different approaches to the delivery of health and long-term care services than are otherwise permitted under Medicaid.

¹⁶Section 1929(b)(2) of the Medicaid statute. There is no expiration date for this provision.

do not have a medically needy program) to allow applicants to place income in excess of that level in trusts to receive Medicaid coverage.¹⁷

Personal Care and Adult Day Care. The largest home and community-based program in Texas is the personal care service, called *Primary Home Care*, which is offered as an optional Medicaid state plan service. About 76,000 persons were served in SFY2002 at a cost of \$511.4 million.¹⁸ The program finances personal care, homemaker, and medical escort services. As discussed above, persons may have income up to 300% of the Supplemental Security Income (SSI) eligibility level (\$1,656/month in 2003 for an individual) under the Special Income Rule. In addition, they must meet SSI's assets limit of \$2,000 (for an individual).¹⁹ The program is available to people of any age with limitations in at least one personal care task. Care is capped at 50 hours per week.

Texas' adult day care program – *Medicaid Day Activity and Health Services* – is covered under rehabilitation services which are offered as an optional Medicaid state plan service. This program covers nursing and personal care, physical rehabilitation, meals, transportation, and social activities during the day, Monday through Friday in adult day care centers. The service is available to people of any age who have a medical diagnosis and who need assistance with at least one personal care task. Participants must have countable incomes at or below 100% of the SSI benefit level (\$552 per month for an individual in 2003) and have assets no greater than \$2,000 for an individual. The program served 14,960 participants in SFY2002; the service cost \$79 million.²⁰ Individuals can receive care up to five days a week.

Medicaid 1915(c) Waiver. The only major Medicaid Section 1915(c) waiver designed to serve the adult population with physical (non-developmental) disabilities is the Community-Based Alternatives (CBA) waiver. This waiver provides a wide range of services including personal assistance, adult foster care, assisted living, nursing, therapies, and respite care.²¹ Participants must need a nursing facility level of care, and their care costs cannot exceed 100% of their Texas Index for Level of Effort (TILE)²² rate (i.e., 100% of what their costs would have been in a nursing

¹⁷Medicaid statute requires that, after the person's death, the state must become the beneficiary of the trust. The statute also requires that the estates of persons who benefit from certain Medicaid services, including home and community-based long-term care services, are subject to recovery by the state after their death. However, Texas has not complied with these federal requirements. As of May 2003, the Texas legislature was considering a bill that would include estate recovery provisions, however.

¹⁸Personal communication with staff from the Budget Division of Texas Department of Human Services, Jan. 10, 2003. Primary Home Care serves children as well as adults. As of Dec. 31, 2002, the program served 87,768 consumers age 18 & over.

¹⁹Certain items are excluded, such as an individual's home; up to \$2,000 of household goods and personal effects; life insurance policies with a face value of \$1,500 or less; an automobile with value up to \$4,500; and burial funds up to \$1,500, among other things.

²⁰Personal communication with staff from the Budget Division of Texas Department of Human Services, Jan. 10, 2003.

²¹ For a full list of services under each of the waivers, see **Appendix Table 1**.

²²TILE – Texas Index for Level of Effort. TILE is Texas' version of a nursing home (continued...)

facility). A participant's countable income cannot exceed 221% of the federal poverty level and financial resources cannot exceed \$2,000. This waiver served 41,128 participants in SFY2002 at a cost of \$397 million.²³ For more detailed information on this and other programs, see **Appendix 1**.

State Programs. There are a number of pathways that establish Medicaid eligibility for home and community-based long-term care services. These include coverage of persons whose income does not exceed 300% of the federal SSI payment level (\$1,656 a month for an individual in 2003) and whose financial resources do not exceed \$2,000 for an individual, as allowed under the Section 1915(c) waiver program. Many people may need community care but cannot meet Medicaid's income limits or resource tests. One of the issues many states have confronted is how to serve these people. Texas has addressed this issue in part through its seven programs which receive state general revenues and SSBG funds. The eighth program – In-Home and Family Support – is strictly general revenue-funded. Regional DHS offices manage these programs as part of the Community Care program.

Family Care, the largest state-funded program provides personal care, homemaker services and medical escort services to people with monthly incomes at or below \$1,656 for an individual (300% of the SSI benefit level) and financial assets that do not exceed \$5,000. The program served 8,460 participants a month in SFY2002 at an annual cost of \$46.5 million. The program is available statewide and is limited to 50 hours of care a week. Its benefit structure is similar to that of the Primary Home Care Program.

In-Home and Family Support, is the second largest state program; it serves persons aged 4 or older who have a physical disability limiting their functional independence. The program provides direct grants to participants or their families that can be used for attendant, home health, or chore services or equipment and home modifications. The program served 4,730 participants a month at an annual cost of almost \$9 million in SFY2002.²⁴ This program is available statewide and has no means test although co-payments start at 105% of the state median income adjusted for household size.

The six other state-funded programs²⁵ each serve fewer than 1,000 persons a month. Funding for all amounted to about \$20 million in SFY2002.²⁶ Each program provides a narrow range of services; two of the programs focus on group residential

(...continued)

payment system designed to relate payment to the disability level of the resident.

²³Personal communication with staff from the Budget Division of Texas Department of Human Services, Jan. 10, 2003.

²⁴Ibid.

²⁵Residential Care, Adult Foster Care, Consumer-Managed Personal Assistance Services, Respite Care, and Special Services to Persons with Disabilities and 24-Hour Attendant Care, Day Activity and Health Services.

²⁶Personal communication with staff from the Budget Division of Texas Department of Human Services, Jan. 10, 2003.

care; two on consumer-directed services; one on respite care; and one on day activity and health services.

Texas Long-Term Care Services for Persons with Mental Retardation and Developmental Disabilities

Services to persons with mental retardation and other developmental disabilities in the United States changed dramatically over the last half of the 20th century as a result of a number of converging factors. These include the advocacy efforts of families and organized constituency groups, various changes to the Social Security law that provided payments to individuals through SSI and SSDI and to service providers through the Medicaid program, and significant litigation brought on behalf of persons with mental retardation.²⁷

Trends in Institutional Care

The early history of services to persons with mental retardation is characterized by the development of large state institutions or training schools begun during the latter part of the 19th century and continuing through the first part of the 20th century. Between 1920 and 1967, institutions quadrupled in size and peaked at almost 200,000 individuals nationwide in 165 free-standing, state-operated mental retardation institutional facilities.²⁸ Today, some states are still faced with the legacy of large state-operated institutions.

Texas, unlike some other states, has not eliminated many of its large state facilities for persons with developmental disabilities. The state closed two of its 15 facilities in 1996; the remainder, some of which began operation in the 1960s still operate. The Austin State School opened in 1917 and still had an average daily census of 437 in 2001; another, the Mexia State School opened in 1946 and had a census of 551 in 2001. (See **Appendix 3** for a list of the institutions that have been closed and those in operation and their 2000 census.)

Part of the reason for the existence of these facilities is the severity of residents' disabilities. Seventy-seven percent of residents of the state's large state facilities for persons with mental retardation and development disabilities have severe or profound mental retardation and 48% of residents also have a mental health diagnosis.²⁹ These

²⁷For a detailed history of the development of services for persons with developmental disabilities, see *The State of the States in Developmental Disabilities* by David Braddock, Richard Hemp, Susan Parish, and James Westrich. University of Illinois at Chicago. American Association on Mental Retardation, Washington, 1998. (Hereafter cited as Braddock, *The State of the States in Developmental Disabilities*.)

²⁸Braddock, *The State of the States in Developmental Disabilities*.

²⁹Texas Department of Mental Health and Mental Retardation, *The Strategic Plan for Fiscal Years 2003-2007*, draft dated 4/25/02. Austin Texas. (Hereafter referred to as Texas Department of Mental Health and Mental Retardation, *The Strategic Plan*).

percentages are about the same as in the U.S. as a whole.³⁰ The state has no plans to close any facilities in the foreseeable future.³¹ Stakeholders and state officials asserted in interviews that parents of persons residing in state schools have been effective in keeping institutions open for their children.

Of the 1500 buildings that TDMHMR operates on 22 campuses, 95% have surpassed their depreciable lives and the costs of upkeep have risen over time.³² For SFY2002, the legislature authorized \$3.3 million for maintenance of these facilities; for SFY2003, the authorization is \$2 million, with an additional \$35 million available from bond sales.

Despite its reliance on institutional care, in SFY2000, TDMHMR only spent about 32% of its service budget on institutions³³ compared to 65% in SFY1989.³⁴ This has resulted, in part, from an initiative called Promoting Independence, the state's response to the Supreme Court's decision in *Olmstead v. L.C.*

Persons living in large institutions with 16 or more residents declined from 74.6% of all persons living in group residences in 1990 to 57.7% in 2000 (**Table 5**). The proportion of persons residing in smaller facilities increased over the decade. Nevertheless, in 2000, Texas ranked 48th in the Nation in its use of smaller facilities (based on the percent of individuals in residences of six or fewer persons).³⁵

³⁰Ibid., *The State of the States in Developmental Disabilities*.

³¹Ibid., Texas Department of Mental Health and Mental Retardation, *The Strategic Plan*.

³²Ibid., Texas Department of Mental Health and Mental Retardation, *The Strategic Plan*.

³³Institution in this case is limited to state schools and state hospitals.

³⁴Texas Health and Human Services Commission, Texas Promoting Independence Plan, Jan. 9, 2001 and information provided by staff of Texas Department of Mental Health and Mental Retardation, Jan. 14, 2003.

³⁵*Disability at the Dawn of the 21st Century and The State of the States*, David Braddock Editor. American Association Mental Retardation, Washington, 2002, p. 86 (Hereafter referred to as *Disability at the Dawn of the 21st Century, 2002*).

Table 5. Persons with Mental Retardation and Developmental Disabilities Served in Residential Settings, by Size of Residential Setting, 1990, 1995, and 2000

Persons served by residential setting ^a			
Setting by size	1990	1995	2000
TOTAL	17,624 (100%)	17,478 (100%)	18,584 (100%)
16+ PERSONS	13,148 (74.6%)	11,205 (64.1%)	10,721 (57.7%)
Nursing facilities	3281	2987	2919
State institutions	7290	5879	5338
Private ICFs/MR	2577	2339	2464
Other residential	0	0	0
7 - 15 PERSONS	4,476 (25.4%)	1,112 (6.4%)	550 (3.0%)
Public ICFs/MR	24	35	177
Private ICFs/MR	2095	558	373
Other residential	2357	519	0
= or >6 PERSONS	0	5,161 29.5%	7,313 39.4%
Public ICFs/MR	0	180	878
Private ICFs/MR	0	3536	3794
Other residential	0	1445	2641

Source: *Disability at the Dawn of the 21st Century and the State of the States*, David Braddock, editor. With Richard Hemp, Mary C. Rizzolo, Susan Parish, and Amy Pomeranz. American Association on Mental Retardation, Washington, 2002.

^a Texas classification categories were <8 persons; 9-13 persons, and 14+ persons. Percentages may not sum to 100% due to rounding.

Trends in Home and Community-Based Care

Texas' reliance on institutional care for persons with mental retardation and developmental disabilities is reflected in the fact that the state has only three relatively small Medicaid Section 1915(c) home and community-based waivers for this population. Participants must meet a requirement that they need an institutional level of care; their incomes cannot exceed 300% of the SSI benefit level; and their countable financial resources cannot exceed \$2,000. No state-funded programs are specifically designed to serve persons with developmental disabilities.

The Home and Community-Based Services Waiver is the largest of Texas' waivers and served 6,731 people of all ages with a diagnosis of mental retardation at a cost of \$263 million in SFY2002.³⁶ The waiver offers a wide range of services including: home modifications, group residential options, case management, habilitation, nursing, therapies, and supported employment. The cost for an individual's services is capped at 125% of the annual payment to an intermediate care facility for the mentally retarded (ICFs/MR). TDMHMR operates this waiver.

Texas Community Living Assistance and Support Services Waiver (CLASS) serves people with developmental disabilities with an onset before age 22. This waiver, which is available in 104 counties, served 1,451 clients a month at a cost of \$45.7 million in SFY2002.³⁷ The waiver provides a narrower range of services than the waiver for persons with mental retardation described above. The CLASS waiver provides case management, habilitation, therapies, adaptive aides and minor home modifications. The cost for an individual's services is capped at 125% of the annual payment to an ICF for people with mental retardation and related conditions. DHS administers this waiver.

The Deaf-Blind Multiple Disabilities Waiver serves only persons who are deaf, blind, and have a third disability. This statewide waiver served 112 clients a month at a cost of \$4.8 million in SFY2002.³⁸ Services include assisted living, case management, nursing, respite, and various therapies. An individual's costs are capped at 115% of the average cost of an ICF/MR. DHS administers this waiver.

³⁶ SFY2002 Quarterly Measures Report, Texas Department of Mental Health and Mental Retardation (Jan. 9, 2003); and SFY2002 Monthly Financial Report as of Nov. 2002, Texas Department of Mental Health and Mental Retardation.

³⁶Personal communication with staff from the Budget Division of Texas Department of Human Services, Jan. 10, 2003.

³⁸Personal communication with staff from the Budget Division of Texas Department of Human Services, Jan. 10, 2003.

Financing Long-Term Care in Texas

In most states, the federal-state Medicaid program is the chief source of financing for long-term care. In Texas, the Medicaid program accounted for \$3.3 billion in long-term care spending in FY2001. Spending for institutions represented 70.8% of Medicaid long-term care spending. While spending on home and community-based services represented less than a third of all Medicaid long-term care spending, spending for home and community-based services increased dramatically from FY1990 to FY2001.

Medicaid Spending in Texas

Medicaid is a significant part of state budgets. After elementary, secondary and higher education spending, Medicaid spending was the largest share of state budgets in 2001. According to data compiled by the National Association of State Budget Officers (NASBO), *federal and state* Medicaid spending represented almost 20% of state budgets for the United States as a whole in 2001.

In Texas, Medicaid is the second largest category of *federal and state spending combined*, behind elementary and secondary education. Of the state's \$52.4 billion budget in 2001, federal and state Medicaid spending represented slightly more than one of every five dollars. Spending for Medicaid almost doubled as a proportion of the state's spending from 1990 to 2001 (**Table 6**).

State spending for Medicaid services in Texas contributed from state funds *only* (excluding federal funds)³⁹ also increased during the 1990s. As a percent of spending for all categories of state spending, state Medicaid spending increased from 6.6% in 1990 to 11% in 2001. (**Table 7**).

³⁹Federal and state governments share the costs of Medicaid spending according to a statutory formula based on a state's relative per capita income (Federal Medical Assistance Percentage, or FMAP). In FY2001, the federal share for Medicaid in Texas was 60.57%.

Table 6. Share of Federal and State Spending by Category, Texas and the United States, 1990-2001
(may not add to 100% because of rounding)

Expenditure category	Texas				All states
	1990	1995	2000	2001	2001
Total Expenditure (in millions)	\$23,531	\$37,005	\$49,390	\$52,356	\$1,024,439
Medicaid	13.0%	20.8%	21.8%	20.1%	19.6%
Elementary & Secondary Education	27.1%	28.4%	29.5%	30.5%	22.2%
Higher Education	16.6%	13.2%	14.1%	13.2%	11.3%
Public Assistance	1.8%	1.4%	1.7%	1.6%	2.2%
Corrections	3.4%	7.4%	6.4%	6.3%	3.7%
Transportation	11.3%	8.0%	9.4%	9.1%	8.9%
All other expenses	26.9%	20.7%	17.2%	19.1%	32.1%

Source: CRS calculations based on National Association of State Budget Officers (NASBO) State Expenditure Reports 1990-2001.

Table 7. State Spending for Medicaid from State Funds as a Percent of State Spending, Texas and the United States, 1990-2001

State spending	Texas				All states
	1990	1995	2000	2001	2001
Total state spending (in millions)^a	\$17,876	\$26,599	\$34,991	\$37,082	\$760,419
State Medicaid spending (millions) ^b –state only funds	\$1,183	\$3,168	\$4,614	\$4,132	\$85,141
State Medicaid spending as a percent of total state spending– state only funds	6.6%	11.9%	13.2%	11.1%	11.2%

Source: CRS calculations based on data from the National Association of State Budget Officers (NASBO), State Expenditure Reports for 1991, 1997 and 2001. Data reported are for state fiscal years. Percentages may not sum to 100% due to rounding.

^a Total state spending for all spending categories, excluding federal funds.

^b State spending for Medicaid, exclusive of federal funds.

Medicaid Long-Term Care Spending in Texas⁴⁰

Long-term care spending represented 28.5% of all Medicaid spending in Texas in FY2001, a decrease from 39.7% in 1990 (**Figure 2 and Table 8**). Although institutions still dominate Medicaid long-term care spending, from FY1990-FY2001, spending on nursing homes and ICFs/MR decreased from 89.7% to 70.8% of total long-term care spending. In FY2001, \$2.3 billion or 20% of all Medicaid spending was for care in institutions, but nursing home spending accounted for more than two-thirds of the total institutional spending (**Table 9 and Figure 2**).

Medicaid long-term care financing in Texas at a glance:

Spending for institutions represented more than 70% of Medicaid long-term care spending in FY2001. Spending for nursing homes alone represented almost half of total Medicaid long-term care spending in FY2001.

Spending for nursing home care grew at less than half the rate of total Medicaid spending from FY1990 to FY2001 (86.3% compared to 193.7%)

Spending for nursing home care decreased as a percentage of long-term care spending from 55.2% in FY1990 to 48.8% in FY2001. During the same period, the portion spent on ICFs/MR decreased from 34.4% to 22.0%.

Less than one of every three Medicaid dollars spent on long-term care is for home and community-based services. However, there has been a significant increase in the spending on home and community-based service waivers from FY1990-FY2001.

Table 8. Medicaid Long-Term Care Spending in Texas, FY1990-2001

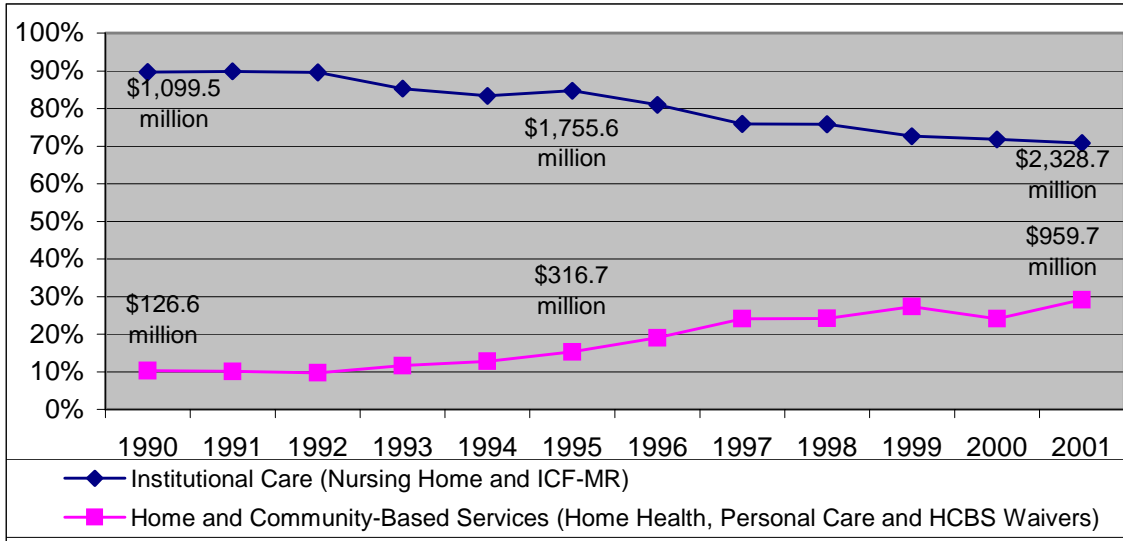
	FY1990	FY1995	FY2000	FY2001
Long-term care spending as a % of Medicaid spending	39.7%	23.8%	28.5%	28.5%
Institutional care spending as a % of long-term care spending	89.7%	84.7%	71.8%	70.8%
Nursing home spending as a % of long-term care spending	55.2%	57.7%	47.7%	48.8%
ICFs/MR* spending as a % of long-term care spending	34.4%	27.0%	24.1%	22.0%
Total home and community-based services spending as a % of long-term care spending	10.3%	15.3%	28.2%	29.2%
HCBS waivers spending as a % of long-term care spending	0.6%	4.4%	20.5%	21.1%

Source: CRS calculations based on CMS/HCFA 64 data provide by The Medstat Group, Inc. For 2000 and 2001, Burwell Brian et al., Medicaid Long-Term Care Expenditures in FY2001, May 10, 2002. For 1995, Burwell, Brian Medicaid Long-Term Care Expenditures in FY2000, May 7, 2001. For 1990, Burwell, Brian Medicaid Expenditures for FY1991. Sytemetrics/McGraw-Hill Healthcare Management Group, January 10, 1992. (Hereafter cited as Burwell, Medicaid Expenditures FY1991-FY2001.) 1990 total Medicaid spending based on HCFA 64 data provided by The Urban Institute, Washington.

*Intermediate care facilities for the mentally retarded.

⁴⁰This section discusses Medicaid spending, both federal and state.

Figure 2. Institutional and Home and Community-Based Services as a Percent of Medicaid Long-Term Care Spending in Texas, 1990-2001



Source: CRS calculation based on Burwell, *Medicaid Expenditures FY1991-FY2001*. 1990 total Medicaid spending, based on HCFA 64 data provided by Urban Institute.

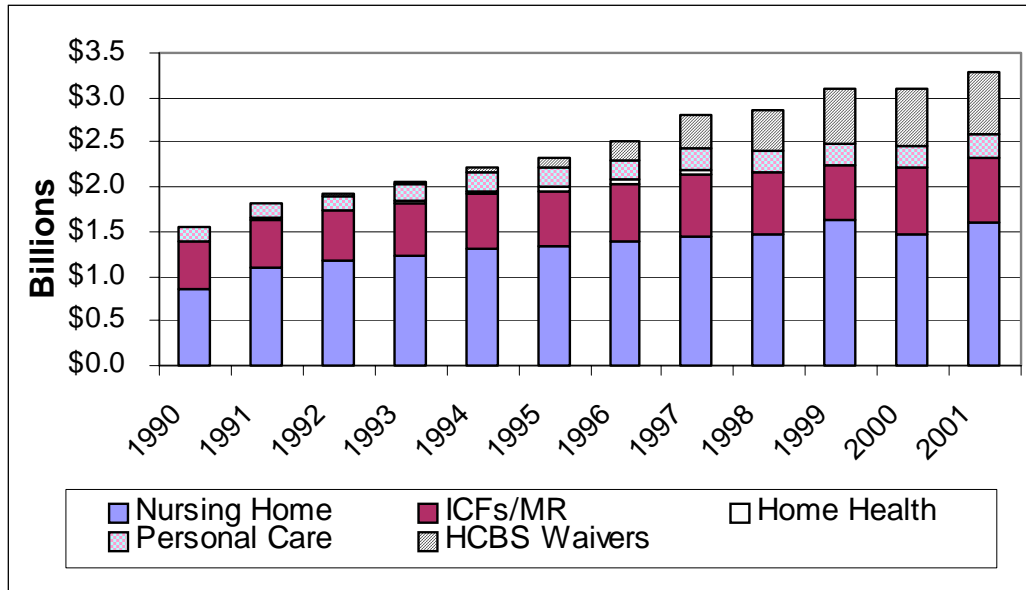
Table 9. Medicaid Spending in Texas, Total Spending and Long-Term Care Spending, by Category, and Percent Change, FY1990-FY2001 in Constant 2001 Dollars
(dollars in millions)

Spending category	1990	1995	2000	2001	Percent change FY1990-FY2001 (in constant 2001 dollars)
Total medicaid	\$3,085.0	\$8,698.4	\$10,622.8	\$11,520.5	193.7%
Total long term care	\$1,226.1	\$2,072.3	\$3,024.3	\$3,288.4	110.9%
Total institutional care	\$1,099.5	\$1,755.6	\$2,171.5	\$2,328.7	66.6%
Nursing home	\$677.2	\$1,196.6	\$1,442.5	\$1,604.1	86.3%
ICFs/MR*	\$422.3	\$559.0	\$729.0	\$724.6	34.9%
Total home and community-based services	\$126.6	\$316.7	\$852.8	\$959.7	496.2%
Home health	\$2.0	\$36.0	\$0.0	\$0.0	-100.0%
Personal care	\$117.8	\$188.8	\$232.4	\$267.4	78.5%
HCBS waivers	\$6.8	\$91.9	\$620.4	\$692.3	7905.4%

Source: CRS calculation based on Burwell, *Medicaid Expenditures FY1991-FY2001*. 1990 total Medicaid spending, based on HCFA 64 data provided by Urban Institute, Washington, D.C.

*Intermediate care facilities for the mentally retarded.

Figure 3. Medicaid Long-Term Care Spending by Category in Texas, FY1990-FY2001
(in constant 2001 dollars)

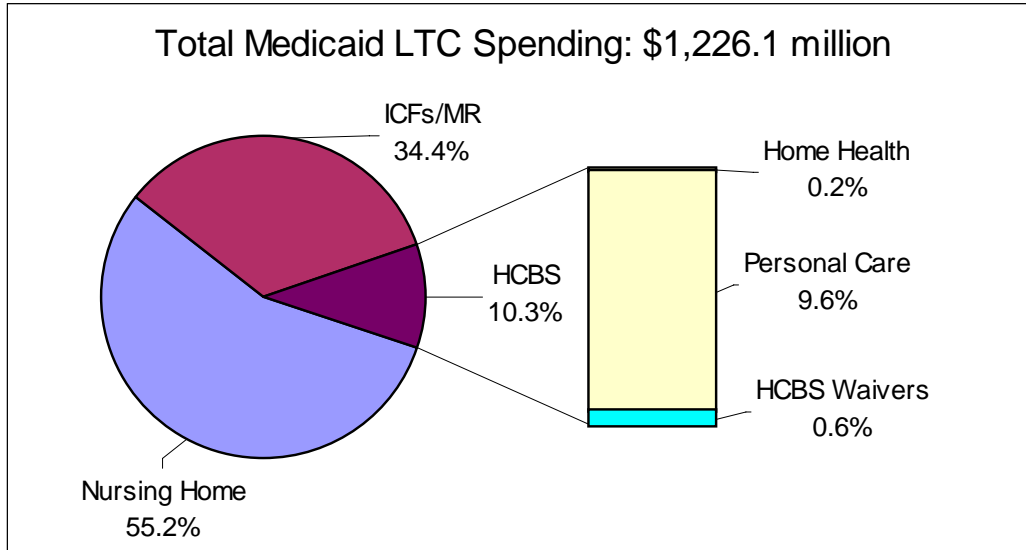


Source: CRS calculations based on Burwell, *Medicaid Expenditures FY1991-FY2001*. 1990 total Medicaid spending, based on HCFA 64 data provided by Urban Institute, Washington.

Figures 4a and b depict changes in long-term care spending patterns from FY1990 to FY2001. In FY1990, 34.4% of Medicaid long-term care spending was devoted to care for persons with developmental disabilities in ICFs/MR; this spending decreased to 22% of long-term care spending by FY2001. The proportion of spending on nursing home services also declined during that time period from 55.2% to 48.8%.

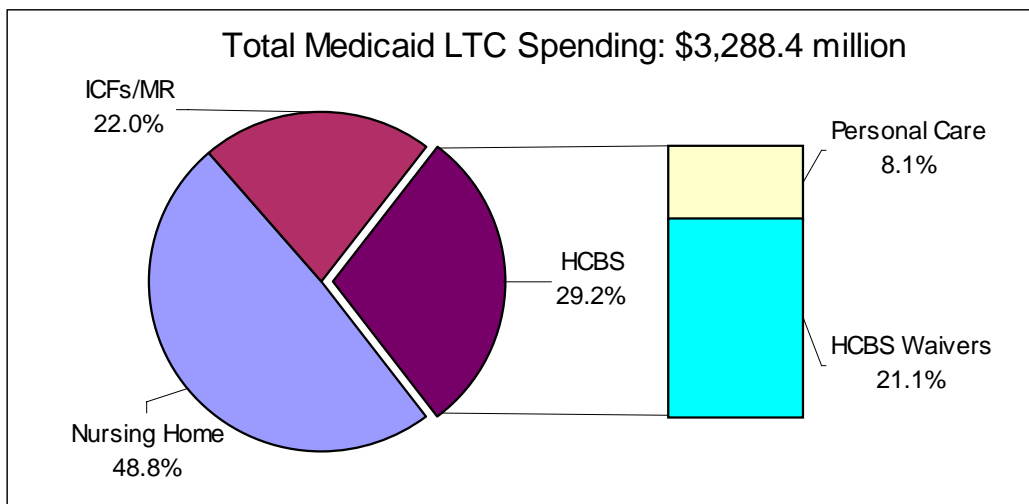
Medicaid spending devoted to home and community-based services represented less than one of every three Medicaid dollars spent on long-term care. However, Texas has made substantial use of the Section 1915(c) home and community-based services programs. Spending on home and community services increased from 10.3% to 29.2% of long-term care expenditures, primarily due to the expansion of Section 1915(c) waivers, which increased from .6% of home and community-based spending to 21.1% in FY2001.

Figure 4a. Medicaid Long-Term Care Spending in Texas by Category, FY1990



Source: CRS calculations based on Burwell, *Medicaid Expenditure FY1991-FY2001*.

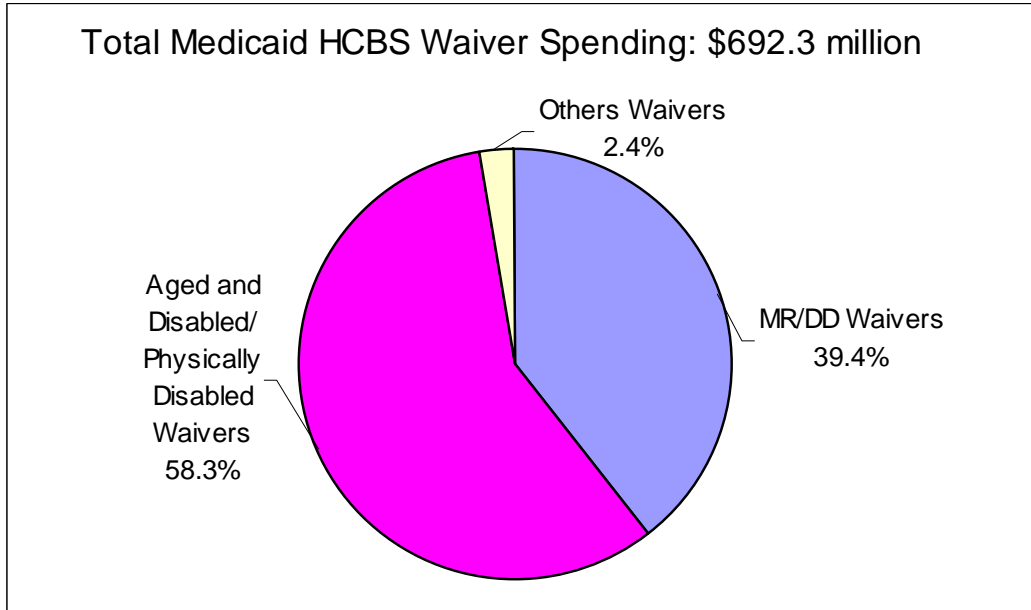
Figure 4b. Medicaid Long-Term Care Spending in Texas by Category, FY2001



Source: CRS calculations based on Burwell, *Medicaid Expenditure FY1991-FY2001*.

Increased funding for waiver services does not affect all populations equally. In FY2001, 58% of waiver spending in Texas was devoted to the aged and persons with disabilities. Waivers for persons with mental retardation and developmental disabilities MR/DD accounted for 39.4% of waiver spending.

Figure 5. Total Medicaid Home and Community-Based Services Waiver Spending by Target Population in Texas FY2001



Source: CRS calculations based on *Medicaid HCBS Waivers Expenditures, FY1995 through FY2001* by Steve Eiken and Brian Burwell, The Medstat Group, Inc., May 13, 2002.

Federal and state spending for persons with mental retardation and developmental disabilities was almost \$1.5 billion in 2000 (**Table 10**). This represented an increase of 68.4% (in constant 2000 dollars) since 1990. Of total 2000 spending, 51.4% came from state resources. Federal waiver funding increased from only \$4.8 million in 1990 to \$145.5 million in 2000, an increase of over 2,000%.

Table 10. Federal and State Spending for Institutional and Community Services for Persons with Mental Retardation/Developmental Disabilities in Texas, 1990 and 2000

	1990 (current dollars)	2000 (current dollars)	Percent of FY2000 total	Percent change in constant 2000 dollars
Services, total	\$703.9	\$1,471.1	100.0%	68.4%
Congregate/institutional services	\$453.0	\$492.0	33.4%	-12.5%
Federal Funds	\$240.1	\$303.0	20.6%	1.7%
State Funds	\$212.9	\$189.0	12.8%	-28.5%
Home and community-base services	\$250.9	\$979.1	66.6%	214.4%
Federal funds	\$44.9	\$412.2	28.0%	639.6%
ICFs/MR funds*	\$32.3	\$166.6	(11.3%)	315.7%
HCBS waiver**	\$4.8	\$145.5	(10.0%)	2355.7%
Title XX/SSBG funds***	\$0.0	\$10.2	(0.69%)	---
Other	\$7.8	\$89.9	(6.1%)	823.3%
State Funds	\$206.0	\$566.9	38.5%	121.8%

Source: CRS calculations based on data presented in *The State of the States in Developmental Disabilities*, by David Braddock et al., 1998. American Association on Mental Retardation, Washington, D.C., p. 404 (for 1990 data). Unpublished data furnished by Richard Hemp, University of Colorado (for 2000 data).

*Intermediate care facilities for the mentally retarded. These funds are used for community services.

**Home and community-based waiver (Section 1915(c)) of the Medicaid statute.

***Social Services Block Grant (Title XX of the Social Security Act).

Issues in Long-Term Care in Texas

The following discussion highlights issues raised in state reports and interviews with state officials and key stakeholders conducted during the Texas site visit during the summer of 2002.

Institutional Bias. Texas has dealt with the institutional bias built into the Medicaid program over the years by increasing funding devoted to home and community services, particularly for its aged and disabled Medicaid beneficiaries. The state was also one of the first to have a comprehensive plan for dealing with the implications of the Supreme Court's Olmstead decision. That plan has fostered a number of changes designed to provide the least restrictive care in home and community-based settings, rather than institutional care.

Texas implemented a three-phase response to Olmstead for nursing home residents. The first phase began in December 2000 and consisted of informing nursing home residents about community-based alternatives. The 2-year second phase began in September 2001 with a pilot program in three sites to relocate nursing facility residents into the community. Pilots involve hiring and training relocation specialists, developing an assessment instrument, and conducting community awareness activities. The third phase will be to divert persons from nursing homes to home and community-based services through pre-admission screening.

In December 2000, Texas implemented its Community ICFs/MR Living Options process, which is designed to inform all residents of ICFs/MR about alternative living arrangements and to determine whether people with developmental disabilities can live successfully in the community. People who wish to leave an ICF/MR and whose interdisciplinary team determines that they are able to live in the community are placed on the Home and Community-based Services Waiver waiting list.

The third major step the state took involved using legislative "riders," which the legislature often uses to impose policy direction on the executive branch. Rider 7, from the 77th Legislature (2002-2003), states that DHS cannot disallow community services for current waiver participants who would otherwise be in a nursing home if additional services are required to keep them in the community. Another recent rider (37) states that as residents leave nursing homes, their funds should follow them into the community and that their use of home and community services will not be counted against the waiver slots; in effect they jump the waiting list for home and community services. In response to Rider 37, the state moves anyone who has lived in a nursing home within the last 6 months to the top of the Community Based Alternatives Waiver waiting list.

Nursing Home Liability Insurance. Due to historical quality assurance problems in nursing homes, Texas requires nursing homes to have liability insurance. Many companies have stopped selling policies to the state's facilities because of perceived high damage awards. The state sponsored an insurance company – the Joint Underwriting Association (JUA) – that will provide insurance but will not cover losses due to punitive damages. According to state officials, the

company's policies cost 50 to 70% less than similar policies available in the private marketplace. However, providers say that premiums remain unaffordable and that many facilities are going without liability insurance as a result. The state has also capped damage awards against nursing homes at \$750,000.

Integration of Health and Long-Term Care Services. Texas has tried to integrate health and long-term care services for persons with disabilities because the state believes that integration could improve service delivery and possibly lead to cost savings. Three efforts are noteworthy but small. The state's *Consolidated Waiver Program* encompasses persons with developmental disabilities and children as well as aged and disabled adults. This program is designed to test consolidation of 5 Medicaid waivers in Bexar county. The waiver will last for three years and will serve 100 persons (50 adults and 50 children) eligible for nursing facility care and 100 persons (50 adults and 50 children) eligible for ICFs/MR. There will be one comprehensive service array, one set of providers, one set of reimbursement rates, and a single functional assessment process.

Bienvivir Senior Health Services operates the state's only *Program of All-Inclusive Care for the Elderly (PACE)* in El Paso, Texas. PACE serves persons aged 55 or older who are eligible for both Medicare and Medicaid and who need a nursing facility level of care. The program provides these dually eligible beneficiaries with all needed medical and supportive services in community-based settings designed to prevent or delay institutionalization. PACE programs receive capitated payments from Medicare and Medicaid. *Bienvivir Senior Health Services* receives capitated payments of 95% of comparable nursing home costs. The program cost \$13.4 million and served 468 clients a month in FY2001.⁴¹

The *Texas STAR+PLUS* waiver in Harris County was originally intended to rely on Medicare and Medicaid waivers to provide integrated health and long-term care services to dual eligibles. The state did not obtain the Medicare waiver necessary for integration and now only covers up to 120 days in a nursing facility under its Medicaid waiver. However, Evercare, one of its Medicaid HMOs, received approval from CMS in 2002 to operate as a Medicare+Choice plan.⁴² To encourage STAR+PLUS dual eligible members to voluntarily enroll in this Medicare+Choice plan, the state has lifted the three prescription per month limit for those who choose this option. This provides a real opportunity for the Medicaid waiver to offer more integrated care. STAR+PLUS already integrates acute and long-term care for Medicaid-only members who comprise approximately half of the program's membership.

⁴¹Texas Department of Human Services, Individual Service Profiles Community Care Programs, Apr. 2002, as updated on May 31, 2002.

⁴²The Medicare+Choice program was created by Congress in the Balanced Budget Act (BBA) of 1997 to give Medicare beneficiaries more access to private health plans, including several types of managed care plans. Typically these plans provide more health care coverage than fee-for-service Medicare in return for beneficiary premiums and Medicare capitated payments. For further information, see CRS Report RL30702, *Medicare+Choice*, by Hinda Ripps Chaikind and Paulette Morgan.

Consumer Direction. Many consumer advocacy groups view consumer-direction, which entails beneficiaries hiring, firing, training, and managing their own personal attendants, as a key priority. Advocates say that this improves quality of life and community integration for persons with disabilities. Consumer direction opportunities do exist in CLASS, the deaf-blind multiple disabilities (DBD) waiver, STAR+PLUS, Primary Home Care and the Community Based Alternatives (CBA) waiver, but at the time of the site visit Texas officials asserted that they were having difficulty getting some of their amendments related to consumer-direction approved by the Center for Medicare and Medicaid Services. Subsequently, the U.S. Department of Health and Human Services announced approval of the Texas plan to allow aged and disabled Medicaid beneficiaries the opportunity to “develop and manage their own services.”⁴³

Housing. Many stakeholders see access to affordable housing as a key prerequisite for moving people from institutions into the community. The state has taken a few steps in this area, such as requiring the Texas Department of Housing and Community Affairs to make 35 housing vouchers available to people leaving nursing homes. However, Medicaid’s use of group residential housing is rather limited.

Waiting Lists for Home and Community-based Care. Waiting lists have been a significant concern for some time in Texas, but the projected \$1.8 billion budget deficit projected for SFY2003, and \$8.1 billion for the 2004-05 biennium will likely forestall any attempt to tackle this issue. In March 2002, the Community Based Alternatives Waiver for the aged and disabled had an “interest list” of 37,667 persons, 54% of whom were estimated to be eligible for services; the median length of time on the interest list is 10.38 months.⁴⁴ About 21,000 of those on the list were already receiving services, primarily from the Primary Home Care and adult day care programs.

The Texas Department of Mental Health and Mental Retardation reports that in February 2002, 16,845 people were waiting for mental retardation services in the home or community; 46% of these people received no services. Data about persons on the various waiting lists show that about 15% eventually drop off the list and 75% live at home with parents. Sixty-one percent of persons on the list want services immediately and 36% want residential services. The CLASS waiver had an interest list of 7,360 in March 2002, half of whom the state estimates were eligible for services; the median length of stay on the list was 3.9 years. About 1,508 persons were already receiving some Medicaid community care. People move off all interest lists on a first-come-first-served basis. The state projected that the Home and

⁴³U.S. Department of Health and Human Services Press Release, Oct. 31, 2001. *HHS Approves Texas Plan to Allow Elderly, Disabled to Direct their own Services.*

⁴⁴Jim Hine, Commissioner of Texas Department of Human Services, Presentation before the Texas Senate Finance Committee on Health and Human Services Demand, Thursday, May 9, 2002. Hereafter referred to as Jim Hine, Commissioner of Texas Department of Human Services Presentation, May 9, 2002.

Community-Based Services Waiver for persons with mental retardation will have a waiting list of 10,720, 32% of whom are likely to request out-of-home placement.⁴⁵

Long-Term Care Staffing. Stakeholders for persons with mental retardation and developmental disabilities stated that there is an inadequate number of state staff to perform case management and monitoring of beneficiaries' care. The number of state staff has not kept pace with the growth in the number of beneficiaries receiving services. In addition, TDMHMR has a problem recruiting and retaining employees, particularly in its state operated facilities. It had a turnover rate of 33.5% in FY2001, compared to a state government wide average of 17.5%. In addition, the provider base for serving persons with MR/DD has been weakened by the labor shortage. There aren't enough licensed nurses and attendant turnover is high. Some of these problems are attributed to low state reimbursement for providers.⁴⁶ Stakeholders also have concerns about the effects of the labor shortage in nursing homes and among home and community care providers serving the aged and disabled populations.

Stakeholders worry about whether the long-term care workforce has sufficient training to handle the increasing medical needs of persons with disabilities in the community. The state has dealt with the problem in nursing homes by providing facilities, beginning in May 2002, with higher payment rates if they raise the number of staff in their facilities.

⁴⁵Jim Hine, Commissioner of Texas Department of Human Services, Presentation May 9, 2002.

⁴⁶Texas Department of Mental Health and Mental Retardation, *The Strategic Workforce Analysis and Plan for Fiscal Years 2003-2007*.

Appendix 1. Major Home and Community-Based Long-Term Care Programs for the Elderly and Persons with Disabilities in Texas

Program	Target group	Functional eligibility		Financial eligibility		Services	No. of persons enrolled/slots approved	Annual cost cap (aggregate/individual)	Admin. oversight	Financial oversight
		Criteria	Determined by	Income/resource limits	Determined by					
Consolidated Waiver Program-Nursing Facility Waiver 1915(c)	Aged and disabled adults and medically dependent children	Nursing facility (NF) level of care http://wikileaks.org/wiki/CRS-RL31968	Health and Human Services Commission	221% of federal poverty level/ \$2,000	Health and Human Services Commission	Assisted living, attendant care, consumable medical supplies, counseling, dental services, dietary supplements, environmental modifications, escort services, foster care, habilitation, independent living skills training, medication management, night supervision, nutrition/meal services, occupational therapy, personal emergency response system, pharmacy, physical therapy, per-vocational services, psychological testing, respite, special medical equipment, language, and supported employment among others. No opportunity for consumer direction.	100 clients served in FY2002	Cost cannot exceed 150% of NF rate corresponding to their level of care	Health and Human Services Commission	Health and Human Services Commission

Program	Target group	Functional eligibility		Financial eligibility		Services	No. of persons enrolled/slots approved	Annual cost cap (aggregate/individual)	Admin. oversight	Financial oversight
		Criteria	Determined by	Income/resource limits	Determined by					
Community Based Alternatives Waiver 1915(c) Began in 1994 and is available statewide	Aged and disabled adult, age 21 and above	Nursing facility level of care http://www.wiki/crs-rl31968	Department of Human Services' regional office	221% of federal poverty level/\$2,000	Department of Human Services regional office	Personal assistance services, adaptive aids and medical supplies, adult foster care, assisted living services, emergency response services, minor home modification, nursing services, occupational, physical and speech therapy services, respite, home delivered meals. No consumer direction option.	41,128 clients FY2002 \$397,000,000 FY2002	Individual cost ceiling of 100% of individual's TILE (Texas Index for Level of Effort) payment rate	Department of Human Services	Department of Human Services
Medicaid Primary Home Care (Offered as an optional Medicaid state plan service under personal care)	All ages	Functional limitation with at least one personal care task based on a medical condition	Physician must order the service and a regional DHS nurse must approve it.	(300% of SSI)/\$2,000	Department of Human Services regional office	Personal care, home management (ie., homemaker), escort for medical purposes only	76,000 clients in FY2002 \$511,375,000 in FY2002	Up to 50 hours of care a week	Department of Human Services	Department of Human Services

Program	Target group	Functional eligibility		Financial eligibility		Services	No. of persons enrolled/slots approved	Annual cost cap (aggregate/individual)	Admin. oversight	Financial oversight
		Criteria	Determined by	Income/resource limits	Determined by					
Medicaid Day Activity and Health Services (Offered as an optional Medicaid state plan service under rehabilitation services)	All ages who are eligible for SSI. Title XX – people age 18+	Medical diagnosis and a functional disability related to the diagnosis where the individual needs assistance with one or more personal care tasks.	Physician must order services and a licensed nurse must supervise them. A DHS regional nurse must approve the service.	SSI eligibility	Department of Human Services Regional office. Department of Human Services Regional office	Daytime services Monday –Friday including: nursing and personal care, physical rehabilitation, noon meal and snacks, transportation, and social educational and recreational activities.	Medicaid-14,960 clients FY2002 Title XX–688 clients FY2001. Medicaid - \$79,000,000 FY2002 Title XX \$3,387,509 FY2001	Up to 50 hours of care a week	Department of Human Services	Department of Human Services
Title XX and State-funded Family Care Available statewide	Adults age 18 and older with disabilities	Functional assessment score of 24+ with an unmet need for personal care or home management. Beneficiaries must need help in performing ADLs. The degree of impairment is measured on a 60 point functional needs assessment scale where the higher the score, the more severe the impairment.	Department of Human Services regional office	Medicaid recipient or 300% of SSI/ \$5,000 for an individual	Department of Human Services regional office	Personal care, home management (homemaker), escort for medical appointments only.	8,460 clients a month in FY2002 \$46,496,322 in FY2002	Up to 50 hours of care per week	Department of Human Services	Department of Human Services

Program	Target group	Functional eligibility		Financial eligibility		Services	No. of persons enrolled/slots approved	Annual cost cap (aggregate/individual)	Admin. oversight	Financial oversight
		Criteria	Determined by	Income/resource limits	Determined by					
<p>State-funded In-home and Family Support</p> <p>Available statewide, with a lengthy wait list in all areas</p>	Age 4 and over	Physical disability that substantially limits the person's ability to function independently	Department of Human Services Regional Office	Copayments begin at 105% of state median income for household size.	Department of Human Services regional office	Direct grants to beneficiaries or their families. They may use grants for equipment, home modifications, health services, counseling & training, attendant, home health, homemaker, and chore services.	4,730 clients a month in FY2002 \$8,996,250 in FY2002	\$3,600 lifetime for equipment or home modifications. \$3,600 annually for services and supplies	Department of Human Services	Department of Human Services
<p>State-funded Residential Care</p> <p>Available in every region but not every county in the state</p>	Age 18 +	Functional assessment score of 18+. Beneficiaries must need help in performing ADLs. The degree of impairment is measured on a 60 point functional needs assessment scale where the higher the score, the more severe the impairment.	Department of Human Services regional office	Medicaid recipient or 300% of SSI/\$5000 for an individual	Department of Human Services regional office	Assisted living facility services provide 24 hour living arrangement. Residents contribute to the cost of their care but retain a personal needs allowance.	799 clients a month in FY2001 \$6,187,564 in FY2001	Not available	Department of Human Services	Department of Human Services

Program	Target group	Functional eligibility		Financial eligibility		Services	No. of persons enrolled/slots approved	Annual cost cap (aggregate/individual)	Admin. oversight	Financial oversight
		Criteria	Determined by	Income/resource limits	Determined by					
<p>State-funded Adult Foster Care</p> <p>Available in every region but not every county in the state</p>	Age 18 +	Functional assessment score of 18+. Beneficiaries must need help in performing ADLs. The degree of impairment is measured on a 50 point functional needs assessment scale where the higher the score, the more severe the impairment.	Department of Human Services regional office	Medicaid recipient or an income that doesn't exceed \$1635 a month for an individual and assets cannot exceed \$5000 for an individual	Department of Human Services regional office	24 hour living arrangement for no more than 3 unrelated adult clients. Services available are personal care and transportation. Client pays room and board.	221 clients a month in FY2001 \$1,112,512 in FY2001	Not available	Department of Human Services	Department of Human Services
<p>State & Title XX-funded Consumer Managed Personal Assistant Services</p> <p>Available in 8 regions</p>	Age 18 +	Capable of consumer-direction with a disability expected to last at least 6 months and needing help with at least one personal care task	Licensed personal assistance service agencies	None but person pays income-related fee when income exceeds \$1,200 a month.	Department of Human Services regional office	Personal assistance services selected and supervised by client.	599 clients a month in FY2001 \$7,143,965 in FY2001	Nursing facility weighted cost.	Department of Human Services	Department of Human Services

Program	Target group	Functional eligibility		Financial eligibility		Services	No. of persons enrolled/slots approved	Annual cost cap (aggregate/individual)	Admin. oversight	Financial oversight
		Criteria	Determined by	Income/resource limits	Determined by					
<p>State-funded Respite Care</p> <p>Available statewide</p>	Age 18 +	Need care or supervision or both and have an unpaid caregiver who needs relief due to stress or is temporarily unable to provide care	Department of Human Services regional office	Medicaid recipient or an income that doesn't exceed \$1,635 a month for an individual; no asset test.	Department of Human Services regional office	Respite may be provided in an institution, adult foster home, adult day health care facility or a person's home.	420 clients a month in FY2001 \$1,130,286 in FY2001	336 hours (ie., 14 days)	Department of Human Services	Department of Human Services
<p>Title XX & State-funded Special Services to Persons with Disabilities & 24-hour Attendant Care</p> <p>Available in 3 regions. 24-hour Attendant Care available only in Houston.</p>	Age 18+	Functional assessment score of 9+. Beneficiaries must need help in performing ADLs. The degree of impairment is measured on a 50 point functional needs assessment scale where the higher the score, the more severe the impairment.	Department of Human Services regional office	300% of SSI/ \$5,000	Department of Human Services regional office	Counseling, personal care, and skills training for community living and 24-hour attendant care in Houston	161 a month in FY2001 \$1,210,141 in FY2001	24-hour attendant care costs cannot exceed nursing facility weighted average cost.	Department of Human Services	Department of Human Services

Program	Target group	Functional eligibility		Financial eligibility		Services	No. of persons enrolled/slots approved	Annual cost cap (aggregate/individual)	Admin. oversight	Financial oversight
		Criteria	Determined by	Income/resource limits	Determined by					
Consolidated waiver program – ICFs/MR waiver 1915(c) Began Nov. 2001	Persons with mental retardation or developmental disabilities and must live in Bexar County – the pilot site	ICFs/MR level of care criteria http://wikileaks.org/wiki/CRS-RL31968	Health and Human Services Commission	221% of federal poverty level/ \$2,000	Health and Human Services Commission	Behavior communication specialist, personal assistance services, social work, habilitation, transportation, adaptive aids and medical supplies, minor home modifications, nursing services, dental, audiology, psychological, child support services, assisted living/residential care, adult foster care, emergency response service, respite, home delivered meals, 24-hour residential habilitation, intervener services, dietary services, orientation and mobility services, physical, occupational and speech therapies, independent advocacy, family surrogate services, prescribed drugs.	100 clients served FY2002 Projected expenditures \$1,466,904 in FY2002 125% of average aggregate ICFs/MR/ RC costs, 150% of nursing facility payment rate	Health and Human Services Commission Health and Human Services Commission		

Program	Target group	Functional eligibility		Financial eligibility		Services	No. of persons enrolled/slots approved	Annual cost cap (aggregate/individual)	Admin. oversight	Financial oversight
		Criteria	Determined by	Income/resource limits	Determined by					
<p>Community Living Assistance and Support Services (CLASS) Waiver Program</p> <p>1915(c)</p> <p>Available in 104 counties</p>	<p>People with Developmental Disabilities of all ages with onset before age 22</p>	<p>Approved related conditions diagnosis, condition such as cerebral palsy and head injuries, adaptive behavior of level II or higher, 3+ functional limitations. People must meet ICFs/MR/RC level of care criteria. People cannot participate if they have mental retardation. Must need habilitation and case management.</p>	<p>Private agency does functional assessment and Department of Human Services does final eligibility determination.</p>	<p>\$1,635/\$2,000 Parental income is not deemed available to children.</p>	<p>Department of Human Services Region Office</p>	<p>Case management, habilitation, respite, nursing, psychological services, physical, occupational & speech therapy, adaptive aids/supplies, minor home modifications, specialized therapies, consumer directed services</p>	<p>1,451 clients a month FY2002</p> <p>\$41,721,474 in FY2002</p>	<p>Individual cost cap of 125% of the cost of institutional care</p>	<p>Department of Human Services</p> <p>Private agencies provide case management.</p>	<p>Department of Human Services</p>

Appendix 2. Population in Large State Facilities

Table A-2. Population in Large State Facilities for Persons with Mental Retardation/Developmental Disabilities, Closure Date, and Per Diem Expenditures

Large state MR/DD facilities or units	Year facility opened	Year closed	Residents with MR/DD on 6/30/01	Average per diem expenditures FY01 (\$)
Abilene State School (Abilene)	1957	--	572	212.92
Austin State School (Austin)	1917	--	437	249.45
Brenham State School (Brenham)	1974	--	457	199.71
Corpus Christi State School (Corpus Christi)	1970	--	386	158.45
Denton State School (Denton)	1960	--	669	157.83
El Paso State Center (El Paso)	1973	--	150	211.7
Lufkin State School (Lufkin)	1962	--	450	209
Mexia State School (Mexia)	1946	--	551	192.17
Ft. Worth State School (Ft. Worth)	1976	1996	--	--
Lubbock State School (Lubbock)	1969	--	392	211.17
Richmond State School (Richmond)	1968	--	566	230
Rio Grande State Center (Harlingen)	1973	--	93	171

Large state MR/DD facilities or units	Year facility opened	Year closed	Residents with MR/DD on 6/30/01	Average per diem expenditures FY01 (\$)
San Angelo State School (Carlsbad)	1969	--	301	182
San Antonio State School (San Antonio)	1978	--	298	210
Travis State School (Austin)	1961	1996	--	--

Source: *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2001*. Research and Training Center on Community Living, Institute on Community Integration/UCEED. University of Minnesota (June 2002).

Appendix 3. About the Census Population Projections

“The projections use the cohort-component method. The cohort-component method requires separate assumptions for each component of population change: births, deaths, internal migration (Internal migration refers to State-to-State migration, domestic migration, or interstate migration), and international migration ... The projection’s starting date is July 1, 1994. The national population total is consistent with the middle series of the Census Bureau’s national population projections for the years 1996 to 2025.” Source: Paul R., Campbell, 1996, *Population Projections for States by Age, Sex, Race, and Hispanic Origin: 1995 to 2025*, U.S. Bureau of the Census, Population Division, PPL-47. For detailed explanation of the methodology, see same available at:

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