An Appraisal of Texas' Level of Effort in Supporting Individuals with Mental Retardation and Related Conditions

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Prepared for:

Advocacy, Inc.

&

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Executive Summary

Texas Level of Effort

- In 2003, Texas furnished Medicaid long-term services (i.e., services furnished in an ICF/MR or through a home and community-based services (HCBS) waiver program) to its citizens with mental retardation and related conditions at the rate of 94.4 persons per 100,000 state residents. This rate was only 53.9% of the nationwide rate of service provision.
- Texas ranked 47th among the states in the rate at which it furnished Medicaid long-term services to individuals with mental retardation and other related conditions.
- The rate at which Texas furnished facility-based ICF/MR services was 52.4% greater than the nationwide rate in 2003. In contrast, Texas ranked last among the states in the rate at which it supported individuals in the community through the HCBS waiver program.
- In order for Texas to have matched the nationwide rate of furnishing Medicaid long-term services, the state would have had to have served an additional 17,872 individuals in 2003.
- Between 1994 and 2003, Texas expanded Medicaid long-term services at a rate greater than state population growth. However, the Texas rate of expansion was significantly below the nationwide rate of increase during the same period.
- In 2003, Texas used the ICF/MR program to serve a greater percentage of individuals than was the case nationwide. Also, there was much heavier reliance on large congregate care ICFs/MR in Texas than was the case elsewhere.
- In 2003, Texas expended $52.68 per state resident to underwrite Medicaid long-term services for persons with mental retardation and related conditions. This was 59.9% of the nationwide spending rate of $88.01 per resident. Texas ranked 44th among the states in terms of its level of financial support for these services.
- A substantially larger proportion of Texas expenditures for Medicaid long-term services expenditures were devoted to ICF/MR services than was the case nationwide. Moreover, a greater share of expenditures underwrote services in the State Schools than was the case elsewhere in the country.
- Between 1995 and 2003, Texas' inflation adjusted expenditures for Medicaid long-term services increased by 58.9%. Most of this growth occurred in expenditures for home and community-based waiver services.
- On a per Medicaid beneficiary basis, Texas expended 8.7% more for Medicaid long-term services than the nationwide average. This stems principally from the state's relatively high reliance on more costly ICF/MR services as a means of serving individuals with mental retardation and related conditions.

Observations

- The sheer magnitude of the Texas waiting list for Medicaid long-term services is not surprising in light of the low rate at which Texas presently is furnishing these services to its citizens with mental retardation and related conditions. The demand for these services falls within the expected range in light of the experiences of other states.
- Absent a significant and sustained expansion of Medicaid long-term services, the prospect is that the Texas waiting list will grow larger in the future.
- Texas could gain resources to reduce its waiting list if it were to rebalance its service delivery system by shifting services from more to less costly types of Medicaid services.
- Significant rebalancing savings could be achieved by significantly scaling back the number of persons served at the State Schools and closing some of the State Schools.
- In 2002, Texas was leveraging its state funds to secure federal Medicaid funding at a lower rate than was true nationwide. To the extent that the state could increase its leveraging of state dollars, additional persons could be served without the appropriation of additional state dollars.
- The development and implementation of a "mid-range" waiver program provides the potential for Texas to meet the demand for Medicaid long-term services at lower cost per beneficiary than through its current waiver programs.

I. Introduction

This report appraises Texas' level of effort in furnishing services to its citizens with mental retardation and related conditions. Specifically:

- The next section of the report compares Texas' level of effort in serving individuals with mental retardation and related conditions along several dimensions to nationwide levels. These comparisons principally focus on Medicaid-funded long-term services, the subject of the *McCarthy* litigation. Comparisons include the number of persons who receive Medicaid long-term services, the distribution of services by type, and expenditures for services. Information also is provided concerning trends in Texas' level of effort in furnishing these services.
- The following section offers observations concerning service demand trends in Texas and how Texas might restructure services in order to extend services to a greater proportion of its citizens with mental retardation and related conditions.

The information upon which this report is based on national data sources and information published by the state of Texas itself. Please see the "Reference" section for a description of the principal national data source upon which this report is based.

II. Texas Level of Effort

A. Background

The federal-state Medicaid program is the single largest source of funding for the specialized long-term services that states provide individuals with mental retardation and related conditions. In FY 2002-2003, nationwide Medicaid long-term services expenditures for this population totaled $25.6 billion.[1] States principally obtain federal Medicaid funding for long-term services for individuals with mental retardation and related conditions in one of two ways:

- **Intermediate Care Facilities for the Mentally Retarded (ICF/MR)**. ICFs/MR are specialized residential facilities that exclusively serve individuals with mental retardation and related conditions. Facilities qualify for Medicaid funding when they are in compliance with federally-prescribed standards. Nationwide and in Texas, ICFs/MR include both state and privately-operated facilities. ICFs/MR range in size from group homes that serve as few as four individuals to very large facilities that serve several hundred persons. In order to obtain federal funding for ICF/MR services, a state must specifically include their coverage in its Medicaid state plan.
- **Home and Community-Based Services (HCBS) Waiver**. By operating an HCBS waiver program, a state may obtain federal Medicaid funding to underwrite community services that provide alternatives to Medicaid institutional services (i.e., services furnished in a hospital, nursing facility or an ICF/MR). In order to operate a waiver program, a state must secure the approval of the Centers for Medicare and Medicaid Services (CMS) at the federal Department of Health and Human Services. Waiver programs are initially approved for a period of three years and may subsequently be renewed for five-year periods. A state may operate several waiver programs that target distinct groups of Medicaid beneficiaries. In the case of services for persons with mental retardation and related conditions, operating a waiver program provides a state the means to obtain federal financial participation in the costs of providing alternative community services to persons

who have been determined to require the level of care furnished in an ICF/MR. Subject to federal review and approval, states have considerable latitude in defining the target population that is served in a waiver program and selecting the services that are offered to waiver program participants. There are no federal limitations on the number of individuals that a state may serve in a waiver program or combination of waiver programs. Federal financial participation is available so long as the individuals who participate in the waiver program meet Medicaid financial eligibility criteria and have been determined to require an institutional level of care.[2]

In addition to the foregoing, a state also may obtain federal Medicaid funding for case management services that are furnished to individuals with mental retardation and other developmental disabilities by including the coverage of "targeted case management" in its Medicaid state plan. Persons who receive Medicaid long-term services also are eligible to receive the health care and other services that a state offers through its Medicaid program.

In the analysis that follows, the focus is on the ICF/MR and HCBS waiver programs. Each program is a means of furnishing long-term services to individuals with mental retardation and related conditions. Persons who are served in either program essentially must meet the same eligibility criteria.[3] These programs are alternative means of furnishing services to persons who have substantial life-long disabilities and, thereby, require the sustained provision of intensive services and supports

B. Comparison of the Rate at which Texas Furnishes Medicaid Services to Nationwide Levels[4]

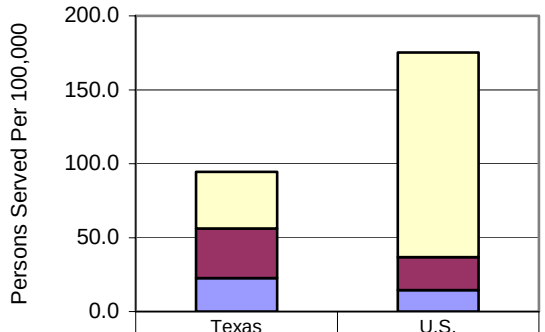
In 2003, Texas served 20,877 individuals with mental retardation and other related conditions in ICFs/MR or through HCBS waiver programs that specifically targeted this population. Nationwide, 509,503 individuals with developmental disabilities were served in these two programs. The distribution of Texans who received Medicaid long-term services by type of long-term service is shown in Table I.

Table 1
Persons Served in Texas by Type of Medicaid Service: 2003

Service Category	Persons Served
ICF/MR – State Schools	5,000
ICF/MR – Other Facilities	7,406
HCBS Waiver	8,471

Chart 1 compares the number of persons who received ICF/MR or HCB waiver services in Texas during 2003 to nationwide figures. This comparison is made by calculating the rate at which individuals were served relative to overall population: i.e., the number of persons who received services per 100,000 in the general population.[5] The chart also breaks Medicaid long-term services utilization into three categories: (a) ICF/MR services furnished in large state-operated facilities (facilities that serve 16 or more persons such as the Texas State Schools): (b) ICF/MR services furnished in other facilities,

Chart 1
Utilization of ICF/MR and HCBS Waiver Services: Texas v. U.S. (2003)



	Texas	U.S.
HCBS Waiver	38.3	138.4
Other ICFs/MR	33.5	22.3
Lge State Facilities	22.6	14.5

including facilities operated by the private sector; and, (c) home and community-based waiver services.

It is immediately evident from the chart that in 2003 Texas furnished Medicaid long-term services to its citizens with mental retardation and related conditions at a markedly lower rate than was the case nationwide. Overall, Texas furnished Medicaid long-term services to 94.4 persons per 100,000 state residents; nationwide, 175.2 persons per 100,000 in the general population received Medicaid funded long-term services, a rate that was 85.6% greater than the Texas rate. Stated another way, the rate at which Texas furnished Medicaid long-term services was only 53.9% of the nationwide rate.

In 2003, Texas ranked 47th among the states in the rate at which it furnished Medicaid long-term services (the combination of HCBS waiver and ICF/MR services). Among the ten most populous states, only Michigan furnished services at a rate lower than Texas.[6] Excluding Michigan, the service provision rates in the most populous states ranged from a low of 119.1 (Georgia) to a high of 304.2 per 100,000 state residents (New York).

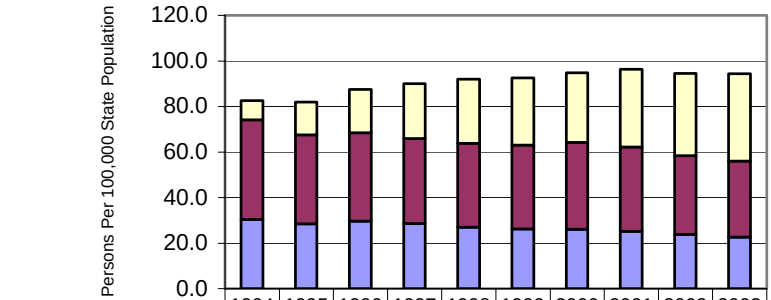
As also can be seen from the chart, Texas provided facility-based ICF/MR services (whether in a State School or a privately-operated facility) at a significantly higher rate than was the case nationwide. In 2003, Texas furnished ICF/MR services at the rate of 56.1 persons per 100,000 state residents, a rate that was 52.4% higher than the nationwide rate. Texas ranked 11th among the states in the rate at which it furnished ICF/MR services. In contrast, substantially fewer individuals received HCB waiver services in Texas. Texas furnished such services at a rate that was only 27.7% of the nationwide rate. ***Texas ranked 51st among the states in the rate at which it furnished community-based waiver services.***

In order for Medicaid funded services to have been as available in Texas as they were elsewhere in 2003 (i.e., if Texas furnished Medicaid long-term services at a rate at least as high as the nationwide average rate), the state would have had to have provided services to an additional 17,872 individuals in 2003.[7]

In recent years, there has been some measure of improvement in Texas' performance in furnishing services to its citizens with mental retardation and other developmental disabilities. Chart 2 shows the population-indexed rate at which Texas furnished Medicaid long-term services by type of service across the ten-year period 1994 – 2003.[8] In 1994, Texas furnished these services at the rate of 82.6 persons per 100,000 in the population. This rate generally increased

Chart 2

Trends in Texas Medicaid Utilization



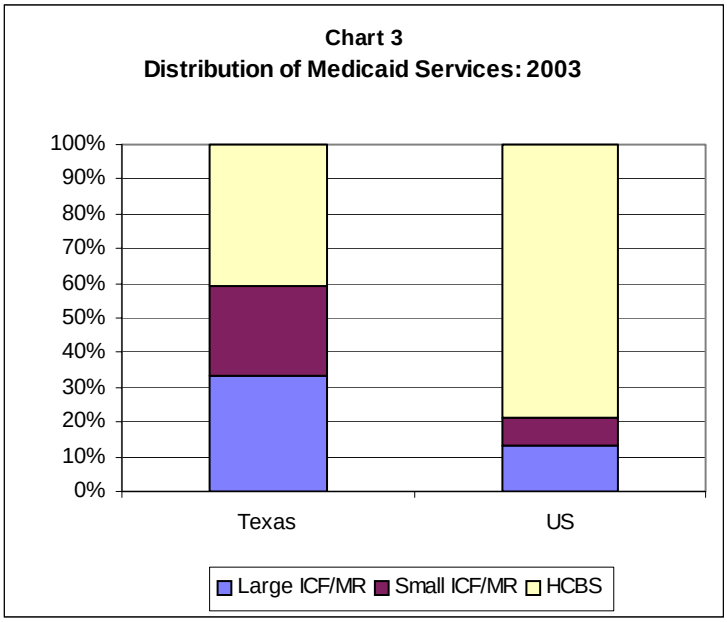
	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
HCBS	8.4	14.4	19.0	24.1	28.2	29.5	30.6	34.2	36.2	38.3
Other ICF/MR	43.8	39.1	38.8	37.2	36.8	36.8	38.1	36.9	34.6	33.5
State School ICF/MR	30.4	28.5	29.7	28.7	27.0	26.2	26.1	25.2	23.8	22.6

year-over-year up to 2001 but after then remained relatively unchanged steady. Between 1994 and 2003, the overall rate at which Texas furnished Medicaid long-term services increased by 14.3%. This means that the number of persons served grew somewhat more rapidly than state population. Nationwide, the rate at which states expanded Medicaid long-term services was significantly greater during this period. It grew from 100.8 per 100,000 in 1994 to 175.2 in 2003, an increase of 73.8%. Since Texas expanded services at a less rapid rate than the nation as a whole, the gap between the rate at which Texas furnished Medicaid long-term services and the nationwide rate widened throughout this period.[9]

In early 2004, Texas secured CMS approval to launch another waiver program targeted to persons with mental retardation. The Texas Home Living Waiver Program will serve a maximum of 3,700 persons once it is fully phased-in.[10] Also, in July 2004, the State obtained CMS approval to add another 500 individuals to its other waiver programs.[11] These steps mean that, going forward, there will be an appreciable increase in the number of persons who receive Medicaid long-term services in Texas. Still, even with these expansions, the number of Texans who receive services relative to state population will continue trail significantly behind nationwide levels.[12]

C. Distribution of Medicaid Services

Chart 3 shows the percentage distribution of Medicaid long-term services in Texas by type of service compared to the nation as a whole. Three service categories are identified: (a) ICF/MR services furnished in facilities that serve sixteen or more persons (including the State Schools and privately-operated larger ICFs/MR); (b) ICF/MR services furnished in facilities that serve fewer than 16 individuals; and, (c) HCBS waiver services. As can be seen from this chart, 59.4% of Texans who received Medicaid-funded services in 2003 were served in ICFs/MR compared to 21.0% nationwide. Moreover, in Texas 33.2% of all persons who received Medicaid-funded services were served in large congregate public and private ICF/MR facilities.[13] Nationwide, only 13.0% of Medicaid beneficiaries were served in larger facilities. Hence, it was less likely for a Texas Medicaid beneficiary to be served in what is generally regarded a more integrated community setting than elsewhere in the nation. In 2003, only two other states served a greater percentage of their Medicaid beneficiaries in large congregate settings than Texas.[14] Only one other state served a smaller percentage of its Medicaid beneficiaries through the waiver program than Texas.[15]



Texas' relatively high reliance on large congregate care facilities as a means of serving its Medicaid beneficiaries and its low utilization of the HCBS waiver program in supporting individuals with mental retardation and related conditions are strong indicators of system

imbalance in light of the distribution of services elsewhere in the nation. Still, during the ten-year period 1994-2003, Texas made some strides in diversifying Medicaid long-term services, as can be seen from Chart 2 in the preceding section. Utilization of ICF/MR services relative to population declined and there was increased utilization of HCB waiver services.

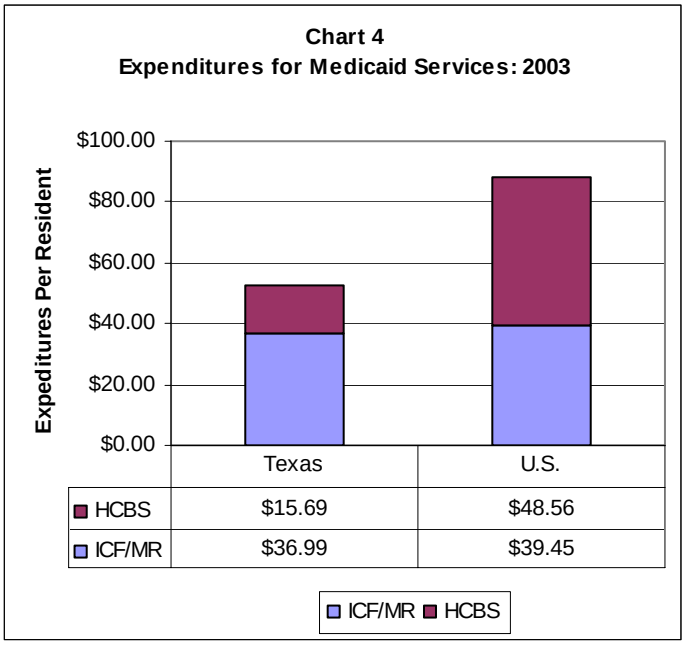
D. Expenditures for Medicaid Services

In 2003, Texas expended $1.165 billion in state and federal funds for Medicaid long-term services for persons with mental retardation and related conditions. The distribution of these expenditures is shown in Table 2.[16] Chart 4 compares Texas expenditures for these services to nationwide levels.

Table 2
Texas Expenditures for Medicaid Long Services by Type of Service: 2003 ($millions)

Service Category	Expenditures
ICF/MR – State Operated	$487.5
ICF/MR – Non-state	$330.8
HCBS Waiver	$347.0

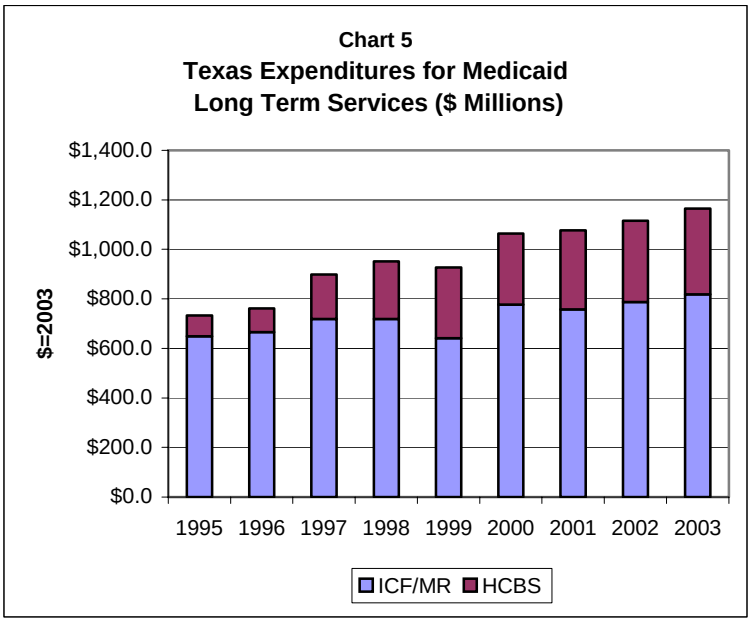
The expenditure comparison is made by calculating expenditures relative to population – i.e., total expenditures divided by total population. In 2003, Texas expended $52.68 per state resident for Medicaid long-term services. In contrast, nationwide expenditures were $88.01 per resident or 67.1% higher than in Texas. In 2003, Texas ranked 44th among the states in terms of its level of financial support for Medicaid long-term services for persons with mental retardation and related conditions.[17] This relatively low level of financial support for Medicaid long-term services is not surprising in light of the low population-indexed rate at which Texas furnishes these services.



In 2003, Texas devoted only 29.8% of its Medicaid expenditures to waiver services. In comparison, nationwide, HCBS waiver expenditures accounted for 55.2% of total expenditures or almost twice the proportion in Texas. Texas State Schools accounted for about 59.6% of ICF/MR spending and 41.8% of total Medicaid expenditures. Nationwide, expenditures for ICF/MR services furnished in state-operated facilities accounted for 27.0% of total Medicaid long-term services expenditures.[18]

Chart 5 on the following page shows Texas inflation-adjusted total expenditures for Medicaid long-term services for the period 1995 – 2003.[19] These expenditures are broken down between ICF/MR and HCB waiver services. As can be seen from the chart, Texas' total expenditures for Medicaid long-term services trended upward year-over-year during this period. Overall, expenditures were 58.9% higher in 2003 in constant dollar terms than in 1995. When population growth is factored in, expenditures per state resident for Medicaid long-term services increased by 35.9% in constant dollar terms during this period.[20]

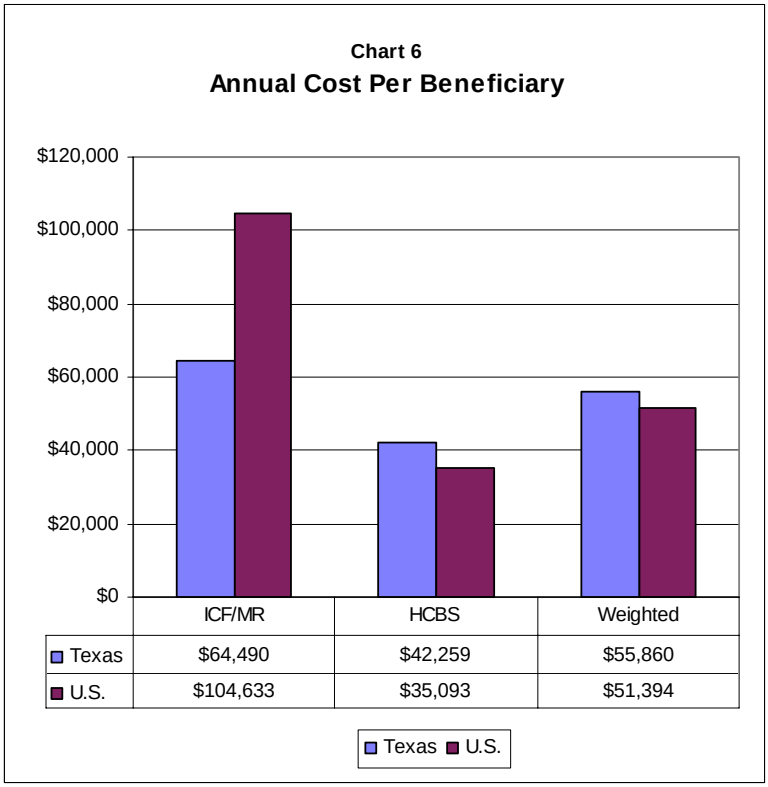
Chart 5 also shows that most of the increase in constant dollar expenditures was the result of growth in spending for home and community services. Even so, expenditures for ICF/MR services increased by 26.1% during this period even though the number of persons who received such services declined by approximately 9.7%.



During this same period, nationwide expenditures for Medicaid long-term services expressed in constant dollars grew by 66.5% in real dollar terms, a somewhat greater rate of increase than in Texas.

E. Expenditures per Medicaid Beneficiary: 2003

Chart 4 shows the annual expenditure per Medicaid beneficiary in Texas and nationwide in 2003 for: (a) persons served in waiver programs; (b) persons served in ICFs/MR; and, (c) the weighted average of both. As can be seen from the chart, Texas' weighted average expenditure per Medicaid were about 8.7% higher than the nationwide level. Texas ranked 17th among the states with respect to its average annual expenditure per beneficiary. The state's expenditure per person served in the waiver program was 20.4% higher than the nationwide average. Texas also ranked 17th nationwide in per person spending for waiver services. On the other hand, state expenditures per ICF/MR resident were significantly below the nationwide average. Expenditures per ICF/MR resident are a composite of expenditures for services provided in the State Schools and services provided in privately-operated facilities. In 2003,



per resident Medicaid expenditures at the State Schools were $95,883; however, per resident expenditures for services furnished in privately operated facilities were much lower: $44,434.[21] Texas ranked 48th among the states in per resident ICF/MR expenditures.

The fact that Texas weighted average expenditures per Medicaid beneficiary were somewhat higher than the nationwide level principally stemmed from two factors: (a) a significantly higher proportion of Medicaid beneficiaries were served in more costly ICFs/MR in Texas than was the case nationwide; and, (b) Texas waiver costs were relatively high because the waiver programs in effect in 2003 concentrated on furnishing services to individuals who require residential services. Higher than average per beneficiary costs is an indicator that Texas was somewhat less efficient in delivering Medicaid long-term services than most other states. The implementation of the Texas Home Living waiver will result in a reduction in HCBS waiver per beneficiary costs because the program limits the total cost of waiver services to no more than $10,000 per beneficiary.

F. Summary

The foregoing results reveal that in 2003 Texas performed markedly below nationwide levels in furnishing Medicaid long-term services to its citizens with mental retardation and related conditions. When measured against population, the number of persons who received Medicaid long-term services was significantly lower in Texas than in the nation as a whole and in all but four other states. Similarly, Texas expenditures for services were substantially below than the nationwide level and the level in all but seven other states, again when measured against population. Furthermore, Texas devoted a higher proportion of Medicaid dollars to services furnished in larger congregate settings than was the case nationwide.

III. Observations

In this part of the report, observations are offered concerning the extent of the Texas waiting list for Medicaid long-term services, potential opportunities for system rebalancing, and other potential avenues for improving funding for services in Texas.

A. Medicaid Service Demand in Texas

In Texas, there is an especially large waiting list of individuals who have requested but are not receiving Medicaid long-term services. Not including individuals who are on the CLASS waiver "interest list," in May 2004 the HCBS waiver waiting list reached 25,543 individuals.[22] This was approximately 5,000 more individuals than the number of persons served in 2003. Some 48% of wait listed persons were receiving no services at all and presumably the remainder received less than the full complement of services that they required. In addition, reportedly, the CLASS waiver "interest list" is approximately 7,000 individuals. In August 2003, the number of persons waiting for a residential service was 6,528. In 2003, Texas furnished residential services to a total of 19,708 individuals. Satisfying this unmet demand for residential services would require about a 33% expansion of residential services in Texas.

Moreover, the number of individuals requesting but not receiving Medicaid long-term services has been growing rapidly. The number of individuals waiting for services in May 2004 (again, not including the CLASS waiver interest list) was 25.2% greater than in November 2002 when 20,395 individuals were on the waiting list. During this period, the waiting list grew at the rate of approximately 270 persons per month.

The sheer magnitude of the Texas waiting list should be no surprise in light of the state's sub par performance in furnishing Medicaid long-term services. In a similar vein, it is not

surprising that there is a large cohort of persons wait listed for residential services because Texas performance in furnishing such services also has been decidedly sub par.[23] Adding the number of persons served in 2003 to the number of persons who were waiting for Medicaid long-term services in August 2003 yields a service demand rate of 186.6 persons per 100,000 state residents, not including persons on the CLASS waiver "interest" list. This level of service demand falls within predictable levels – i.e., it is in the same general range that are found in other states. The fact that the waiting list has surged over the past two years is not surprising either. Population growth alone would lead to an expected increase in persons seeking services of about 700 persons each year. Demand in Texas has been growing more rapidly than what population growth alone would predict. This phenomenon also is being experienced in other states, including states that furnish Medicaid long term services at an appreciably high rate than presently is the case in Texas.[24]

Since the Texas waiting list is composed of individuals who request services, the potential exists that some of these individuals will not meet Medicaid eligibility tests when their needs are fully assessed. In other words, the waiting list possibly may overstate unmet demand for services in Texas. But, it probably is more likely that the waiting list understates unmet demand because in states where the prospects of receiving services in the near term are not high, many individuals elect not to seek services. When services become more available, states often experience a surge in service demand.[25]

In a nutshell, Texas' very large waiting list for Medicaid long-term services obviously is the byproduct of the state's especially low level of effort in furnishing services to its citizens with mental retardation and related conditions. Expressed but unmet demand for services (as recorded by the waiting list) is about at the level one would expect given experience in other states. The general pattern is that the demand for Medicaid long-term services is running in the range of 225 to 250 persons per 100,000 in the population. Including the CLASS waiver interest list, this is about where service demand in Texas is presently running. Nor is it surprising that the Texas waiting list is growing at a rapid pace. Going forward, the Texas waiting list for services will not stabilize or start to recede unless the state appreciably steps up its level of effort in furnishing Medicaid long-term services. If services expand at a relatively slow pace, then more and more individuals will back up onto the waiting list and the waiting list itself will not move at a reasonable pace.

B. Rebalancing

Texas' system of furnishing Medicaid long-term services is imbalanced. In comparison to the nation as a whole, Texas utilizes costly institutional ICF/MR services at a higher rate than the substantial majority of states. In 2003, Texas furnished services in large public institutions at the rate of 22.6 persons per 100,000 state residents.[26] This was 53.7% greater than the nationwide rate of 14.7 persons per 100,000 in the general population. Texas ranked 9th among the states in the extent of its reliance on large public institutions as a means of serving individuals with mental retardation and other related conditions. Some 30 states employed large public institutions at a rate less than the nationwide average; of these, the utilization rate in 16 states was one-half or less of the nationwide average.

As previously observed, 41.8% of Medicaid long-term services dollars pay for services at the Texas State Schools even though the Schools serve only about 23.9% of all Medicaid long-term services beneficiaries. Between 1994 and 2003, the number of persons who received ICF/MR services at the State Schools declined by about 11.2%. During the same period, utilization of ICF/MR services in large public institutions nationwide declined by 33.3%.

As previously observed, on a per beneficiary basis, services furnished in the State Schools are the most costly Medicaid long-term service that Texas provides. Moreover, per beneficiary costs at the State Schools have increased year-over-year. Between 1996 and 2003, the annual per beneficiary cost increased by 45.9% in nominal dollar terms and 27.1% in constant dollar terms.[27] As a consequence, State School spending increased by approximately 9.0% in real dollar terms because the reduction in the number of persons served in these facilities was more than offset by escalating per beneficiary costs.[28] Over time, there has been an appreciable decline in the efficiency with which services are provided at the State Schools.

Going forward, the prospect is that State Schools operations will continue to claim a disproportionate share of Medicaid long-term services spending. It is anticipated that the number of persons served at the State Schools "will continue its downward trend, albeit at a much slower pace than in previous years."[29] A slow rate of decline in State School residents means that the costs per facility resident will continue to rise in real dollar terms because fixed facility costs will be spread over a diminishing number of residents. Moreover, the estimated capital costs of maintaining the present cohort of State Schools is $410 million for the period 2004-2009.[30]

"Rebalancing" refers to shifting services from more to less costly types. As discussed above, the present Texas system is imbalanced because it relies more heavily on public institutional services than is the case in the majority of states.[31] Due to the costs of operating the State Schools, this imbalance results in the disproportionate allocation of Medicaid long-term services dollars to State School services and, thereby, diminishes the state's ability to expand services to additional individuals. Rebalancing offers the prospect of freeing up dollars to secure some reduction in the waiting list.

With respect to the State Schools, going forward, Texas can consider two rebalancing strategies, either singly or in combination. One strategy is to consolidate State School operations. While the number of persons served at the State Schools has declined, the number of facilities that the State is operating has remained the same since the closure of the Fort Worth and Travis State Schools in 1996.[32] Consolidation is a strategy that could aid in reducing the rate at which per resident costs increase at the State Schools and also assist in avoiding some capital outlays. Consolidation potentially could yield some savings that could be employed to reduce the waiting list, particularly if consolidation took the form of closing the most costly facilities.[33] Consolidation would improve cost efficiency; however, it would not reduce Texas' over reliance on large congregate facilities to meet the needs of Medicaid beneficiaries with mental retardation and related conditions.

The second rebalancing strategy is to significantly scale back the number of individuals served at the State Schools through community placement and close outright some of the facilities in favor of expanding less costly service options. As previously noted, in 2003, Texas served markedly more individuals in large public facilities than most other states. Scaling back the number of individuals served at the State Schools to the nationwide 2003 norm for the utilization of large public facilities would entail a reduction in State School population of 1,747 persons. A population reduction of this magnitude would permit the outright closure of 4-6 of the current facilities. Obviously, scaling back State School operations to this extent would require a multi-year effort.

From a financial standpoint, this rebalancing strategy likely would yield substantial savings over the long-term. The amount of such savings obviously would hinge on the costs of securing community placements for the State School residents who would be affected by

facility closure. Facility closure – rather than scaling back the size of facilities – is necessary in order to maximize the savings associated with accelerated State School census reduction.[34]

Table 3 below shows the potential financial outcomes associated with different scenarios of facility census reduction and closure. The first scenario posits that the net savings (e.g., the difference in cost between serving an individual in a State School and in the community) from community placement would be $15,000 per year per resident placed. The second scenario posits that the savings would be $25,000 per year per resident placed. Under each scenario, the total potential net savings are calculated along with the number of additional persons who could be served by reallocating the net savings to community services: (a) at the current cost of HCB waiver services (i.e.,, $42,259 per waiver participant) and (b) alternatively through the implementation of a "mid-range" waiver program that had an average per participant cost of $25,000 (i.e., about mid-way between the costs of the Home Living Waiver and the current HCS waiver program). In the next section of the report we discuss the potential benefits of operating such a mid-range program.

Table 3: Rebalancing Scenarios

Scenario # 1: Net Savings of $15,000 per Community Placement			
Number of State School Residents Placed in the Community	Rebalancing Savings	Number of Persons Who Could be Served at HCS Waiver Cost	Number of Persons who Could be Served in a Mid-Range Waiver Program
500	$7,500,000	177	300
1,000	$15,000,000	355	600
1,500	$22,500,000	532	900
1,750	$26,250,000	621	1,050
Scenario #2: Net Savings of $25,000 per Community Placement			
500	$12,500,000	296	500
1,000	$25,000,000	592	1,000
1,500	$37,500,000	888	1,500
1,750	$43,750,000	1,035	1,750

Under either scenario, the amount allowed to pay for the costs of supporting State School residents in the community is relatively high by Texas standards ($82,000 per year under Scenario #1 and $72,000 per year under Scenario #2). This anticipates that State School residents might need above funding in order to be successfully placed in the community. Each scenario yields a significant gain in the number of additional persons who could be served with rebalancing savings, although obviously the number would be greater were a mid-range waiver to be implemented. Depending on a variety of other factors, rebalancing savings could be higher than those shown on the table.[35]

It is important to emphasize that the foregoing savings would be realized post-closure/post-placement. During the period while a facility is being closed, it is difficult to secure sufficient savings to offset community placement costs. The most cost-efficient facility closure strategy is to accomplish the closure as quickly as possible to minimize interim double-funding of facility operations and community placements.

Rebalancing is a means for a state to increase the cost-efficiency of its purchase of Medicaid long-term services for individuals with mental retardation and related conditions. In the end, more individuals can be served without increased state funds. In Texas, the most significant

opportunity for improving cost efficiency through rebalancing is to substantially scale back the scope of State School operations.

C. Additional Opportunities

There may be additional opportunities for Texas to expand services for its citizens with mental retardation and other related conditions. In particular:

- In 2002, it appeared that Texas had been less successful in leveraging its state dollars to secure federal Medicaid funding than most other states. In particular, 23% of the dollars that Texas expended on services for persons with mental retardation and related conditions were not being employed as match to secure federal Medicaid dollars.[36] Nationwide, the figure was 14%. To the extent that Texas could redeploy unmatched state dollars to Medicaid services, the state could expand services without increasing state appropriations.[37] However, Texas' present status with respect to leveraging federal Medicaid dollars is not known. Since 2002, the amount of unmatched state funds may have declined due to state budget reductions and the state's implementation of leveraging strategies (e.g., the implementation of the Texas Home Living waiver program). A much closer examination of the current status of Texas services and programs would be necessary in order to determine whether there remain substantial opportunities for the state to secure more federal Medicaid dollars through increased leveraging.

- In the foregoing discussion of rebalancing, the potential of Texas operating a "mid-range" waiver program was raised. In recent years, a number of states have designed and implemented such programs which do not include the provision of 24-hour supervised residential services.[38] Instead, the objective of such programs is to furnish moderately intensive services to individuals who live with their families or who can live in their own living arrangement with support. These programs are designed to improve the efficiency with which a state furnishes community-based alternatives to persons who require Medicaid long-term services. The Texas Home Living waiver program is this type of program. However, it is targeted to individuals who have the least intensive needs among persons who qualify for Medicaid long-term services and the program has a very low expenditure cap.[39] A program with a higher expenditure cap potentially could provide a means of serving persons with somewhat more intensive service needs at a lower cost than through the present Texas waiver programs.

  Going forward in Texas, efforts to reduce the state's very large waiting list for community services will be enhanced to the extent that the state is able to configure the provision of community-based services as economically as possible. The design and implementation of a mid-range waiver could be of assistance in this regard. While there is a large number of persons on the waiting list who are requesting residential services and thereby potentially need the types of services furnished through the HCS waiver program, the substantial majority of persons on the waiting list are not requesting residential services but instead are seeking in-home and community support services. With a mid-range waiver program, the state likely could meet the needs of these persons at an appreciably lower cost per beneficiary (albeit at a somewhat higher cost than through the Texas Home Living program). For example, Washington State recently reconfigured its waiver program into four distinct programs as a means of improving the efficiency with which it furnishes home and community-based services.

In summary, to the extent that there remain opportunities for Texas to increase the extent to which it leverages federal Medicaid dollars, services in Texas can be expanded at no additional

cost to the state. Revisiting and restructuring the configuration of Medicaid home and community-based services potentially could position Texas to expand services in the most cost-efficient way possible.

Reference

Robert Prouty, Gary Smith, and K. Charlie Lakin (eds.) (2004). *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2003.* Minneapolis: University of Minnesota, Research and Training Center on Community Living.

Annually the Research and Training Center on Community Living (RTCCL) at the University of Minnesota conducts a survey of the states to compile information concerning the provision of residential services to persons with developmental disabilities. The scope of this survey includes state provision of services through the ICF/MR and HCBS waiver programs. The present report relies heavily on this information, which contains the most extensive and up-to-date information concerning Medicaid long-term services furnished to individuals with developmental disabilities. The Texas figures cited in the present report (except where otherwise noted) are drawn from this report and were furnished by Texas state officials to RTCCL. Figures in the present report for years prior to 2003 are drawn from previous RTCCL reports dating back to 2004. In the endnotes, this report is cited simply as Prouty et al. (2004).

End Notes

[1] Prouty et al., 2004

[2] While there are no federally-imposed limitations on the number of persons a state may serve in its HCBS waiver program(s), federal financial participation is only available to the extent that the average per person costs of waiver services is no greater than the average per resident costs of ICF/MR services.

[3] As previously noted, in order to be served in an HCBS waiver program, individuals with mental retardation and related conditions must be determined to require the level of care furnished in an ICF/MR. A state may impose additional eligibility criteria governing participation in a waiver program that restrict a program's target population to a subset of persons who meet level of care criteria (e.g., limit a program to persons with a specific diagnosis – for example, autism – or by age). Eligibility for a waiver program can be no broader than eligibility for the level of care for which the waiver program stands as an alternative. The foregoing notwithstanding, individuals who participate in an HCBS waiver program require the same level of care as persons served in ICFs/MR and, thus, it can be said that both programs serve the same population.

[4] Unless otherwise noted the figures cited in this and subsequent sections are from Prouty et al., 2004

[5] The national and Texas population figures employed in calculating the population-based indexed service provision rates are those published by the U.S. Census Bureau (Annual Estimates of the Population for the United States and States, and for Puerto Rico: April1, 2000 to July1, 2003 (NST-EST2003-01)). It is noted that the population-based service provision rates calculated for this report differ from those published in Prouty et al. (2004). Post-publication it was discovered that the population figures upon which similar calculations were based in the RTCCL publication were not correct.

[6] The following table contains the state-by-state figures for the ten most populous states:

Provision of Medicaid Long-Term Services to Persons with Developmental Disabilities: Ten Most Populous States (2003)			
State	ICF/MR Residents Per 100,000 State Residents	HCBS Waiver Participants Per 100,000 State Residents	Total ICF/MR and HCBS Waiver Recipients Per 100,000 Population
California	27.7	151.5	179.2
Texas	56.1	38.3	94.4
New York	49.3	254.9	304.2
Florida	19.4	142.8	162.2
Illinois	79.4	77.3	156.7
Pennsylvania	32.1	206.6	238.7
Ohio	62.3	88.3	150.6
Michigan	1.7	86.2	87.9
Georgia	16.6	102.5	119.1
New Jersey	36.7	94.0	130.7
North Carolina	53.5	67.7	121.2

It should be noted that Michigan's figures likely are significantly understated.

[7] Calculated by multiply the difference between the U.S. and Texas service provision rates by the population of Texas in 2003.

[8] The values upon which the chart is based are contained in the following table:

Persons Receiving Medicaid Long-Term Services in Texas: 1994 - 2003										
	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
State School ICF/MR Residents	5,631	5,384	5,735	5,652	5,436	5,380	5,470	5,372	5,169	5,000
Other ICF/MR Residents	8,111	7,388	7,489	7,333	7,396	7,562	7,983	7,885	7,515	7,406
HCBS Waiver Participants	1,564	2,728	3,658	4,753	5,666	6,058	6,406	7,304	7,873	8,471
Total Persons Served	15,306	15,500	16,882	17,738	18,498	19,000	19,859	20,561	20,557	20,877

[9] In 1994, the rate at which Texas furnished Medicaid long-term services was 81.9% of the nationwide rate. As noted, in 2003, the Texas rate was only 53.9% of the nationwide rate.

[10] *Texas Home Living – Initial Request 2004 – 2007* (Texas Department of Mental Health and Mental Retardation). This program was approved by CMS to become effective March 1, 2004. In its waiver application, the state targeted enrollment in this program to 1,938 persons who already are receiving services and 1,766 individuals waiting for services. By enrolling persons already receiving services, the state is leveraging dollars it already expends for services to acquire additional federal Medicaid funds to expand services to unserved individuals.

[11] Centers for Medicare and Medicaid Services (July 9, 2004 Press Release). "HHS APPROVES TEXAS PLAN TO HELP MORE DISABLED INDIVIDUALS AT HOME"

[12] The recent waiver expansions would raise the rate at which Texas furnishes services to approximately 115 persons per 100,000 population. This rate would still be about 34% less than the nationwide rate in 2003.

[13] In addition to the 5,000 persons served in the State Schools, another 1,926 individuals received ICF/MR services in large public-sector ICFs/MR.

[14] Illinois and Mississippi

[15] District of Columbia

[16] The breakdown in ICF/MR expenditures between publicly-operated and privately-operated facilities is from: Steve Eiken, Brian Burwell, and Michael Schaefer (2004). "Medicaid Long Term Care Expenditures in FY 2003." Cambridge MA: MEDSTAT. Available at: hcbs.org/files/34/1686/HCBSWaivers2003.Doc.

[17] In terms of overall expenditures for mental retardation services (including services funded by non-Medicaid sources), Texas also has historically ranked low among the states. In 2002, Texas ranked 42nd among the states in terms of its overall fiscal effort in support of mental retardation services. Mary C. Rizzolo, Richard Hemp, David Braddock and Amy Pomeranz-Essley (2004). *The State of the States in Developmental Disabilities*. Washington DC: American Association on Mental Retardation. Available at: www.cu.edu/ColemanInstitute/stateofthestates/summary_2004.pdf.

[18] Eiken, Burwell and Schaefer (2004). *Op. Cit.*

[19] The adjustment for inflation employs price indices for government consumption expenditures as published by the U.S. Bureau of Economic Analysis.

[20] In 1995, Medicaid long-term services expenditures were $38.77 per state resident, expressed in 2003 dollars.

[21] Annual per resident expenditures are calculated by dividing spending for publicly and privately operated facilities as reported in Eiken, Burwell and Schaefer (2004). by the average daily populations reported in Prouty et al. (2004)

[22] Texas Department of Mental Health and Mental Retardation (May 31, 2004). "Persons Waiting for Community Mental Health and Mental Retardation Services."

[23] In 2003, Texas furnished residential services at the rate of 89.1 persons per 100,000 state residents versus the nationwide rate of 138.3 per 100,000 in the general population. Prouty et al., 2004.

[24] For example, Wyoming furnished Medicaid long-term services at the rate of 322.8 persons per 100,000 state residents in 2003, a rate that was more than three times as high as Texas. However, the state has not been able to avoid having to wait list individuals for services, although the number of persons wait listed has typically been proportionately small. Trends in Wyoming point toward service demand continuing to grow for the foreseeable future. Gary A. Smith (2003). *Forecasts of Service Demand in Wyoming*. Tualatin OR: Human Services Research Institute.

[25] In Florida, for example, the state agreed to furnish services to all persons who were wait listed as of July 1999 as part of the settlement of the *Prado-Steiman v. Bush* litigation. This led to a significant expansion of the state's HCBS waiver program for persons with developmental disabilities. Since 1999, another 13,000 individuals have come forward to seek services.

[26] Prouty et al., 2004

[27] In 1996, annual State School costs were $66,485 or $76,328 in 2003 dollars. In 2003, annual costs were $97,006. Prouty et al., 2004.

[28] The escalating costs of operating the State Schools most likely is the byproduct of their slowly declining resident population. In 1996, the thirteen State Schools served an average of 450 residents. In 2003, they

served an average of 385 individuals. Because State School fixed costs must be spread over fewer residents, the result is that average real dollar costs rise.

[29] Program Statistics and Planning, Texas Department of Mental Health and Mental Retardation (2004). *Report Update for State Mental Retardation Facilities – Working Draft '04-'05*. It also is worth noting that during the first quarter of FY 2004 the weighted average cost per bed day at the state schools had climbed to $280.05 (TDMHMR (2004). *State Mental Retardation Facilities: Mission, Vision, Goals, and Performance Indicators – 2nd Quarter FY 2004 Statewide Performance Indicators*).

[30] Program Statistics and Planning, Texas Department of Mental Health and Mental Retardation (2004). *Report Update for State Mental Retardation Facilities – Working Draft '04-'05*

[31] The Texas system also is imbalanced due to the extent of its reliance on ICFs/MR in general. However, the privately-operated ICF/MR facilities are much less costly on a per resident basis than the State Schools. In 2003, the majority of privately-operated ICF/MR beds were in facilities that served six individuals, although, as previously noted, a relatively large number were located in large congregate facilities that serve sixteen or more individuals. Since the cost of private ICF/MR services in Texas is relatively low, there is less financial benefit associated with attempting to rebalance the system by reducing private ICF/MR utilization. However, from the standpoint of community integration and consumer choice, there might be other benefits associated with reducing the utilization of private sector ICFs/MR, especially the larger facilities.

[32] It is worth pointing out that between 1996 and 2003, the number of State School residents decreased by about 700. This decline did not trigger the closure of additional facilities even though it was sufficient to have permitted the closure of at least one-to-two facilities.

[33] The bed day costs at the smaller State Schools which might be the most likely candidates for consolidation are generally higher than the costs of the larger facilities but not substantially higher. If consolidation yielded a $10/day reduction in overall State School per costs, the net gain would be about $18.2 million or enough funds to provide HCB waiver services to approximately 430 persons.

[34] Absent the outright closure of facilities, scaling population back by approximately one-third would cause facility costs to escalate and thereby reduce the amount of funds that could be reallocated to lower cost community options.

[35] To the extent that there is attrition in the State School census, facility census reduction and closure would require fewer dollars to pay for community placements.

[36] Rizzolo et al. (2004), *op. cit.*

[37] If Texas had leveraged federal Medicaid dollars at the nationwide rate during 2002, then the state could have obtained roughly $150 million more in federal Medicaid dollars. This would have permitted serving approximately 3,550 more individuals through the waiver program.

[38] Robin Cooper and Dan Berland (2004). *Using a "Supports" Waiver Program to Achieve Targeted Policy Goals*. Alexandria VA: National Association of State Directors of Developmental Disabilities Services, Inc.

[39] The Texas Home Living Waiver Program is limited to individuals who meet Level One ICF/MR level of care criteria, the minimum criteria under which individuals may qualify for Medicaid long-term services in Texas.