

**Rebalancing Long-Term Care Systems in Texas:  
Experience up to July 31, 2005**

**Abbreviated Report**

submitted to the

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The overall project is being conducted through a Task Order under a CMS Master Contract between CMS and the CNA Corporation, Arlington, VA, and subcontracts and consultant agreements between CNAC and the various researchers. The 3-year study calls for case studies of the experience of 8 states—other states in the study are: Arkansas, Florida, Minnesota, New Mexico, Pennsylvania, Vermont, and Washington. This baseline case study covers a period through July 31, 2005; updates will be prepared for the period ending July 31, 2006 and 2007.

A slightly earlier version of this Abbreviated Report was discussed at A CMS Open Door Forum, February 22, 2006. The statements and opinions in the report are those of the writers and do not necessarily reflect the views of CMS or any of its staff, or the State liaisons to the project, or any other state staff or persons who spoke to us from participating states. We thank the Texas liaisons to the study, initially Tom Phillips, Project Manager, Texas Department for Aging and Disability Service, and later Marc Gold, Manager, Promoting Independence Initiative, Texas Department of Aging and Disability Services.

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## Rebalancing Long-Term Care Systems in Texas: Abbreviated Report

### Highlights

The State of Texas has been seriously engaging in efforts to promote community service choices for several decades.<sup>1</sup> Historically, Texas has been above average among States in the utilization of community service options compared to institutional ones, but not in relative expenditures between the 2 sectors. Texas has proceeded with its rebalancing efforts in collaboration with strong and sophisticated consumer stakeholders and with provider stakeholders. Notable features related to rebalancing in the Texas service delivery system include:

- A massive reorganization and consolidation of health and human services organizations into a newly organized umbrella agency, Health and Human Services Commission (HHSC), with four operating departments, among them the Department for Aging and Disability Services (DADS), which now combines policy, planning, operations, and quality assurance for all long-term supports in the community and in institutions for all populations needing such support including seniors, children, people with physical and/or cognitive disabilities, The Texas Department of State Health Services provides services to persons with mental illness.
- Coordinated use of Medicaid state plan services along with home and community based waiver services, supplemented social service block grant funding, Older American Act Funding, and some pure state programs.
- A major investment in attendant care, with a consumer directed option within it. Texas has large state plan amendment personal care program, Primary Home Care for persons at the SSI income level. Additionally, Texas is the only state in the country to take advantage of the 1929(b) provisions to provide service for persons up to 300% of SSI. Both of these Medicaid attendant programs have the availability of consumer directed options. The state also funds a small attendant program with Title XX dollars.
- A state-led process of consultation and joint planning with both consumer and provider stakeholders.

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<sup>1</sup> This abbreviated report is a synopsis of a much longer report on rebalancing long-term care systems in Arkansas, performed under contract between the University of Minnesota and CNAC Corporation through a Master Contract between CMS and CNAC. The full-length report, which contains organizational charts, references, and much more detail, will appear over the next few months on the website [HCBS.org](http://HCBS.org) and on the University of Minnesota's Principal Investigator's Website <http://www.hpm.umn.edu/LTCResourceCenter/>. Similar abbreviated and full case studies have been prepared for the States of Arkansas, Florida, Minnesota, New Mexico, Pennsylvania, Vermont, and Washington. The report covers a period up to July 31, 2005; subsequent reports will update the case study as of July 2006 and July 2007.

- A strong vision for consumer choice and community integration within an “enterprise” model of health and human services that also emphasizes efficiency, accountability, and out-sourcing roles to the private sector with government monitoring.
- Pioneering efforts to model “money follow the person” so that individuals leaving institutions can take resources with them without reducing the total number of community slots.

### **Context**

Among the contextual factors influencing the rebalancing efforts in Texas and described in the full report are the following:

- The large and diverse urban and rural populations in Texas and the sheer scale of a state with large numbers of people spread over a very large space and in 254 county jurisdictions.
- A service system whereby state agencies may have no direct authority over how lead agencies in the local delivery system organize themselves (e.g., mental health authorities, area agencies on aging,) except through what can be influenced in contractual arrangements . DADS has authority over its aging and physically disabled service system.
- A philosophy of minimum taxation (Texas has no state income tax) combined with an economic down-turn and budget deficit in the early 21<sup>st</sup> century. (The year this report was prepared, the deficit situation had turned around and the legislature added additional dollars to reduce the “interest lists” of people waiting for service.
- A sophisticated and large consumer advocacy community, representatives of which have been actively engaged in comprehensive post-Olmstead planning since 1999.
- Law suits related to “interest lists” and lack of access to community services for people with cognitive disabilities.

### **Real Choice Systems Change (RCSC) Grants**

Texas received \$3,616,963 in six Real Choice Systems Change Grants between 2001 and 2004.<sup>2</sup> The state has made strategic use of these funds to promote system navigation, build an infrastructure for its already operating Money Follows the Person policy, strengthen the service

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<sup>2</sup> In 2001, Texas received a Nursing Facility Transition Grant (\$308,170), which allowed the Texas Association of Centers for Independent Living to develop community capacity for transitions from nursing homes. In 2002, Texas received a System Change Grant (\$1,285,000), and in 2003, Texas received a Community-Integrated Personal Assistance and Support Services (C-PASS) grant (\$599,763), a Money Follows the Person Grant (\$730,422), a feasibility grant to explore treatment for children with severe disabilities (\$93,600), and a Quality Assurance/Quality Improvement Grant (\$500,000). In 2005 (after the time period for this baseline case study), Texas received an Aging and Disability Resource Center grant (\$793,262).

system and its quality monitoring for its waivers, pilot a Service Responsibility Option (SRO) to provide another service alternative for consumer direction, and consider the feasibility of a new children's mental health waiver. Taken together, these RCSC grants have been used strategically to develop local awareness and capacity throughout the State, to engage Centers for Independent Living in the efforts, build community coalitions and to develop training materials. These grants led to operational programs. For instance, the SRO has been incorporated into the attendant programs, and the State plans to move ahead with its children's mental health waiver. The QA/QI grant formed the basis for a large-scale individual experience survey across all DADS' Medicaid waiver programs as well as the ICF/MR program and also funded the design of a person-centered database crossing all agency disability populations.. The Nursing Facility Transition Teams, funded through the MFP grant, identified barriers and recommended systematic changes to help clients with significant needs make transitions into the community.

### **Programs and Services**

Through DADS, Texas operates eight Home and Community Based Waivers, including its very large Community-Based Alternatives (CBA) waiver, a large waiver for people with mental retardation, a waiver for people with related disabilities, several smaller waivers for persons with MR, and a Consolidated Waiver, operating on a demonstration basis in San Antonio (combining management of services for people on the interest lists for any of the other waivers). Through DADS, Texas also operates 5 Medicaid state plan services for long-term support, including its nursing facility program and its Intermediate Care Facility for the Mentally Retarded (ICF/MR); this program includes its state schools. Also in the state plan are: an optional personal care program, in Texas called Primary Home Care) which funds people of all ages, provides a wide array of services, with eligibility at SSI; an optional Community Attendant Services program (built on the 1929(b) provisions) and which similarly serves all ages up to 300% of SSI; and a large adult day care program. DADS operate two PACE sites, and also has responsibility for operating the many block-grant and state-funded programs that wrap around Medicaid and Medicaid waivers, including Older Americans Act Programs.

Texas operates the nation's first mandatory capitated program that combines acute and long-term services for SSI-related consumers through its Star+Plus program in the Houston area. This large program has been considered successful by evaluators and advocates, though a full-scale evaluation of outcomes and costs over time taking into account case-mix has not been done. The 79<sup>th</sup> Texas Legislature (2005) required certain changes to the STAR+PLUS model because of UPL concerns. The revised model will be expanded to four service delivery areas (SDA)s.

The 79<sup>th</sup> Texas Legislature also required the development and implementation of new non-capitated managed care system known as an Integrated Care Management (ICM) model. This model is currently being developed using an Administrative Service Organization as its central point. This model will be implemented in the Forth Worth and Dallas areas.

## **Featured Management Approaches**

### **State Agency Consolidation**

In 2003 the Texas legislature enacted an ambitious consolidation of 12 state agencies into 5 agencies: an umbrella Health and Human Services Commission (HHSC) headed by an Executive Commissioner and 4 operating agencies, each with a Commissioner, a Deputy Commissioner, and an Advisory Council. One of these, the Departments of Aging and Disability Services (DADS) is the focal point for most long-term care and support services in the community and in institutions, including policy-setting, service management, and quality monitoring. (The other departments are Assistive and Rehabilitative Services (DARS), State Health Services (DSHS), and Family and Protective Services (DFPS).) The reorganization brought together into DADS those responsible for aging and most disability programs (including mental retardation services, aging services, and most children's services) into the same units to work along functional lines; programs for persons who have hearing and/or visual impairments are served by DARS; persons with behavioral health disabilities are served by DSHS; and certain children's programs are served by HHSC. DADS itself is organized with 3 cross-cutting centers for policy/program coordination/consumer and external affairs and 3 operational units, each with an Assistant Commissioner (Intake and Access Services, Provider Services, and Regulatory) and across disability groups on topics such as access, service development, and quality monitoring. The new organizational structure was meant to reduce costs and improve accountability, including data capacity. It is also being used strategically to expand the ability of the state to envisage and manage high quality, consumer-centered HCBS services for all Medicaid populations regardless of age or disability.

### **Money Follows the Person**

Texas was the first state to implement a strategy of allowing Nursing Facility (NF) residents to receive long term services and supports in the community by using their NF allocated dollars to fund waiver services. These individuals "by-pass" the waiver interest list but do not take away the waiver community slots. The monies are transferred from the NF line item into the Community line on a periodic basis. However, once the person no longer is utilizing community services those dollars are transferred back to the community. Only those dollars necessary to fund the community services are transferred up to the amount that would have been paid in the NF. Beginning in 2001 as Rider 37, the policy continued with additional consumers in 2003 as Rider 28, and was re-affirmed in state law in 2005 as House Bill 1867. A 2003 Real Choice System Change Grant for Money Follows the Person developed local community NF Transition and funded training for this re-location initiative. Since 2001, the program successfully resulted in 9,296 relocations (3204 for Rider 37 and 6,092 for Rider 28), of whom 6352 individuals were still receiving HCBS in August 2005. The MFP population is elderly but approximately one-third of the population is under the age of 65. DADS did not track detailed Rider 37 data. According to DADS data for 4432 of the 6,092 Rider 28 consumers, 66% were over 65, 1514 consumers were over 80 and 324 were over age 90. Advocates favor expanding Money Follows the Person to ICF-MRs as one mechanism for change. The 2005 Legislature did not accept this last recommendation, but authorized funding to help move up to 50 children from ICF-MRs.

## **Stakeholder Relations and Promoting Independence Initiative**

DADS and its precursor agencies have a history of active engagement and joint planning with advocacy groups. The Olmstead planning process, called the Promoting Independence (PI) Initiative, begun in 1999, is guided by a strong stakeholder advisory council, which reports annually on progress. As designated lead agency for the PI Initiative, DADS participates actively with stakeholders in the process and has assigned a senior policy analyst reporting to the DADS' Commissioner to staff the efforts. Further, the new DADS organization includes a highly-placed Center for Consumer and External Affairs, directly under the Deputy Director, with a unit dedicated to stakeholder relations within it. Five Real Choice Systems Change (RCSC) Grants, awarded from 2001 to 2004, totaling \$3,613,963 have been used strategically to explore or pilot programs of interest and concentrate on areas such as consumer direction, coordination at local levels, strengthening children's services, and developing local community collaborations for Money Follows the Person.

## **Relocation Specialist Outreach**

The Promoting Independence Advisory Council (PIAC) emphasized the need to identify and assist people who wish to leave nursing homes. Two mechanisms to assist in this process are: 1) the development of relocation specialists (contracted staff) and 2) utilization of Section Q1a of the nursing facility Minimum Data Set (MDS). Relocation specialists reach out to provide outreach, assistance and facilitation. At present, four Centers for Independent Living are the contracted organizations. State officials and advocates are encouraged that this is a good method of helping people in nursing homes learn about HCBS options and assisting them in realizing preferences to leave institutions. The money available for these relocation contracts is still not optimal.

Section Q1a of the MDS asks residents whether they would like to live elsewhere, but the information has been unavailable except as state aggregate figures to protect resident confidentiality. To use the individual information, Texas is considering securing a data use agreement from CMS that will permit it to release to state-contracted relocation specialists the names of people who wish to leave nursing facilities. Taken together, these approaches, which could be replicated by other states, create a motivated independent labor source for relocation assistance and offers them some tools to identify potential relocation candidates.

## **Consumer Direction within Agency Services**

Expansion of consumer-directed services is a priority. The state was proactive in the development of a consumer-directed model and has implemented it in its attendant care programs and most of its waivers. The two remaining waivers for persons with cognitive disabilities will be incorporated consumer-direction in January 2007.

Using a Real Choice System Change C-PASS grant awarded in 2003, DADS developed and tested a Service Responsibility Option (SRO) which models a new variation on the consumer-directed system. SRO allows consumers select, train, and manage their own care while a home care agency manages the fiscal aspects of the service instead of them in the original CDS version. This strategy brings consumer direction to individuals who are leery of taking on full payroll-related employer functions.

## **Access Improvement**

With an Assistant Commissioner for DADS dedicated to access and intake, much planning has been devoted to improving the way individuals get information about and access to services at the local level in a fragmented system with 3 front doors which was a result of the pre-consolidated system and through the guardianship program which was placed in DADS. Texas used a 2002 Real Choice Grant to test two models of system navigators. In addition, a 211 number has been utilized for consumers, and training has been developed. A new assessment has been developed and piloted. The most ambitious effort, occurring at the level of the Health and Human Services Commission is called IEE. IEE will consolidate applications to a wide variety of programs including those operated by DADS and is predicated on new information technology, and ultimately will permit applications by phone, mail, and e-mail as well as at a streamlined number of in-person sites.

## **Multifaceted Quality Initiatives**

DADS has a strong emphasis on quality. The Department's Quality Assurance and Improvement embraces all institutional, residential and HCBS services, includes a focus on critical incident monitoring, data-driven best practices, and visits to institutions aimed at improving quality apart from those to assess and enforce regulatory compliance.

DADS' conducts over 2000 technical assistance visits to nursing facilities each year and more than 2000 NF residents receive a structured assessment in key areas and are asked to respond to consumer satisfaction questions through the Long Term Care Quality Review.

A grant-funded project is being used to develop a consumer-centered quality focus across agency populations along the lines of CMS' Quality Framework. Based upon recommendations of the QA/QI Task Force funded by the state's 2003 Real Choice Grant, DADS undertook a large-scale individual experience survey across all DADS' Medicaid waiver and ICF/MR programs. A statistically valid sample of 1980 individuals received a face-to-face interview using the National Core Indicators or Participant Experience survey instrument as appropriate. An Additional 1500 families with children receiving waiver services were mailed experience surveys. Results of the surveys will become a key component of the quality management strategy at the agency.

## **Quantitative Markers of Rebalancing**

### **Changing Patterns in Nursing Home Use as Marker of Rebalancing**

To assess the potential effect of HCBS on nursing home use, we examined the MDS data on all Texas nursing facilities for the years 2002, 2003, and 2004. We reasoned that if HCBS was having an effect, the case mix in nursing homes should become higher, i.e., the level of disability (both functional and cognitive) should increase. Because nursing facilities serve at least two streams of clients, one requiring post-acute care (PAC) after discharge from hospitals and the more traditional long-term resident, we examined the case mix at two points in time: admission

and three months after admission. The former would include the PAC population, but the latter should be a more direct reflection of long-term care that HCBS was intended to defray.

Table 1 shows the changes in the NF case mix on admission and 3 months after admission for 2002, 2003, and 2004. The latter is a better test of the long-term care population. Between 2002 and 2004, the functioning level of elders admitted to NHs in TX improved slightly from the average ADL score of 14.78 in 2002 to an average ADL score of 14.56 in 2004 (the possible score of the ADL variable is between 0 and 24; a higher score means higher ADL dependence). The proportion of residents admitted with no ADL dependencies, or very few, remained stable over these three years. During the same period of time, the cognitive functioning of elders admitted into NFs also improved slightly. The average CPS score went down from 2.03 in 2002 to 1.89 in 2004 (the possible score for CPS is between 0 and 6; a higher CPS score means lower cognitive functioning). Moreover, the rate of persons with no cognitive impairment or mild impairment increased. This pattern suggests that HCBS may have achieved part of its goals in deflecting the clients with lower ADL needs to other sources. The same effect was also seen for cognition.

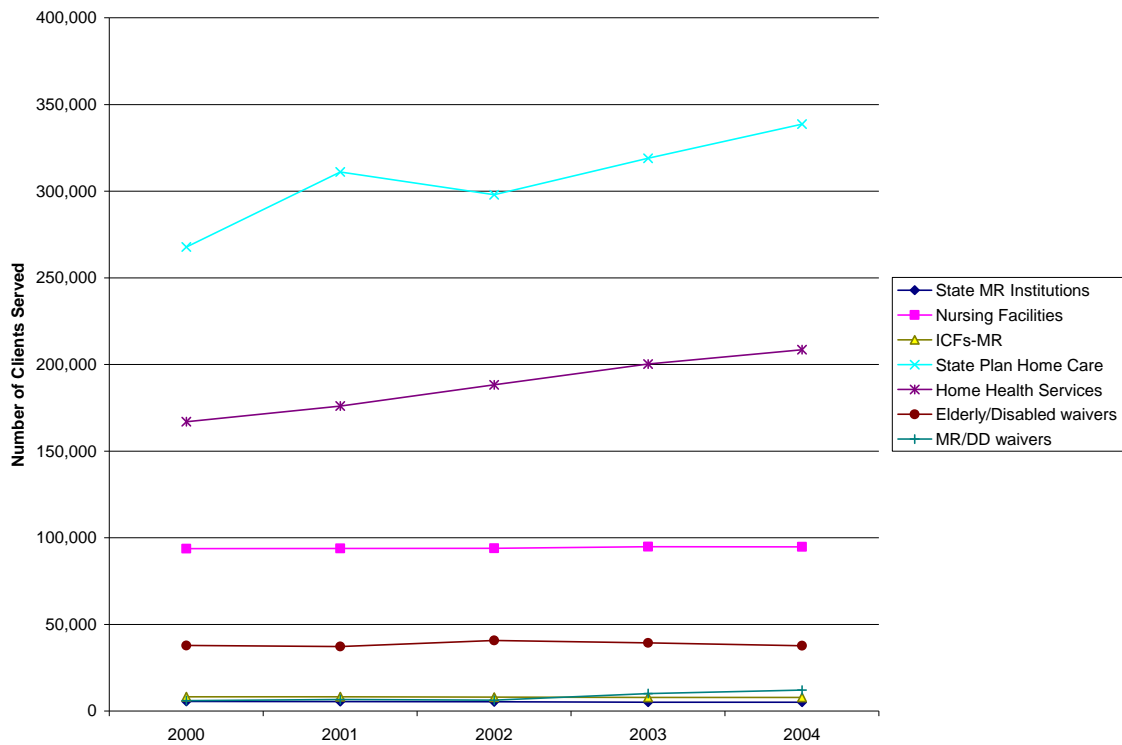
**Table 1: Change in Nursing Home Acuity at Admission and 3 Months Post Admission in Texas, 2002-2004**

	2002	2003	2004
<b>At Admission</b>			
Mean ADL	14.78	14.57	14.56
Mean CPS	2.03	1.98	1.89
<b>3 Months Post Admission</b>			
Mean ADL	12.77	12.95	13.28
Mean CPS	2.53	2.60	2.64

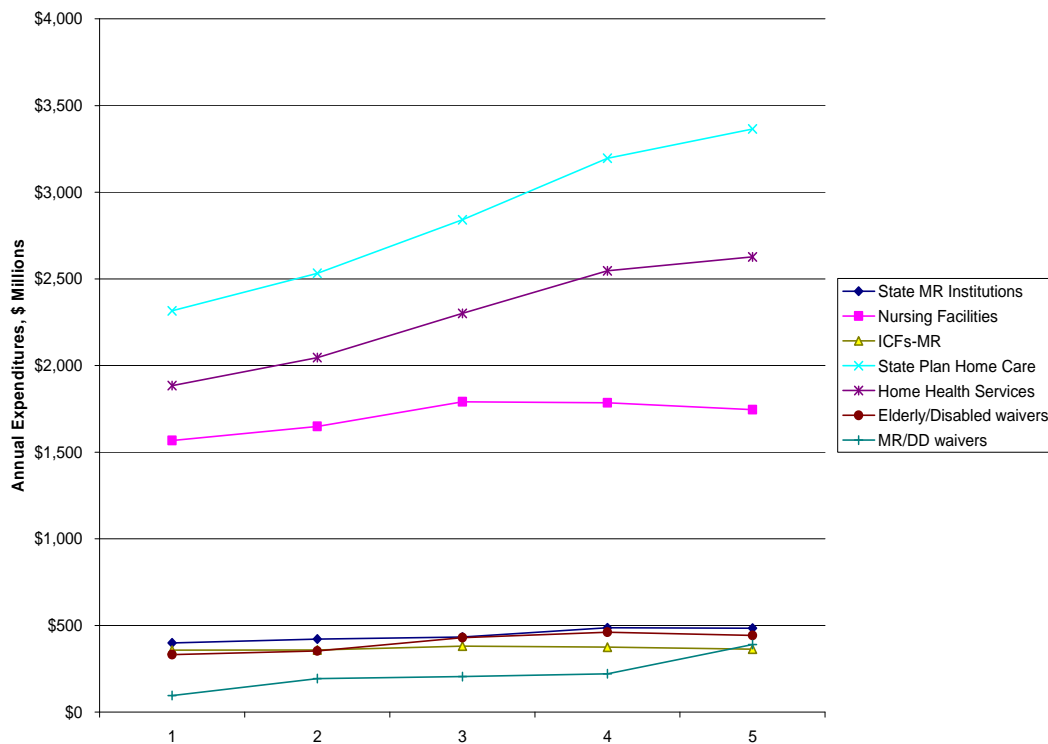
### **Balance Between Institutional and Community Care**

Figure 1 compares the numbers of clients served each year in several programs. Home care under the State Medicaid Plan (i.e., the Primary Home Care program) serves the largest number of clients. Substantially more clients are served in nursing facilities than are served by waivers. Mental retardation institutions, whether state run or private, serve comparatively few clients.

Figure 2 traces the annual Medicaid expenditures for several programs. The most money is spent on attendant services under the State Health Plan's Primary Home Care program. Expenditures for nursing facilities greatly exceed those for all waiver programs combined. However, while other expenditures have grown, the nursing facility expenditures have begun to decline.

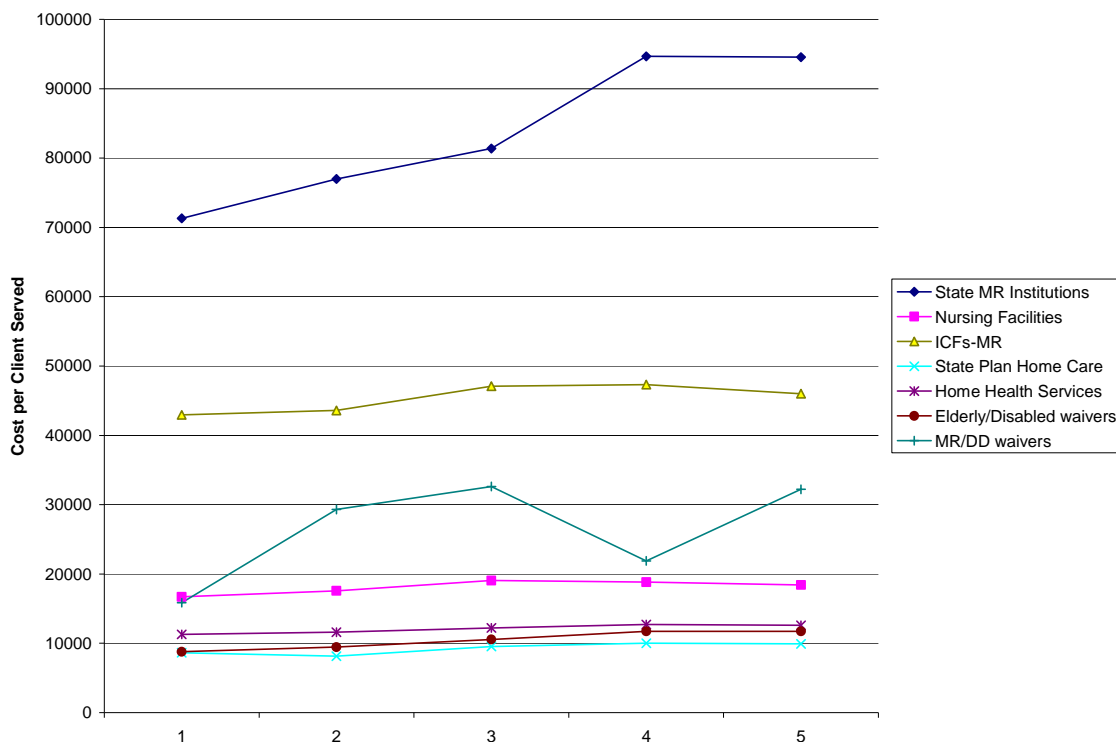


**Figure 1. Clients Served in Selected Texas Programs, 2000-2004**



**Figure 2. Expenditures for Selected Texas Programs, 2000-2004.**

Figure 3 examines the Medicaid costs per client served. These costs may be affected by the fact that not all clients are served for a full year. The costs per client served in a nursing facility are substantially higher than those served in the community; but here again, the costs for community care are increasing slightly while the nursing facility costs are falling.



**Figure 3. Per Capita Expenditures for Selected Texas Programs, 2000-2004**

### Conclusion

Texas has made substantial progress towards rebalancing and serves large numbers of community clients. Despite increases in the number of long-term support clients in the community, however, Texas still contends with a large numbers of people who receive institutional care in ICF-MRs, state schools, and nursing facilities (although nursing home occupancy has hovered around 78% for many years). Texas also contends with long interest lists of people wishing services in non-entitlement programs, such as waivers. With a large and sophisticated group of consumer advocates, Texas has developed a comprehensive Promoting Independence Plan, which is closely monitored annually for specific progress on its recommendations by the Promoting Independence Advisory Council. Consumer directed opportunities are built into most Texas programs and by January 2007 in all of its programs, and Texas has introduced a Service Responsibility Option (consumer direction minus payroll

functions) into its state plan personal care program (Primary Home Care). An innovative Money Follows the Person program for nursing facilities residents was initiated in 2001 and codified into law in September 2005.

The consolidation and reorganization of services in the Texas Health and Human Services Commission and its 4 operating departments and the further consolidation of most of its long-term care programs into one of those departments—the Department of Aging and Disability Services (DADS) — is notable and interesting for its reorganization of personnel and efforts along functional lines regardless of the disability population served or the place of service. Leadership has been reorganized and invigorated and accountability highlighted by this new structure.

### **Issues for Future Observation**

- Developments with Money Follows the Person, including whether the effort can be expanded to ICF-MRs and, if so, how the operational problems are addressed.
- The expansion of the Service Responsibility Option (SRO) that permits consumer direction while agencies manage payrolls. It will be identify the kinds of consumers by age and other characteristics who find SRO appealing as opposed to full consumer direction with payroll responsibilities.
- The further development of the data-driven quality initiatives.
- Progress in streamlining and rationalizing entry to services at the local level. In that context the experience of the Aging and Disability Resource Center funded in 2005 will be of interest, as will the IEE implementation.
- The further development of housing initiatives in Texas, Housing has been identified as a problem and the Department of Housing and Community Affairs has been an effective partner in securing housing vouchers. A very ambitious agenda in the housing area was set forward by Promoting Independence Advisory Committee.
- Whether inroads are made into the ICF/MRs and state schools ??????, and reducing reliance on large ICF-MRs (with more than 16 beds).
- Progress with various emerging labor force issues, including the significant turnover rate and dearth of personal attendants in some localities.
- The success in strengthening mental health services for people with behavioral disabilities along the lines suggested by various planning groups.
- Further experiences with integrating acute care and long-term care through capitation such as Star+Plus and PACE, and the new Integrated Care Management project that does not involve capitation.

- Ideas emanating from consumer stakeholders. Consumer advocates in Texas are creative problem solvers with much ability to shape policy and to use existing policy in the service of choice, community integration, and rebalancing. As the programs initiated in Texas such as the Money Follows the Person initiative and the attendant care and waiver programs continue to grow, advocates and state officials together are likely to identify ways to refine the service system to further advance high quality community services.
- Finally, given that the massive reorganization and consolidation of the Human Services Commission is barely complete, the experience with the new structure now in place will be important to observe.