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EXECUTIVE SUMMARY

Background

This report meets the requirements of Senate Bill 222, passed by the Texas Legislature during the 82nd Regular session in 2011, which directs the Texas Health and Human Services Commission (HHSC) in conjunction with the Texas Department of Aging and Disability Services (DADS) to use existing data and information to identify:

“(1) the reasons medical assistance recipients of long-term care services are placed in nursing facilities as opposed to being provided long-term care services in home or community-based settings;

“(2) the types of medical assistance services recipients residing in nursing facilities typically receive and where and from whom those services are typically provided;

“(3) community-based services and supports available under a Medicaid state plan program, including the primary home care and community attendant services programs, or under a medical assistance waiver granted in accordance with Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n(c)) for which recipients residing in nursing facilities may be eligible; and

“(4) ways to expedite recipients' access to community-based services and supports identified under Subdivision (3) of this subsection for which interest lists or other waiting lists exist.”

Summary of Findings

Medicaid Long-Term Services and Supports in Texas

Medicaid long-term services and supports (LTSS) available in Texas include:

- The Texas Medicaid Nursing Facility Program that provides institutional nursing care and comprehensive services to individuals who require regular licensed nursing care. This program served over 60,000 individuals each month in 2011, at an average monthly cost to Medicaid of $3,130 per person.

- A number of Home and Community Based Services (HCBS) long term care programs:
The Community Based Alternatives (CBA) waiver program offers comprehensive services intended to substitute for NF care. In 2011, an average of 22,849 individuals received CBA services each month, at an average monthly cost of $1,600 per person.

The STAR+PLUS waiver program also offers comprehensive services intended to substitute for NF care. In August 2011, 21,930 persons received comprehensive LTSS under STAR+PLUS, at an average monthly cost to the state of $1,829.

The Primary Home Care (PHC) state plan program provides attendant services to eligible adults. In 2011, an average of 53,625 individuals received PHC services each month, at an average monthly cost of $858 per person.

The Community Attendant Services (CAS) state plan program provides attendant services to eligible people of all ages. In 2011, an average of 45,641 individuals received these services each month at an average monthly cost of $834 per person.

The STAR+PLUS program also provides non-waiver personal attendant services to 33,895 persons at an average monthly cost of $350.

The Day Activity and Health Services (DAHS) state plan program provides adult day care services Monday-Friday in licensed facilities. An average of 17,924 individuals received these services each month in 2011, at an average monthly cost of $535 per person.

STAR+PLUS provides DAHS services to 4,288 persons at a monthly cost of $418.

Since March 2012, the majority of persons receiving CBA, PHC, and DAHS services have been transferred to the STAR+PLUS program.

The Program of All-inclusive Care for the Elderly (PACE) provides comprehensive services for a capitated monthly fee. In 2011, this state plan program served an average of 989 individuals per month, at an average monthly cost of $2,932 per person.

LTSS is also available outside the Medicaid program. Texas offers several types of HCBS with Title XX Block Grant funds. The Area Agencies on Aging provide services and assistance with care planning. Some services are available through Medicare and private payment. Finally, three million Texans act as informal caregivers, assisting family members or friends who have disabilities or health problems.

Texans Receiving Medicaid Nursing Facility Care

In August 2011, over 60,000 Texans (0.26 percent of the Texas population) received Medicaid NF services. Following are some details about them.

- The majority (79 percent) were over age 65.
- The majority (66 percent) were women.
- The majority (62 percent) were Anglo.
- The majority (64 percent) were located in the Texas Health and Human Services Regions that contained the four largest urban areas.
• Slightly over one-fourth (26 percent) were dependent on technology such as respirators, feeding tubes and intravenous treatments, had complex conditions or required extensive assistance with transfer, toileting or eating. About one in eight (13 percent) had very low needs.

• Nine percent received both Medicare and Medicaid funding for their NF services. These people were still within the first 100 days after a qualifying hospital stay.

• The majority (86 percent) would not qualify for full Medicaid benefits if they did not need NF or other long-term services.

• The majority (75 percent) made an applied income payment to their NF. The average amount of the applied income payment was $692 per month.

• The majority (59 percent) indicated that they wanted to return to live in the community.

Comparison of Texans Receiving Medicaid NF versus Medicaid Home and Community-based Services

• In August 2011, about 200,000 Texans received Medicaid HCBS, while over 60,000 received Medicaid NF services.

• In comparison to people who received Medicaid NF services in 2011, individuals who received Medicaid HCBS tended to:
  o Be younger. About one-third of people receiving NF services were over age 85, at least twice the percentage of the same age group receiving HCBS.
  o Be Hispanic or Black. Whereas Hispanics and Blacks comprised 33 percent of people receiving Medicaid NF services, they comprised 50 percent of those receiving Medicaid waiver services, and 65 percent of those receiving Medicaid personal care (attendant) services.
  o Have lower level needs. In the CBA program, 50 percent of individuals had low or very low levels of need, compared with 20 percent of people receiving Medicaid NF services.

Factors contributing to use of NFs instead of HCBS

• NF placement is immediate; applicants for some HCBS services must wait for services on long interest lists—up to three to four years.

• Enrollment for HCBS takes longer and is more complicated than for NFs.

• Demographic factors including age, being widowed, not owning a home, and limited social networks are associated with increased risk of NF use.

• The following health factors are also associated with NF use: having multiple medical conditions, having cognitive impairment, being incontinent, and needing assistance with activities of daily living (ADLs) and /or instrumental activities of daily living (IADLs).

• Health service use factors such as prior hospitalization, lack of a primary care physician, having multiple prescriptions, and previous NF use are also associated with NF entry.
Texas’ Efforts to Improve Access to Home and Community-based Services

- Of all Texas Medicaid spending for LTSS for people who are aging or have physical disabilities, nearly half is spend on home and community based services. Only six other states spend a higher share on HCBS for these populations.

- Texas offers a wide array of services in the community, including comprehensive services under the CBA and STAR+PLUS waiver programs.

- The Money Follows the Person (MFP) program allows individuals receiving Medicaid NF services to immediately transfer to one of three waivers: CBA (for adults) or the Medically Dependent Children’s Program (MDCP), or the Community Living Assistance and Support Services (CLASS) waiver for individuals with developmental disabilities. Over the past 11 years, the MFP program has enabled over 25,000 people to leave NFs and receive waiver services without waiting on an interest list.

- Aging and Disability Resource Centers (ADRCs), which serve as “front doors” for older adults and people with disabilities seeking support, are now operating in 14 locations throughout the state. Area Agencies on Aging (AAAs), which are essential components of ADRCs, offer benefits counseling, even in areas where ADRCs do not yet operate.

- Texas is currently conducting two federally funded Community Living Options (CLO) demonstration projects that aim at diverting people who are not yet eligible for Medicaid from entering nursing facilities.

- Texas recently applied for federal funding for the Balancing Incentive Program (BIP). If approved, the BIP will provide expansion of the ADRC system statewide, standardized assessment tools and changes to case management.

Other States’ Efforts to Improve Access to Home and Community-based Services

Strategies used by some other states to support a shift from NF to HCBS services include:

- Providing detailed information about HCBS services to all who are planning to enter a nursing facility.

- Offering expedited HCBS enrollment with presumptive Medicaid eligibility for people who are likely to be Medicaid eligible and who are at risk of NF placement.

- Using standardized assessment tools that allow simultaneous eligibility determination for multiple services.

- Using multiple contracting strategies to ensure that sufficient numbers of community-based service providers are willing and able to provide immediate care.

- Supporting local partnerships among NFs, state agencies, AAAs, hospitals, HCBS providers, and rehabilitation facilities so that arrangements for HCBS can be made quickly.

Recommendations to Expedite Access to HCBS

Texas could use several strategies to expedite access to HCBS including:
• Improve knowledge of the reasons why people use Medicaid NF services instead of HCBS by (1) gathering data from individuals who have recently begun to receive these services (or their family members); and (2) improving the amount and quality of data about people receiving Medicaid HCBS.

• Continue to pursue funding opportunities to support program improvement, including the Balancing Incentive Program, Community First Choice, and Money Follows the Person demonstration, among others.

• Increase funding for HCBS services to shorten interest list waiting periods.

• Explore the option of expedited personal care and short-term waiver services with presumptive Medicaid eligibility for people who are likely to be Medicaid eligible and at risk of NF placement.

• Enhance and expand ADRCs to make it easier for people to obtain HCBS more quickly.

• Enhance hospital and NF discharge planning so that a move or return to the community is effectively supported.

• Offer financial and other incentives for NF providers to facilitate community discharge.

• Enhance caregiver support and encourage private-pay HCBS so that individuals can avoid using Medicaid services altogether.
INTRODUCTION

This report was prepared to satisfy the requirements of Senate Bill 222, passed by the 82nd Texas Legislature in 2011. Section 4 directs the Texas Health and Human Services Commission (HHSC) in conjunction with the Texas Department of Aging and Disability Services (DADS) to:

“…prepare a written report regarding individuals who receive long-term care services in nursing facilities under the medical assistance program. The report should use existing data and information to identify:

• the reasons medical assistance recipients of long-term care services are placed in nursing facilities as opposed to being provided long-term care services in home or community-based settings;

• the types of medical assistance services recipients residing in nursing facilities typically receive and where and from whom those services are typically provided;

• community-based services and supports available under a Medicaid state plan program, including the primary home care and community attendant services programs, or under a medical assistance waiver granted in accordance with Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n(c)) for which recipients residing in nursing facilities may be eligible; and

• ways to expedite recipients’ access to community-based services and supports identified under Subdivision (3) of this subsection for which interest lists or other waiting lists exist.”

Appendix A: Senate Bill 222 presents the full text of this bill.

The report also presents related information requested by Senate legislative staff. Appendix B: Additional Information Requested details the additional information requested.
SECTION I: MEDICAID LONG TERM SERVICES AND SUPPORTS IN TEXAS

Medicaid was created in 1965 through Title XIX of the Social Security Act, and was established in Texas in 1967. Medicaid is a federal health care program that is jointly funded by federal and state money. In State Fiscal Year 2012, 58.42 percent of Medicaid funding for the state of Texas was obtained from the federal government and 39.58 percent was derived from the state.

In Texas, Medicaid is administered by the Texas Health and Human Services Commission (HHSC). Long-term services and supports (LTSS) are administered through the Department of Aging and Disability Services (DADS) and through managed care programs managed by HHSC. DADS is the state agency that serves older adults and people with disabilities. DADS responsibilities include nursing facility (NF) services and home and community-based services (HCBS) for people with developmental or other disabilities, including those who are aging.

This report is concerned with services designed for people with physical disabilities who are aging, not services designed for people with intellectual and developmental disabilities.

The Texas Medicaid Nursing Facility Program

The Texas Medicaid Nursing Facility Program provides institutional nursing care for Medicaid-eligible individuals whose medical condition requires the skills of a licensed nurse on a regular basis. Under this program, Medicaid-certified NFs provide for the total medical, nursing, and psychosocial needs of each resident. Residents must undergo a comprehensive assessment and have an individual plan of care.

Services in a Medicaid-certified NF can be grouped into three broad areas:

- **Skilled nursing** or medical care and related services;
- **Rehabilitation** needed due to injury, disability, or illness;
- **Long-term care**—health-related care and services (above the level of room and board) needed regularly due to a mental and/or physical condition.

There is no exhaustive list of services a NF must provide, in that unique resident needs may require particular care or services in order to reach the highest practicable level of wellbeing. The services needed to attain this level of wellbeing are established in the individual’s plan of care. Services provided through the Texas Medicaid Nursing Facility Program include:

- Room and board including room maintenance services and dietary services individualized to the needs of each resident;
- Nursing and related services (including nursing care, medical equipment and supplies, drug administration, etc.);
- Social services;
• Over-the-counter drugs (prescription drugs are covered through the Medicaid Vendor Drug program or Medicare Part D);
• Specialized rehabilitative services (physical, occupational, and speech therapy);
• A professionally directed program of activities to meet the interests and needs for the wellbeing of each resident;
• Emergency dental services;
• Routine personal hygiene items and services; and
• Hospice services.

Eligibility

To be eligible for the Medicaid NF program, an individual must:
• live in a Medicaid-certified NF for 30 consecutive days;
• meet medical necessity requirements (described below); and
• be eligible for Supplemental Security Income (SSI) from the Social Security Administration or be determined by the Texas Health and Human Services Commission to be financially eligible for Medicaid, meeting both income and asset limitations.

Medical Necessity

According to Texas rules (§19.2401), an individual must meet one of two general criteria for medical necessity:

1. The individual must demonstrate a medical condition that:
   o is of sufficient seriousness that the individual's needs exceed the routine care which may be given by an untrained person; and
   o requires licensed nurses' supervision, assessment, planning, and intervention that is available only in an institution.

   OR

2. The individual must require medical or nursing services that:
   o are ordered by a physician;
   o are dependent upon the individual's documented medical conditions;
   o require the skills of a registered or licensed vocational nurse;
   o are provided either directly by or under the supervision of a licensed nurse in an institutional setting; and
   o are required on a regular basis.
Nursing Facility Residence

Most people are not yet eligible for Medicaid when they enter a NF. Nursing facilities accept them with a signed agreement that the new resident will pay for all costs not covered by Medicare, Medicaid, or other payers. If the individual is determined eligible for Medicaid, the date of eligibility will begin when all financial requirements are and medical necessity is determined. Medicaid will also cover unpaid medical bills for Medicaid covered services up to three months before the person submitted an application for Medicaid. Therefore, in many cases, Medicaid covers the early portion of the NF stay. Facilities usually have sufficient cash flow and familiarity with the Medicaid system that they are willing cover the costs until Medicaid or the individual’s private funds reimburse them.

Financial Eligibility

In order to be financially eligible for Medicaid NF services, an individual must meet one of two types of financial criteria:

1. The individual must be eligible for Supplemental Security Income (SSI):
   - age 65 or over or disabled;
   - total income that amounts to less than 75 percent of the federal poverty level; and
   - countable assets of no more than $2,000 for an individual, $3,000 for a couple;

   OR

2. The individual must be eligible for Medical Assistance Only (MAO):
   - total income less than or equal to three times the SSI level;
   - countable assets of no more than $2,000 for an individual, $3,000 for a couple; and
   - have a need for LTSS.

People become financially eligible for Medicaid LTSS in two major ways: Some are eligible for Supplemental Security Income (SSI) and others receive Medical Assistance Only (MAO).

SSI Eligibility

The Social Security Administration determines eligibility for SSI. SSI recipients automatically qualify for Medicaid services. People who receive SSI and live in the community receive a federal payment that brings their monthly income up to the SSI level (currently $718 for an individual, $1068 for a couple). If they live in an institution (such as a NF) and only receive SSI income, the SSI payment is eliminated. Texas Medicaid pays the entire cost of their care plus an additional $30 per month personal needs allowance. The SSI payments are discontinued for people who receive SSI and other income. Eligibility is then determined by the State.

MAO Eligibility

Other individuals qualify for Medicaid LTSS as Medical Assistance Only (MAO). They have incomes above the SSI level but less than three times the SSI level (equivalent to 225 percent of
the federal poverty level). Some also qualify for certain types of assistance with Medicare cost sharing without receiving LTSS. They have countable assets of no more than $2,000 for an individual or $3,000 for a couple.

People who qualify for Medicaid NF services as MAO usually qualify for Medicaid only if they need LTSS. They usually contribute almost all of their income to the cost of their care (these contributions are called “applied income”). They retain $30 for personal needs. Deductions are available for spouses and dependents, as well as other expenses people pay from their personal income (e.g., guardianship fees, health and dental insurance, dental care procedures, durable medical equipment). Texas Medicaid pays the remaining cost of their care.

People who use Medicaid LTSS must have very few “countable resources”. A homestead, personal effects, and a vehicle are usually exempt. Other countable resources people own, such as investments, real estate other than a homestead, and other holdings preclude becoming Medicaid eligible. Federal law requires imposing a penalty on payment for LTSS when assets are given away for no compensation that equates to the fair market value.

Many people who enter a NF pay for their own care in the beginning. They dispose of assets and spend the proceeds to pay for care. When their assets are spent down, they usually become eligible for Medicaid. The Medicaid eligibility process can begin while assets are being spent down.

**SPECIAL PROVISIONS – SPOUSAL IMPOVERISHMENT AND QUALIFIED INCOME TRUSTS**

Some people who enter nursing facilities have a spouse still living in the community. If the NF resident’s entire income were used as applied income for NF care, the spouse might not have sufficient income for living expenses. Similarly, if the person in the NF spent all his/her assets to become Medicaid eligible, the community spouse might have no assets.

In order to protect the community spouse and preserve his or her independence, Medicaid has provisions to protect against “spousal impoverishment”. Those rules allow some or all of the income and resources of the person in the NF to be reserved for the community spouse’s use. Similar provisions may apply to protecting income for a dependent such as a disabled adult child living in the community.

Medicaid eligibility for LTSS is generally limited to people with incomes no greater than three times the SSI level, (currently $2,094 per month). Monthly Medicaid NF costs average around $3,800 per month. Persons with moderate incomes (between $2,094 and $3,800 per month) would be unable to pay for their own care and unable to qualify for Medicaid. The Qualified Income Trust (QIT), also sometimes called a Miller Trust, creates a mechanism that allows such individuals to qualify for Medicaid LTSS. Income placed in the trust is not countable income against the $2,094 limit. However, all the income placed in the trust is applied to the cost of services, with Medicaid only paying what the QIT does not cover. People who become eligible for Medicaid NF services by establishing a QIT contribute almost all their income to the cost of their care.
MEDICARE AND MEDICAID

Most people receiving Medicaid NF services are dually eligible for both Medicare and Medicaid. About 80 percent of Medicaid NF residents are over age 65 and are therefore eligible for Medicare. Some of those under age 65 are also eligible for Medicare through Social Security Disability provisions.

If a person is eligible for Medicare and Medicaid and needs regular health services (e.g., physician or hospital care), Medicare pays most of the cost and the individual is not liable for the deductibles and coinsurance. Medicaid pays deductibles and coinsurance for these individuals, but under current state policy, Medicaid generally will only pay up to the Medicaid rate for the same service.

People dually eligible for Medicare and Medicaid obtain most of their prescription drug coverage through Medicare Part D. They have no premium and no co-payments. Some drugs are not covered by Medicare Part D but are covered by Medicaid.

Medicare only pays for NF care on a limited basis. After a hospital stay of three or more days, Medicare pays 100 percent of the cost for up to 20 days and 80 percent of the cost for up to 80 more days. If the individual cannot pay the 20 percent copayment, Medicaid may pay some or all of the cost. Medicare NF services are often termed skilled nursing facility (SNF) services, which are intended for rehabilitation or recuperation.

After 100 days, or whenever Medicare payments cease, the individual, family, Medicaid, or some other source (e.g., veteran’s benefits, private insurance) must pay all costs. Medicare may stop funding before the 100 days is up if the individual’s condition has stabilized and no further progress is expected.

The majority of people who enter NFs use Medicare and private funding only. If they stay past the time covered by Medicare, they are then likely to become Medicaid eligible.

Availability

An individual seeking NF services can typically receive those services immediately. NFs accept residents without pay while the Medicaid eligibility process is pending. The individual must agree to pay for the NF services rendered if he or she is found ineligible for Medicaid. When the individual is found eligible for Medicaid, the NF is reimbursed for services provided for up to three months during the eligibility determination process.

Costs

Table 1 below shows the average costs and numbers of participants in the Medicaid Nursing Facility program. Some individuals may receive SNF services for part of a month and daily care for the rest of the month. The net cost is the amount paid by Medicaid, after any individual applied income payment. See page 9 for an explanation of applied income.
Table 1. Nursing Facility Program Statistics

<table>
<thead>
<tr>
<th>Daily Care, costs paid by Medicaid and individual applied income</th>
<th>FY 2010</th>
<th>FY 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average number receiving Medicaid-funded NF services per month</td>
<td>55,659</td>
<td>56,403</td>
</tr>
<tr>
<td>Average daily NF rate</td>
<td>$127.53</td>
<td>$125.97</td>
</tr>
<tr>
<td>Average amount of individual income applied to the daily cost of care</td>
<td>$22.95</td>
<td>$23.07</td>
</tr>
<tr>
<td>Net monthly NF cost per month</td>
<td>$3,181.39</td>
<td>$3,130.14</td>
</tr>
<tr>
<td>Average number receiving personal needs allowance per month</td>
<td>12,695</td>
<td>12,695</td>
</tr>
</tbody>
</table>

**Skilled Nursing Facility, most costs covered by Medicare**

| Average number receiving nursing facility co-payments per month | 6,496 | 6,414 |
| Net Medicaid/Medicare co-pay per individual for nursing facility services per month | $1,951.95 | $1,977.99 |

The average monthly cost of NF services paid by Medicaid in Texas in 2011 was $3,130 per person.

**Texas Medicaid Home and Community-based Services**

The Texas Medicaid program offers an array of HCBS as cost-effective alternatives to NF care. Two Section 1915(c) Medicaid waivers, the Community Based Alternatives (CBA) and the (c) waiver portion of the STAR+PLUS program, offer services specifically intended to substitute for NF care. In limited geographic areas, the Program of All-inclusive Care for the Elderly (PACE) also offers comprehensive services. Additional programs that offer less comprehensive services, but may also contribute to the delay or prevention of NF entry, include Primary Home Care (PHC), Community Attendant Services (CAS), the Day Activity and Health Services (DAHS) programs. These programs are described in detail below. (A number of additional HCBS programs funded by sources other than Medicaid are also summarized in Appendix G.)

**Community Based Alternatives**

The CBA waiver program provides HCBS to persons age 21 and older who would qualify for NF care. CBA is the most comprehensive program offered by DADS as an alternative to NFs. Services include personal assistance services, adaptive aids, medical supplies, adult foster care, assisted living/residential care, emergency response services, nursing services, minor home modifications, occupational therapy, physical therapy, respite care, speech and language pathology services, home delivered meals, and transition assistance services. People receiving CBA services are eligible for the full array of Medicaid services.

Table 2 below lists the most commonly used services in the CBA program during fiscal year 2011. On average, each person in the program used 4.5 of the available services during the year. By far, the most commonly used service was personal assistance services. More than 92 percent of CBA enrollees used this service, at an average of 24 hours per person per week. Personal assistance services accounted for more than 80 percent of CBA expenditures in fiscal year 2011.
Table 2. Most Commonly Used Services, CBA Waiver Program

<table>
<thead>
<tr>
<th>Service</th>
<th>Percent of Program Expenditures</th>
<th>Percent of Individuals Using Service</th>
<th>Annual Cost Per Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Assistance Services</td>
<td>81.6%</td>
<td>92.3%</td>
<td>$14,193.04</td>
</tr>
<tr>
<td>Nursing Services (all types)</td>
<td>4.2%</td>
<td>97.7%</td>
<td>$695.32</td>
</tr>
<tr>
<td>Requisition and Specification Fees*</td>
<td>0.6%</td>
<td>98.2%</td>
<td>$93.04</td>
</tr>
<tr>
<td>Dental</td>
<td>2.5%</td>
<td>20.7%</td>
<td>$1,921.34</td>
</tr>
<tr>
<td>Adaptive Aids / DME</td>
<td>1.4%</td>
<td>28.5%</td>
<td>$800.17</td>
</tr>
<tr>
<td>Meals</td>
<td>1.6%</td>
<td>24.1%</td>
<td>$1,071.25</td>
</tr>
<tr>
<td>Assisted Living (all types)</td>
<td>3.2%</td>
<td>5.1%</td>
<td>$9,934.20</td>
</tr>
<tr>
<td>Minor Home Modifications</td>
<td>2.3%</td>
<td>13.4%</td>
<td>$2,807.51</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>0.9%</td>
<td>27.8%</td>
<td>$517.20</td>
</tr>
<tr>
<td>Emergency Response Services (ERS)</td>
<td>0.5%</td>
<td>36.2%</td>
<td>$227.80</td>
</tr>
<tr>
<td>Respite (all types)</td>
<td>5.5%</td>
<td>0.7%</td>
<td>$1,912.94</td>
</tr>
</tbody>
</table>

*Note: Requisition and Specification Fees (fees paid to HCSSAs for arranging the purchase of adaptive aids, dental and other services) were reduced in State Fiscal Year 2012, eliminating about 80 percent of the cost.

Individuals receiving CBA services may live in their own home or a family member’s home, a licensed assisted living facility, or an adult foster care home contracted with DADS to provide CBA services. Individuals may choose services provided by a Home and Community Support Services Agency (HCSSA) or by a Consumer Directed Services Agency (CDSA). Under consumer directed services (CDS), individuals select and supervise their own attendants and, if needed, nurses, therapists and other service providers.

**Eligibility**

People receiving CBA services must:
- meet the medical necessity requirements for NF services;
- choose waiver services instead of NF care based on an informed choice;
- be 21 years of age or older and not live an area served by STAR+PLUS; and
- meet the same financial requirements as people receiving Medicaid NF services.

**Availability**

The number of persons served by CBA is limited by legislative appropriations and enrollment limits. People interested in receiving CBA services are placed on an interest list, which is operated on a first-come, first-served basis. Since interest lists are managed at the regional level, wait times vary by region. Once a slot becomes available and an individual’s name reaches the top of the interest list, a formal application and an assessment of medical need are made. This application and assessment process typically takes 6-8 weeks.

In April 2012, 12,761 individuals were on the CBA interest list. As Table 3 below shows, of these individuals, 1 percent (98 persons) had been waiting between 2 and 3 years, and 9 percent
(1,135 persons) had been waiting for 1-2 years. 90 percent (11,528 persons) had been on the interest list for less than one year, reflecting their more recent placement on the interest list.

**Table 3. Time on Interest List for the CBA Waiver Program: Percent and Number of Individuals, April 2012**

<table>
<thead>
<tr>
<th>Time on Interest List</th>
<th>Percent of Individuals</th>
<th>Number of Individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1 year</td>
<td>90.3%</td>
<td>11,528</td>
</tr>
<tr>
<td>1-2 years</td>
<td>8.9%</td>
<td>1,135</td>
</tr>
<tr>
<td>2-3 years</td>
<td>0.8%</td>
<td>98</td>
</tr>
</tbody>
</table>

In March 2012, more than half of individuals waiting for CBA services were transferred to the STAR+PLUS interest list. Those who are receiving SSI will receive waiver services without further waiting; those who are not will continue to wait on the STAR+PLUS list.

People who receive Medicaid NF services may qualify for CBA services under the Money Follows the Person (MFP) program without waiting for a slot to become available. These individuals may receive assistance with the transition from NF to a community setting, such as counseling and support from contracted Relocation Specialists as well as funding (up to $2,500) for the cost of setting up a household.

**Costs**

The cost of an individual service plan for CBA may not exceed 200 percent of the reimbursement rate that would have been paid for the same person to receive services in a NF. If the individual requires other medical care (such as physician or hospital services), Medicaid pays for those services. If the individual is also eligible for Medicare, Medicaid pays the deductibles and copayments.

In 2011, an average of 22,849 individuals received CBA services each month, at an average monthly cost of $1,600 per person.

**Applied Income**

People receiving CBA services in an assisted living or adult foster care setting contribute all income to the cost of room and board except for a monthly personal needs allowance of $85. Individuals living in their own home or a family member’s home only make applied income payments if their income exceeds 300 percent of the SSI amount (around $2,100 per month). Most people receiving CBA services (90 percent) live in their own home or a family member’s home.

**STAR+PLUS**

STAR+PLUS is a Medicaid waiver program designed to provide comprehensive health and LTSS through a managed care system. Like CBA, STAR+PLUS provides HCBS to persons age 21 and older who would qualify for NF care. Unlike CBA, however, participants enrolled in
STAR+PLUS choose a Managed Care Organization (MCO) that is available in their county and receive Medicaid services through that MCO.

ELIGIBILITY

In STAR+PLUS service areas, most adults eligible for Medicaid are served through STAR+PLUS only (not CBA). The STAR+PLUS program serves most urban areas in Texas. Services available under the STAR+PLUS waiver are the same as those provided under the CBA waiver. STAR+PLUS does not serve people who receive services in a NF or through a Medicaid program for people with intellectual and developmental disabilities.

AVAILABILITY

People in STAR+PLUS areas who are already on Medicaid and who need any HCBS can receive those services without waiting on an interest list. Eligible people in STAR+PLUS areas who seek CBA services through MAO eligibility must wait on an interest list; when a slot becomes available they are served through STAR+PLUS. Table 4, below, details time on an interest list for STAR+PLUS waiver services.

Table 4. Time on Interest List for the STAR+PLUS Waiver Program: Percent and Number of Individuals, April 2012

<table>
<thead>
<tr>
<th>Time on Interest List</th>
<th>Percent of Individuals</th>
<th>Number of Individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1 year</td>
<td>55.0%</td>
<td>8,029</td>
</tr>
<tr>
<td>1-2 years</td>
<td>28.0%</td>
<td>4,072</td>
</tr>
<tr>
<td>2-3 years</td>
<td>13.9%</td>
<td>2,019</td>
</tr>
<tr>
<td>3-4 years</td>
<td>3.1%</td>
<td>443</td>
</tr>
</tbody>
</table>

COSTS

STAR+PLUS is a capitated program. The MCOs are paid the same monthly amount for each individual with similar characteristics. The MCOs receive increased funds for people enrolled in the STAR+PLUS waiver, averaging $1829 per month.

Primary Home Care

The PHC program provides attendant services to adults (age 21 and over) with a medical need for assistance with personal care tasks. Attendants help individuals with activities of daily living (ADLs) such as bathing, dressing and grooming, as well as instrumental activities of daily living (IADLs) such as meal preparation and housekeeping. On average, individuals are authorized to receive approximately 16 hours of assistance per week.

People receiving personal care services may live in their own home or with family or friends. They may choose to receive services from a HCSSA or under the CDS option.
**ELIGIBILITY**

PHC serves adults who are Medicaid eligible. To qualify for Medicaid as an adult, individuals must have a maximum income of $692 and maximum assets of $1,000.

People receiving PHC must meet functional and medical eligibility criteria, which include:

- a functional limitation with at least one personal care task based on medical condition;
- a medical practitioner’s statement of medical need;
- an unmet need for a purchased task(s); and
- at least the minimum score on a functional assessment administered by DADS staff.

People receiving PHC are not assessed to determine if they meet the medical necessity requirements for NF or waiver services. The functional and medical criteria for this program are designed to be less stringent than those for NF or waiver services.

**AVAILABILITY**

Because PHC is an entitlement program under the Medicaid State Plan, it is available to anyone who is eligible and applies for the program. There is no interest list for this program as the Texas Medicaid Program cannot deny or delay entitlement services for eligible individuals. The application, assessment, and authorization process takes one to two months. Providers can be paid for services provided before the authorization is complete, but the financial risk involved discourages providers from doing so.

**COSTS**

In 2011, an average of 53,625 individuals received PHC services each month at an average monthly cost of $858 per person. In March 2012, more than half of the people receiving PHC transferred to STAR+PLUS

**STAR+PLUS Attendant Services**

Adults receiving Medicaid (usually through SSI eligibility) in STAR+PLUS areas may receive attendant services through STAR+PLUS. Services are managed and authorized by the MCOs. Services and functional eligibility criteria are the same as for PHC.

In August 2011, the STAR+PLUS program provided non-waiver personal attendant services to 33,895 persons at an average monthly cost of $350.

**Community Attendant Services**

The CAS program serves people of all ages. Like the PHC program, CAS provides attendant services to individuals who have a medical need for assistance with personal care tasks. Attendants help individuals with ADLs and IADLs. On average, individuals are authorized to receive approximately 17 hours of assistance per week. People receiving CAS services do not receive other Medicaid services, such as physician and hospital care or prescription drugs.
People receiving CAS services may live in their own home or with family or friends. They may choose to receive services from a HCSSA or under the CDS option.

**Eligibility**

People receiving CAS must meet the same functional and medical eligibility criteria as those receiving PHC. These criteria include:

- a functional limitation with at least one personal care task based on medical condition;
- a medical practitioner’s statement of medical need;
- an unmet need for a purchased task(s); and
- at least the minimum score on a functional assessment administered by DADS staff.

People receiving CAS are not assessed to determine if they meet the medical necessity requirements for NF or waiver services. The functional and medical criteria for this program are designed to be less stringent than those for NF or waiver services.

The financial eligibility requirements for CAS are similar to those for NF and CBA services. Individuals receiving services must have a monthly income within 300 percent of the monthly income limit for SSI ($2,094 per individual, $4,188 per couple) and have countable resources of no more than $2,000 per individual or $3,000 per couple. Qualifying Income Trusts and spousal impoverishment provisions do not apply to CAS.

Most people receiving CAS program services (69 percent) are over age 65 and are eligible for Medicare, but are responsible for their own premiums, copayments, and deductibles. Some people receiving CAS are eligible for one of the Medicare Savings Programs that use Medicaid funds to provide assistance with Medicare costs. People receiving CAS services also receive Extra Help with their prescription costs under Medicare Part D (reduced premiums and copayments).

**Availability**

Because CAS is an entitlement program under the Medicaid State Plan, it is available to anyone who is eligible and applies for the program. There is no interest list as the Texas Medicaid Program cannot deny or delay entitlement services for individuals who are eligible. The application, assessment, and authorization process takes one to two months. Applicants for CAS may experience a longer application, assessment, and authorization process than those for PHC because they must also apply for Medicaid financial eligibility, which can require additional time. Providers can be paid for services provided before the authorization is complete, but the financial risk involved discourages providers from doing so.

**Costs**

In 2011, 45,641 individuals received CAS services at an average monthly cost of $834 per person. The number of people served by CAS is not affected by the STAR+PLUS expansion. CAS services are not managed by MCOs, as in STAR+PLUS, but by DADS.
Day Activity and Health Services

The DAHS program provides daytime services Monday through Friday in a licensed adult day care facility. Services are designed to address an individual’s physical, mental, medical, and social needs include nursing and personal care, noontime meal, snacks, transportation, and social, educational, and recreational activities.

Eligibility

People receiving DAHS services under Medicaid must be at least 18 years old and be fully Medicaid eligible—usually a person receiving SSI benefits. They must also have:

- a medical diagnosis and physician’s orders requiring the care of a licensed vocational nurse or a registered nurse;
- a functional disability related to the medical diagnosis;
- one or more personal care or restorative needs that can be stabilized, maintained or improved by participation in DAHS; and
- prior approval granted by a DADS regional nurse.

Availability

Under the Medicaid State Plan, DAHS is an entitlement program. Like PHC and CAS, DAHS services are available to anyone who is eligible and applies for the program and there are no interest lists. However, except in Region 11, only a small number of DAHS providers exist, limiting practical access to services. Where sufficient providers exist, services are usually available approximately one month after the application is submitted.

Costs

An average of 17,924 individuals received DAHS services each month in 2011, at an average monthly cost of $535 per person.

STAR+PLUS DAHS

In STAR+PLUS areas, DAHS services are provided through STAR+PLUS, and managed and authorized through the MCOs. In August 2011, STAR+PLUS provided DAHS services to 4,288 persons at a monthly cost of $418. In March 2012, the majority of regular DAHS participants transferred to STAR+PLUS.

Program of All-inclusive Care for the Elderly

PACE uses a comprehensive care approach, providing an array of services for a capitated monthly fee paid by Medicaid. PACE funds all health-related services, including in-patient and outpatient medical care, and specialty services (dentistry, podiatry, social services, in-home care, meals, transportation, day activities, and housing assistance.)
**Eligibility**

A recipient must:
- be 55 or older;
- meet the medical necessity for NF admission;
- live in a PACE service area (Amarillo, El Paso, or Lubbock);
- be determined by the PACE interdisciplinary team as able to be safely served in the community;
- have a monthly income within 300 percent of the Supplemental Security Income (SSI) monthly income limit ($2,094); and
- have countable resources of no more than $2,000.

**Availability**

PACE has a legislatively established enrollment limit. At each site, interest lists are used, and wait times vary by site. PACE is not affected by STAR+PLUS.

**Costs**

PACE served an average of 989 individuals each month in 2011, at an average monthly cost of $2,932 per person.

**Comparison of Medicaid NF and HCBS Programs**

Table 4 summarizes Texas Medicaid LTSS programs, including types of services offered, average number of individuals served, average monthly cost paid for by Medicaid, availability, and service area.
<table>
<thead>
<tr>
<th>Program</th>
<th>Services</th>
<th>Average # Served per Month, 2011</th>
<th>Average monthly cost per individual paid by Medicaid</th>
<th>Availability (Time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NF</td>
<td>Comprehensive</td>
<td>60,000+</td>
<td>$3,130</td>
<td>Immediate</td>
</tr>
<tr>
<td>CBA</td>
<td>Comprehensive</td>
<td>22,849</td>
<td>$1,600</td>
<td>Interest list of 2-3 years</td>
</tr>
<tr>
<td>STAR+PLUS</td>
<td>Comprehensive</td>
<td>21,930</td>
<td>$1,829</td>
<td>Interest list of 3-4 years</td>
</tr>
<tr>
<td>waiver</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHC</td>
<td>Attendant</td>
<td>53,625</td>
<td>$858</td>
<td>Immediate</td>
</tr>
<tr>
<td>Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STAR+PLUS</td>
<td>Attendant</td>
<td>33,895</td>
<td>$350</td>
<td>Immediate</td>
</tr>
<tr>
<td>Attendant</td>
<td>Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAS</td>
<td>Attendant</td>
<td>45,641</td>
<td>$834</td>
<td>Immediate</td>
</tr>
<tr>
<td>Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DAHS</td>
<td>Adult Day Care</td>
<td>17,924</td>
<td>$534</td>
<td>Immediate</td>
</tr>
<tr>
<td>STAR+PLUS</td>
<td>Adult Day</td>
<td>4,288</td>
<td>$418</td>
<td>Immediate</td>
</tr>
<tr>
<td>DAHS</td>
<td>Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PACE</td>
<td>Comprehensive</td>
<td>989</td>
<td>$2,932</td>
<td>Interest list wait varies by site</td>
</tr>
</tbody>
</table>

**Services outside Medicaid**

Long-term services and supports are provided outside the Medicaid program, and non-Medicaid services can play a key role in preventing nursing facility admission. Details on non-Medicaid services may be found in Appendix G.

DADS provides non-Medicaid HCBS with funds from the Title XX Block Grant. These services are either non-medical or are targeted to individuals whose income or assets are too high for Medicaid.

Through the Area Agencies on Aging (AAAs), DADS provides an array of nutrition, transportation and support services to individuals over age 60. AAAs also provide benefits counseling to assist individuals in obtaining the services they need.

Medicare funded Home Health Services are used by individuals eligible for Medicare, usually during a period of recovery after hospitalization.

LTSS is available on a private pay basis for those with sufficient funds. Individuals and families may purchase assisted living services, private duty home care, day care services, and various kinds of respite care.
Informal caregivers, who provide regular care or assistance to a family member or friend who is elderly, has a long-term illness, or disability, are the largest source of long-term services and supports. According to a 2010 survey, about three million Texans act as informal caregivers.

The Texas Lifespan Respite Care Program (LRCP) was created in 2009 by the 81st Texas Legislature, to enhance and expand the coordination and availability of respite services for family caregivers. The LRCP seeks to increase Texas caregivers’ knowledge of the role of caregiving, and the options, services and resources available in their communities. The program funds community organizations to provide respite services on a limited basis.

As directed by the legislature DADS is collecting and analyzing information about caregivers when individuals seek Medicaid services or services through the Area Agencies on Aging.

In 2009, DADS received grant funds from the U.S. Administration on Aging (AoA) to establish the Texas Respite Coordination Center (TRCC). Today, the TRCC is:

- implementing a caregiver awareness campaign;
- supporting the respite coordination and outreach efforts of the Texas Respite Coalition, aging and disability resource centers, and respite contractors under HB 802;
- compiling and updating the Texas Inventory of Respite Services consisting of nonprofit, governmental, for-profit and faith-based respite care providers;
- conducting five respite forums across the state for providers and stakeholders;
- developing outreach and educational materials for caregivers; and
- developing media kits and training and best practice tools for providers of respite services.
SECTION II: CHARACTERISTICS OF TEXANS RECEIVING MEDICAID NF SERVICES

In 2011, more than 60,000 Texans1 (0.25 percent of the Texas population)² received Medicaid NF services each month. The demographic characteristics, service needs, and financial characteristics of these Texans are described below.

Age
The majority of people (79 percent) who received Medicaid NF services in 2011 were over age 65. As Figure 1 below shows, the older the age group, the higher the proportion of the NF population represented. Individuals age 22-35 comprised 1 percent of the Texas NF population receiving Medicaid support while people age 85 and older comprised 33 percent of that population.

Figure 1. Texans Receiving Medicaid NF Services, Percent by Age, 2011

Approximately 100 people under age 22 received Medicaid NF services in Texas each month during that year. Of these, about half were legally adults (ages 18-21) but were children for purposes of Medicaid eligibility. Because people under age 22 comprised a very small proportion of the Medicaid NF population in 2011, this report focuses on the adult NF population age 22 and over. Appendix C presents data on children and other small population groups receiving Medicaid NF services.

1 Data note: This report focuses on unduplicated monthly counts. That is, any one in a NF on Medicaid in a given month is counted, even if they were only there for one day. The result is a larger number than that normally reported in DADS financial documents. Financial reporting focuses on the number of days of service for which the state paid. Unduplicated monthly counts allow for the use of more demographic detail and better comparisons with other data. Unless otherwise stated, data are for August 2011. Because delays in billing may take months to resolve, more recent data may be incomplete.

2 Calculated from 2010 US Census data.
Figure 2 below shows the usage rate for Medicaid NF services—the percentage of all Texans of a given age who receive Medicaid NF services. While approximately 0.01 percent (one out of every 100,000) Texans under age 22 received Medicaid NF services in 2011, the usage rate for people over age 85 was nearly 7 percent or about one out of every 14. Details on usage rates are in Appendix H.

**Figure 2. Percent of Texas Residents Receiving Medicaid NF Services, by Age**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Medicaid NF Usage Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 22</td>
<td>0.00%</td>
</tr>
<tr>
<td>22-35</td>
<td>0.01%</td>
</tr>
<tr>
<td>36-50</td>
<td>0.05%</td>
</tr>
<tr>
<td>51-59</td>
<td>0.18%</td>
</tr>
<tr>
<td>60-64</td>
<td>0.39%</td>
</tr>
<tr>
<td>65-74</td>
<td>0.76%</td>
</tr>
<tr>
<td>75-84</td>
<td>2.22%</td>
</tr>
<tr>
<td>85+</td>
<td>6.93%</td>
</tr>
<tr>
<td>Total</td>
<td>0.26%</td>
</tr>
</tbody>
</table>

**Gender**

As shown in figure 3, females comprised approximately two-thirds (66 percent) of the population receiving Medicaid NF services in 2011. Under age 65, men were slightly more likely to receive Medicaid NF services than women were; over age 65, women were more likely than men to receive such services. Over age 85, the usage rate for women is more than twice that of men. This may reflect the fact that, in the older groups, men are more likely to be currently married, not widowed. People who are currently married are less likely to use NF services.

**Figure 3. People Receiving Medicaid NF Services by Gender**

Aug. 2011
**Race/Ethnicity**

As Figure 4 below depicts, more than 60 percent of people receiving Medicaid NF services in 2011 were Anglo (non-Hispanic Whites); seventeen percent were Hispanic; 16 percent were Black; and 5 percent were of “Other” race/ethnicity. In the interest of brevity, the terms “Black” (for non-Hispanic African-Americans) and “Anglo” (for non-Hispanic whites) are used throughout the report. The term “Hispanic” includes Hispanic and Latino. “Other” includes Native Americans, Asians, Pacific Islanders, and people whose race/ethnicity is unknown or of some other category.

![Figure 4. People Receiving Medicaid NF Services by Race/Ethnicity](chart)

At all ages, Blacks are more likely to use Medicaid NF services than Anglos or Hispanics. Younger Hispanics have a higher usage rate for Medicaid NF services than do Anglos, but the difference disappears among older groups.

**Location**

Most people receiving Medicaid NF services live in the urban areas of the state. As Figure 5 below shows, the regions with the largest number of people receiving Medicaid NF services are also the regions with the most populous urban areas. (A map of the Texas Health and Human Services Regions is presented in Appendix D.)
The usage rate varies by region. The regions with the lowest usage rates are 10 (El Paso) and 6 (Houston). The regions with the highest usage rates are 4 (Tyler), 2 and 9 (Abilene), and 7 (Austin). In Region 4, the usage rate for people over 85 is 8.4 percent, while in Region 10 it is 3.9 percent.

**Service Needs**

People who receive Medicaid NF services have diverse needs. The most widely used tool to measure and describe those needs is a classification system called the Resource Utilization Groups (RUGs; see Appendix E for additional details). There are 34 RUGs, each based upon medical and functional needs, diagnoses, and care plan. For simplicity, this report uses six clusters of RUGs.

**Cluster 1: Special Care or Extensive Services**

This cluster includes six of the ten most costly RUGs; people in this cluster have severe and complex needs. They may use devices such as intravenous feeding or ventilators and may have conditions like quadriplegia or multiple skin ulcers. Among Texans receiving Medicaid NF services in 2011, 15 percent were in this cluster. This cluster is more common among younger people, and declines steadily with age. In 2011, approximately 80 percent of Texans under age 22 receiving Medicaid NF services were in this cluster. Among adults under age 35, about 60 percent were in this cluster.

**Cluster 2: Rehabilitation**

This cluster includes the remaining four of the ten most costly RUGS. People in this cluster receive 45 minutes or more of physical, occupational, or speech therapy several days each week in addition to other NF services. Among Texans receiving Medicaid NF services, almost 24
percent were in this cluster. This cluster was most common among people between the ages of 65 and 84.

**Cluster 3: High Activities of Daily Living (ADL) Needs**

People in this cluster do not qualify for the special, extensive or rehabilitation groups, but do require extensive, hands-on assistance with ADLs such as toileting, transfer from bed to chair or eating. Among Texans receiving Medicaid NF services in 2011, 11 percent were in this cluster. Categorization within this cluster becomes more likely as age increases.

**Cluster 4: Low ADL Needs**

People in this cluster need some assistance with transferring or toileting, but it may be as basic as providing reminders and cueing. Among people receiving Medicaid NF services in Texas in 2011, 7 percent were in this cluster.

**Cluster 5: Very Low ADL Needs**

This cluster includes six of the seven least costly RUGs. People in this cluster do not have clinically complex conditions or any of the needs that qualify for extensive or special services. They may have behavioral issues or be cognitively impaired, but these issues do not interfere with their performance of ADLs. Among Texans receiving Medicaid NF services in 2011, 13 percent were in this cluster. This cluster is most common among individuals in their 50’s and early 60’s.

**Cluster 6: All Others**

People in this cluster need at least some assistance with toileting, transfer, bed mobility, or eating, but less than individuals in the high ADL group. They may have clinically complex conditions, but not those that qualify for special or extensive services. Among people receiving Medicaid NF services in Texas in 2011, 31 percent were in this cluster.

Figure 6 shows the distribution of RUGs clusters.

*Figure 6. RUGs Clusters of Texans Receiving Medicaid Services in NFs, 2011*
Except for age, the distribution of RUGs clusters does not differ significantly by demographic characteristic. As Figure 7 below shows, as age increases, the proportion of persons in the special and extensive cluster decreases sharply. The opposite is generally true for other clusters.

**Figure 7. RUGs Clusters of Texans Receiving Medicaid Services by Age Group, 2011**

<table>
<thead>
<tr>
<th>Aug. 2011</th>
<th>22-35</th>
<th>36-50</th>
<th>51-59</th>
<th>60-64</th>
<th>65-74</th>
<th>75-84</th>
<th>85+</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. All Other</td>
<td>12%</td>
<td>23%</td>
<td>27%</td>
<td>32%</td>
<td>29%</td>
<td>31%</td>
<td>34%</td>
<td>31%</td>
</tr>
<tr>
<td>5. Very Low ADL Need</td>
<td>6%</td>
<td>16%</td>
<td>19%</td>
<td>16%</td>
<td>14%</td>
<td>12%</td>
<td>11%</td>
<td>13%</td>
</tr>
<tr>
<td>4. Low ADL Need</td>
<td>3%</td>
<td>4%</td>
<td>5%</td>
<td>6%</td>
<td>6%</td>
<td>7%</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>3. High ADL Need</td>
<td>8%</td>
<td>7%</td>
<td>6%</td>
<td>8%</td>
<td>9%</td>
<td>12%</td>
<td>13%</td>
<td>11%</td>
</tr>
<tr>
<td>2. Rehab</td>
<td>14%</td>
<td>17%</td>
<td>19%</td>
<td>19%</td>
<td>27%</td>
<td>26%</td>
<td>23%</td>
<td>23%</td>
</tr>
<tr>
<td>1. Special and Extensive</td>
<td>57%</td>
<td>34%</td>
<td>23%</td>
<td>20%</td>
<td>15%</td>
<td>13%</td>
<td>11%</td>
<td>15%</td>
</tr>
</tbody>
</table>

**Financial Characteristics**

In 2011, average monthly cost for NF services was $3,832. The majority of Texans who entered NFs that year paid for costs through Medicare and private funding only. Among those who qualified for Medicaid services, the majority were eligible under the Medical Assistance Only (MAO) rules (see page 15 for additional details).

**Medicare and Medicaid**

In 2011, 9 percent of all people receiving Medicaid NF services had a portion of their services paid for by Medicare (see Figure 8 below). These individuals were still within the first 100 days after a qualifying hospital stay.
Supplemental Security Income

In 2011, approximately 14 percent of individuals receiving Medicaid NF services were also eligible for SSI benefits. See Figure 9, below. Younger people receiving Medicaid NF services, many of whom have life-long disabilities, are more likely to be eligible for SSI than older people who receive Medicaid NF services.

In 2011, 487,000 adults in Texas received SSI benefits. Approximately 6,350 (1.3 percent) of these also received Medicaid NF services. People over 75, and especially over 85, who receive SSI benefits, are less likely to use Medicaid NF services than are Texans the same age with higher incomes. Among people age 85 and older, fewer than 5 percent of SSI beneficiaries received Medicaid NF services, compared to over 7 percent of the general population. Older people receiving SSI may have a lifelong history of poverty, but not necessarily of disability.
Applied Income

In 2010, over 75 percent of all Texans receiving Medicaid NF services made an applied income payment. In most cases, nearly all of the individual’s income, except for $30 per month for personal needs, went to pay for NF care. Medicaid paid the remaining cost.

As Figure 10 shows, a little more than half of all persons receiving Medicaid NF services made applied income payments between $600 and $2,100 per month in 2010. Another 18.2 percent made applied income payments of less than $600 per month. Only 22.7 percent of people receiving Medicaid NF services made no applied income payment at all. The average applied income payment among all people receiving Medicaid NF services in 2010 was $692 per month.

There are two major reasons people using Medicaid NF services may make very small or no applied income payments. Some are eligible for SSI, and receive no income while they are in a facility. Others with small applied income payments may have a spouse or other dependent still living in the community. In that case, some or all of the NF resident’s income is protected for the use of the person in the community. Please see details on page 10.

Approximately 7.3 percent of people receiving Medicaid NF services had applied income amounts of more than $2,100. It is likely that these individuals were using Qualified Income Trusts (QITs). Please see details on page 10.

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3 Data note: Data on applied income are for all of calendar year 2010. It includes everyone who used Medicaid NF services at any time during the year. It is necessary to use full year data from a completed year in order to allow for billing and authorization cycles.
People over 65 who received Medicaid NF services had higher applied income amounts than their younger counterparts. Younger people were more likely to be SSI recipients and were less likely to have substantial incomes from Social Security or other sources.

*Figure 11. Estimated Monthly Applied Income by Age, 2010*

As shown Figure 12, among people over age 65 who received Medicaid NF services in 2010, men were more likely than women to have little or no applied income. Older men, even those in NFs, are more likely than women to have a living spouse. When the couple’s income is modest, and especially when the wife has little or no Social Security in her own right, all or nearly all of the husband’s income will be protected for the wife under spousal impoverishment rules.

*Figure 12. Estimated Monthly Applied Income by Gender, People Age 65 and Over, 2010*
Among people over age 65, monthly applied income amounts were higher for Anglos than for any other group and lowest for people of “Other” race/ethnicity. See Figure 13.

**Figure 13. Monthly Applied Income by Race/Ethnicity for People Age 65 and Over, 2010**

<table>
<thead>
<tr>
<th>Income Bracket</th>
<th>Anglo</th>
<th>Black</th>
<th>Hispanic</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over $2100</td>
<td>9.2%</td>
<td>7.1%</td>
<td>5.7%</td>
<td>5.6%</td>
</tr>
<tr>
<td>$1200-$2100</td>
<td>24.1%</td>
<td>15.4%</td>
<td>11.2%</td>
<td>10.8%</td>
</tr>
<tr>
<td>$600-$1200</td>
<td>38.7%</td>
<td>36.6%</td>
<td>32.9%</td>
<td>18.0%</td>
</tr>
<tr>
<td>Less than $600</td>
<td>14.9%</td>
<td>23.6%</td>
<td>28.1%</td>
<td>20.1%</td>
</tr>
<tr>
<td>None</td>
<td>13.2%</td>
<td>17.3%</td>
<td>22.1%</td>
<td>45.5%</td>
</tr>
</tbody>
</table>

**Assets and Spend-Down**

Many people who enter a NF pay for their own care in the beginning, or after exhausting 20 days of Medicare coverage. When all but $2,000 worth of non-exempt assets have been spent on care, an individual can become eligible for Medicaid. Since average NF care costs more than $3,800 per month, modest savings may be used up quickly.

Available data indicates that few NF residents are spending down large sums. First, according to federal data on all NF residents from the Minimum Data Set (MDS)\(^4\) in 2011, only 12.5 percent of all NF residents paid for their own care, either alone or with family contributions. Second, most people admitted to NFs left without becoming eligible for Medicaid. An analysis of all new admissions to Texas NFs (regardless of payment source) found that only one third became eligible for Medicaid NF services within two years. Of those, over 90 percent (31 percent of all admissions) received Medicaid NF services within one year. Approximately two thirds of individuals who eventually received Medicaid NF services did so during their first quarter in the NF. That is, 21 percent of all persons who entered a Texas NF received Medicaid services in the first quarter. Most of those who did not receive Medicaid died or left the facility.

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\(^4\) Minimum Data Set, admissions occurring during July-September 2011. A total of 33,703 assessments were included.
Figure 14 shows, by quarter after admission, the percentage of people in nursing facilities who enrolled in Medicaid.

**Figure 14. Medicaid Enrollment after NF Admission, by Quarter**

<table>
<thead>
<tr>
<th>Quarter</th>
<th>% on Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>21%</td>
</tr>
<tr>
<td>Q2</td>
<td>28%</td>
</tr>
<tr>
<td>Q3</td>
<td>30%</td>
</tr>
<tr>
<td>Q4</td>
<td>31%</td>
</tr>
<tr>
<td>Q5</td>
<td>32%</td>
</tr>
<tr>
<td>Q6</td>
<td>32%</td>
</tr>
<tr>
<td>Q7</td>
<td>33%</td>
</tr>
<tr>
<td>Q8</td>
<td>33%</td>
</tr>
</tbody>
</table>

Additional data on the characteristics of people most likely use Medicaid after entering a nursing facility can be found in Appendix F.

**Goals for Long-Term Residence**

As part of regular assessments using the MDS, NF residents are asked about their goals. If the resident is unable to answer, family members or other surrogates may provide an answer. Figure 15 below summarizes 2011 data from the MDS on NF residents’ goals for long-term residence. The majority of residents of NFs (59 percent) indicated that they wanted to return to live in the community. About a quarter planned to remain in the NF. Approximately 3 percent planned to go to another institution, either a different NF or another type of facility.

**Figure 15. Residential Goals of People Admitted to NFs, 2011**

As shown in Figure 16, people who had Medicaid at the time of admission were the least likely to have a goal of returning to the community. Those who had not applied for Medicaid were the most likely to indicate the goal of returning to the community.
As shown in Figure 17, people who were admitted to the NF from a hospital or rehabilitation facility were more likely to have a goal of returning to the community. Those admitted from the community or another NF were more likely to have a goal of remaining in the NF. About 78 percent of admissions in the 2011 data were from a hospital.

As shown in Figure 18, when a family member or guardian indicated a long-term residential goal for a resident, the majority chose that the resident remain in their current NF. When the resident indicated the goal, more than 70 percent indicated a desire to return to the community.
Figure 18. Resident Goals by Source

<table>
<thead>
<tr>
<th>Source</th>
<th>Family</th>
<th>Guardian</th>
<th>Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown</td>
<td>15.45%</td>
<td>11.30%</td>
<td>8.91%</td>
</tr>
<tr>
<td>This NF</td>
<td>51.33%</td>
<td>61.86%</td>
<td>17.18%</td>
</tr>
<tr>
<td>Other Inst</td>
<td>5.25%</td>
<td>8.47%</td>
<td>1.91%</td>
</tr>
<tr>
<td>Community</td>
<td>27.96%</td>
<td>18.36%</td>
<td>72.00%</td>
</tr>
</tbody>
</table>
SECTION III: COMPARISON OF TEXANS RECEIVING MEDICAID NF VERSUS HCBS

Differences in the purpose, authorization procedures, payment structures, and geographic limitations of the various Medicaid HCBS programs mean that the types of data available are also different. This diversity limits the ways that that people receiving Medicaid HCBS can be compared to those receiving Medicaid NF services.

In August 2011, about 200,000 persons received Medicaid HCBS services designed for adults who are aging or have physical disabilities. This number includes STAR+PLUS, CBA, PACE and non-waiver services, but does not include waivers designed for children or people who have intellectual or developmental disabilities. More than three times as many Texans received Medicaid HCBS than received Medicaid NF services.

**Demographic Differences**

People receiving Medicaid HCBS tend to be younger than people receiving Medicaid NF services (see Figure 19 below). In 2011, approximately one-third of people receiving Medicaid NF services were over age 85, at least twice the percentage in the same age group among people receiving waiver (CBA or STAR+PLUS) or personal care (CAS or PHC) services. Conversely, people receiving waiver services are about twice as likely to be under age 65 compared to people receiving Medicaid NF services. People receiving Medicaid HCBS are less likely to be over 85, but the total number who are over 85 and receiving waiver and personal care services is higher than the number the same age who are receiving Medicaid NF services.

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Data for this section are drawn from two sets of programs: the waiver programs CBA and STAR+PLUS, and the CAS and PHC programs which provide only personal attendant services. The DAHS and PACE programs are not included due to the geographic limitations of those programs.
All Medicaid LTSS programs, whether NF or HCBS, have similar distributions by gender: between 30 and 39 percent of participants are male.

As shown in Figure 20, people receiving Medicaid NF services are more likely to be Anglo while people receiving Medicaid HCBS services are more likely to be Hispanic or Black.

**Functional Needs**

Among Texas Medicaid HCBS, CBA is the only program for which medical and functional assessment data are available. Fortunately, the assessment tool and records for CBA are the
same as for NF services. The MDS is used to produce a RUGs score for each person in CBA. Thus, RUGs scores allow approximate comparisons to be made between the needs of people receiving CBA services in the community and those of individuals receiving Medicaid NF services.

The distribution of RUGs among people using CBA services is strikingly different from that of people using NF services, as shown in Figure 21, below. While approximately half of people receiving CBA services have low or very low ADL needs, only 20 percent of people receiving Medicaid NF services have such low needs. Very few people receiving CBA services are in either the Rehab or High ADL groups.

While it is reasonable to say that people receiving CBA are more likely to have lower needs than people receiving NF services, it is important to note that 11 percent of people receiving CBA are in the Special and Extensive RUGs cluster.

**Living Arrangements**

Data on the living arrangements of people receiving CBA program services show that the majority of people (58 percent) live with family (see Figure 22 below).
Almost one-third live alone. Much smaller numbers live with other waiver participants, in adult foster care, or in assisted living.

As Figure 23 below shows, the groups most likely to live alone are those with low or very low ADL needs.

**Figure 23. Living Arrangements by RUGSs Cluster, CBA**

Those with higher needs are most likely to live with family. Other living arrangements, including Adult Foster Care, Assisted Living, and shared arrangements with other waiver recipients are most often used by people in the Rehab and Very Low ADL Need groups.
In summary, people receiving Medicaid HCBS are younger, more likely to be eligible for SSI, and less likely to be Anglo compared to people receiving Medicaid NF services. There is limited information about the functional needs of people in HCBS, except in the CBA waiver. About half of people receiving CBA waiver services have low or very low ADL needs; a much higher proportion than among people receiving Medicaid NF services. More than 10 percent of people receiving CBA services have special or extensive care needs.
SECTION IV: FACTORS CONTRIBUTING TO USE OF NURSING FACILITY INSTEAD OF COMMUNITY SERVICES

A number of factors are associated with increased use of NFs instead of HCBS. These include administrative issues like:

- the immediate availability of NF services compared to a wait of weeks or years for HCBS services; and
- HCBS’ more complicated enrollment process.

Research has found certain characteristics and histories associated with using nursing facility services. Some examples are:

- demographic variables such as increased age;
- greater health and functional problems; and
- a history of higher health services use.

In general, people receive NF services because they need medical care and assistance with ADLs and cannot obtain timely and sufficient help in the community. People who are older, not married, have multiple medical problems, and limited contact with others are at greater risk of entering a NF. Nursing facility admissions often occur in an atmosphere of crisis, either because of a hospitalization or because of a breakdown in caregiving arrangements. These and other factors that contribute to NF instead of HCBS placement are detailed below.

**Immediate NF versus HCBS Interest List Placement**

When an individual who meets medical necessity requirements seeks NF services, he or she can typically begin receiving those services immediately. Staff at NFs are familiar with Medicaid eligibility requirements and can advise families if the prospective resident is likely to become Medicaid eligible, and how soon. Often facilities will accept new residents without payment, while waiting for Medicaid eligibility to be established. No interest lists exist for NF entry.

In contrast, when an individual who may qualify for HCBS applies for such services, the individual must frequently wait on an interest list until a slot for those services becomes available. The application process then begins when a slot becomes available. In April 2012, 12,761 individuals were on the interest list for the CBA program: of these, 98 individuals had been on the interest list for 2-3 years, and another 1,135 individuals for 1-2 years. The STAR+PLUS program had longer waiting periods. Out of 14,563 individuals on the interest list in April 2012, 443 had been waiting for 3-4 years; another 2,019 for 2-3 years; and 4,072 for 1-2 years.
More Complicated Enrollment Processes for HCBS

Enrollment processes are also longer and more complicated for HCBS.

In order to receive any Medicaid long-term service or support, an individual must do the following:

- be determined financially eligible for Medicaid;
- be determined functionally or medically eligible for the specific service;
- select a provider; and
- have a plan of care developed by the provider; and

The basic processes are shown in figures 24 and 25. The figures describe the process for an individual who is not already eligible for Medicaid and who does not have assets that exceed the Medicaid limit.

Figure 24. Nursing Facility Enrollment Process

1. Select Facility
2. Enter facility and receive services
3. Facility submits medical need data
4. Apply for Medicaid
   - Facility provides application and assists with completion
5. Financial eligibility determined
   - 45 days if no complications
6. Facility receives payment
Nursing Facility Process

An individual seeking NF services can typically begin receiving services while waiting for the Medicaid eligibility process to be completed. Often NFs accept residents, without payment, while the Medicaid process is pending. The individual must agree to pay for the NF services if he or she is found ineligible for Medicaid. When the individual is found eligible for Medicaid, the NF is reimbursed for services provided during the eligibility determination process. Medicaid will pay for services provided up to three months before the person is determined eligible. Medicare may pay for some or all of services provided during the interim.

An individual can transfer directly from the hospital to the NF and begin to receive services immediately. The individual (and family) must select a provider with an available bed. The plan of care will be developed by NF staff, who will submit documentation for medical necessity to Medicaid. NF staff often assist with the Medicaid financial application.

Community Service Process

An individual seeking HCBS services must complete all of the steps outlined in Figure 28 above before any services are received. The eligibility application and determination process typically takes two to three months. While waiting to complete the process, the individual may seek other services. Medicare Home Health services or private duty home care may meet some or all of the

Figure 25. Community Service Enrollment Process

1. Request application
2. Apply for Medicaid
3. Financial eligibility determined
   • 45 days if no complications
4. Functional and medical assessment
   • 2-3 weeks
5. Select provider
6. Individual service plan developed
7. Receive services
8. Provider receives payment
individual’s needs. The individual, family, or some other source must pay any costs not covered by Medicare during this period. Providers can be reimbursed for Medicaid-eligible services provided during the application period, but are not generally willing to take the financial risk involved.

Individuals or families may need to research the types of service available, the eligibility requirements, and any sources of assistance with the process. Area Agencies on Aging and hospital social workers are the most likely sources of assistance.

If the individual seeks CBA or STAR+PLUS, he or she must also wait on the interest list until a waiver slot becomes available. The application process begins after a waiver slot becomes available. An individual may receive non-waiver services while waiting for waiver services.

**People Already Eligible for Medicaid**

People who are already eligible for Medicaid (usually through SSI eligibility) can establish eligibility for services more quickly. In a NF, payment begins as soon as the documentation of medical need is completed—no more than a few days.

If a person who is already eligible for Medicaid seeks community services, there will be a wait of at least a few weeks while the functional assessment is completed and provider arrangements are made. Medicare Home Health may meet some needs in the interim, but private duty home care is likely to be too costly for a person receiving SSI payments.

If a person who is already eligible for Medicaid seeks waiver services, he or she may need to wait until a waiver slot becomes available, but may receive non-waiver services such as Primary Home Care or DAHS in the interim. If the individual lives in a STAR+PLUS area, there is no additional wait for waiver services.

**Spending Down and Special Arrangements**

If the individual seeking Medicaid LTSS (in any setting) has assets that exceed the Medicaid eligibility limits for LTSS, those assets must be spent (usually in paying for services) before the individual becomes eligible for Medicaid. In a NF, an individual pays the facility for services. Basic NF services will be the same whether they are paid by Medicare, private payment or Medicaid. The plan of care may change, but the individual will receive continuous services.

In the community, the individual may spend down assets by paying any co-pays on Medicare Home Health and by paying for private duty home care. The individual and family must research and arrange the private services. When the individual becomes Medicaid eligible, it is often necessary to change providers, and services may operate under different rules and expectations. When the individual becomes eligible for a Medicaid waiver program, he or she must choose a provider that is contracted to deliver waiver services and must follow waiver program requirements.

If an individual has income that exceeds the Medicaid limits, he or she must establish a Qualified Income Trust (QIT, see page 10) in order to receive waiver or NF services. A QIT cannot be used to become eligible for CAS services. Establishing a QIT requires the services of an
attorney and takes additional time. The QIT can be established while the individual is already in a NF. A person seeking waiver services must establish the QIT before Medicaid eligibility can be determined.

**Summary of Research Findings**

Recent research described below has identified a number of factors associated with NF use, and especially with long-term NF use. Long-term use is of particular interest because it is most similar to Medicaid NF use.

**Demographic and Socio-economic Variables**

**Age:** Greater age is consistently a risk factor for NF use, both long-term and short-term\(^6\) \(^7\) \(^8\). Among the oldest individuals (age 85 and older) the rate of long-term use is declining, but remains higher than in any other age group\(^9\).

**Race/Ethnicity:** Historically, Anglos were more likely to use NF services than Blacks or Hispanics. Data that is more recent shows that overall NF use (regardless of payment source) is increasing among members of minority groups, while use by Anglos is declining\(^10\) \(^11\) \(^12\).

**Gender:** Findings in this area are complex and sometimes contradictory. Women are more likely than men to be in NFs, but that may relate to a woman’s greater life expectancy and greater likelihood of being widowed. Among people under 65, men are more likely to be in NFs than women. The female share of the NF population increases sharply with age\(^13\) \(^14\) \(^15\).

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\(^9\) DADS internal data analysis, using QAI datamart and U.S. Census data


\(^11\) DADS internal data analysis, using QAI datamart and U.S. Census data

\(^12\) Feng, Z., Fennell, M. L., Tyler, D. A., Clark, M., & Mor, V. (July 2011). Growth of Racial And Ethnic Minorities In US Nursing Homjes Driven By Demographics And Possible Disparities In Options. *Health Affairs*, 1358-1365.


\(^14\) DADS internal data analysis, using QAI datamart and U.S. Census data

**Family status:** People who are currently married are less likely to be in NFs. Widowed men are at greater risk of NF placement than widowed women are. People who have adult children may be at less risk of NF entry, but the difference is affected by age and marital status.  

**Economic status:** People who own their own homes are less likely to enter a NF. The role of income in NF residence has received little attention, in part because the requirements of Medicaid eligibility distort the data.

**Social connection:** People with limited social networks (few friends, little interaction with others) are more likely to enter a NF.

**Health and Functional Status**

The factors most often cited as predicting NF use are related to health and the ability to care for oneself. In general, an increase in the number of a person’s health and functional problems increases the likelihood of NF admission.

Some of the most important factors are:

- **Need for assistance with ADLs** such as bathing, dressing, or toileting.
- **Need for assistance with IADLs** such as preparing meals, shopping, cleaning house, and paying bills.
- **Incontinence**
- **Delirium, dementia, or other cognitive impairment**
- **Having multiple diseases or medical conditions**
- **Falls, especially falls causing an injury**

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Use of Health Services

The following health services factors also appear to be related to greater likelihood of entering or staying in a NF:

**Prior hospitalization:** Most NF admissions are made from the hospital, and the overall use of post-hospital Medicare Skilled Nursing Facility (SNF) services has increased. Hospitalization greatly increases the likelihood of long-term NF placement.  

**Lack of a primary care physician:** Medicare beneficiaries who do not have a primary care provider managing their overall care are at greater risk of becoming long-term NF residents after a hospital stay.

**Having multiple prescriptions:** People who take multiple prescription drugs are at greater risk of entering a NF and of making a long-term stay after hospitalization.

**Previous NF use:** People who have had a previous stay in a NF, especially one that is not simply for post-hospital rehabilitation, are at greater risk of using NF services for a long period.

Some of the health care use factors may interact. For example, risk of NF use after hospitalization is greater without a primary care physician and multiple prescriptions may reflect the absence of a primary care physician.

**Key Informant Input**

Staff interviewed or corresponded with individuals familiar with the NF placement process, including DADS staff, benefits counselors, and other staff from Area Agencies on Aging. The following items were consistently cited as factors in the decision to use NF services, and particularly Medicaid-funded NF services.

**The individual’s health and functional status reaches a point where staying at home seems impossible or unsafe.** This may be a result of slow decline or, more often, decline resulting from a hospital stay. A hospital stay may also draw attention to on-going issues and precipitate a decision to use NF services. Some factors cited as triggers include:

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• Dementia, especially if there is concern about wandering or unsafe behavior.

• Inability to manage drugs, including forgetting doses, resistance to taking drugs or confusion resulting from complex drug regimens.

• Incontinence, when it can no longer be managed by the individual.

A caregiving relationship breaks down. Caregivers may become unable or unwilling to continue providing care. A change in the health status of the caregiver or of the individual needing care may cause such a change. Other factors may include a change in the financial circumstances of caregiver or cumulative stress and exhaustion.

The decision to enter a NF nearly always occurs in an atmosphere of crisis. Nursing facility services are available quickly, and Medicaid HCBS is not. Arranging home-based services is complicated, arranging NF care is far simpler. NF services are well understood and appear to families in crisis to be a safe, logical, available option.

Services in a NF can often be arranged without immediate payment and home care services cannot. Staff at NFs are familiar with Medicaid eligibility requirements and can advise families if the prospective resident is likely to become Medicaid eligible, and how soon. Often facilities will accept new residents without payment, while waiting for Medicaid eligibility to be established. HCSSAs do not usually offer this option, because they do not have the necessary cash flow to support it.
SECTION V: TEXAS’ EFFORTS TO IMPROVE ACCESS TO HCBS

Texas is a national leader in some aspects of LTSS. The annual report on Medicaid Expenditures for Long-Term Services and Supports published by Thomson/Reuters, ranks states according to the percentage of LTSS funds that are spent on HCBS. Texas spends nearly half of all LTSS for people who are aging or have physical disabilities on HCBS. Only six states spend a larger share of their LTSS for these populations in the community than does Texas. Texas’ MFP program and its strong commitment to personal care and waiver services are particular strengths of the system.

Texas’ efforts to promote the use of HCBS may be grouped into four major categories:

Service Array

Texas offers a wide array of services in the community, including comprehensive waiver services under both CBA and STAR+PLUS. Innovative services like home telemonitoring and overnight companion services for people who cannot safely be alone in their homes have made HCBS feasible for people with very high needs. On the other hand, low-cost services like personal care, emergency response services (ERS), and DAHS mean that HCBS can be available to many people.

Service Access

Texas has established Aging and Disability Resource Centers (ADRCs) which serve as "front doors" for older adults and people with disabilities who are seeking services and supports. Texas currently has 14 of these centers in operation. DADS continues to expand the number and functionality of ADRCs to achieve statewide coverage. ADRCs are designed to provide "one-stop shopping" for people who need help. They make it possible for people seeking services to be routed to the right programs and/or services without having to locate the information themselves. Additionally, once a person's information is provided the first time, that data can be transferred to the appropriate entity so that the person does not have to provide the information repeatedly.

Even where an ADRC is not available, the Area Agency on Aging (AAA) offers benefits counseling. This includes providing information regarding public benefits, private benefits, and community support programs. Benefits counseling services include assisting older Texans with understanding their rights, applying for benefits, and receiving appropriate referrals; exercising choice; benefiting from services and opportunities authorized by law; and maintaining their rights.

Texas has undertaken a revision of parts of the service application process, using online tools where appropriate. These tools enable families to learn about the array of DADS services and to download a write-able version of the application. Changes in the application process may make it easier for individuals and families to consider and to apply for HCBS rather than NF care.
Even if NF care is necessary after hospital discharge or other crisis situations, families may be better able to consider HCBS after the immediate crisis has been resolved.

**Money Follows the Person**

In 2001, Texas began its Money Follows the Person (MFP) initiative. This program allows adults who are receiving Medicaid NF services to transfer to the CBA or STAR+PLUS waiver without waiting on the interest list. Children receiving Medicaid NF services can transfer to the MDCP waiver in the same way. Since 2001, the MFP program has enabled over 25,000 people to leave NFs and return to the community. Over 6,000 are still residing in the community. People of all ages and degrees of disability have used the MFP option. The MFP program is supported by:

- Relocation Specialists who contract with DADS to assist individuals with planning and carrying out their move
- Transition Assistance Services that provide money for household startup costs
- A limited Housing Voucher Program in cooperation with housing agencies
- Money Follows the Person Transition Teams in NFs

The Texas MFP program became a model for a Federal initiative of the same name. Texas received federal MFP demonstration funds to expand and improve the program. Much of the MFP demonstration focuses on individuals receiving DADS services for persons with intellectual and developmental disabilities (IDD), but the following components are aimed at assisting people in NFs to live in the community:

- Services to NF residents with complex needs
- Intensive post-transition services
- Services to NF residents with co-occurring behavioral health needs

MFP has shown that people of all ages and needs can successfully move from a NF to the community successfully. The program has also shown that targeted support services can be helpful to people who might otherwise have difficulty making that transition.

**Diversion**

Two of Texas’ ADRCs (Central Texas and Tarrant County), were funded by the federal Agency on Aging to conduct Community Living Options (CLO) demonstration projects. These projects identify individuals in hospitals who are at risk of becoming long-term residents of a NF. The goal is to prevent or delay nursing home placement and spend down to Medicaid. A family-centered plan is developed using the following core services:

- Evidence-based Care Transitions Intervention is a formal set of tools that assists individuals and families transfer from hospital to home safely and smoothly.
- Support and skills training for family caregivers reduces stress and increases important skills in the physical and emotional tasks of caregiving.
• Funds for community-based formal support services are provided under the Older Americans Act.

The projects focus on people who are not eligible for Medicaid but could easily spend-down and become eligible if they were in a NF.

A preliminary evaluation of the Central Texas CLO project found that:
• Reaching older adults through community-healthcare partnerships is feasible.
• Most participants avoided nursing home placement, although discussions about such placement were occurring.
• Consumer emergency room and hospital use was reduced.
• Caregiver burden was reduced.
• Families were satisfied with services.

The Central Texas ADRC is working to make CLO a permanent part of the local service delivery system. The Tarrant County ADRC is working to replicate and adapt the Central Texas program to their local circumstances.

These CLO projects have shown that efforts to divert people from using NFs are promising, and that intensive cooperation on the community level is needed to make the effort work. Widespread implementation of diversion projects will require the commitment of time, effort, and funds from multiple players.

In the 82\textsuperscript{nd} legislative session, DADS was appropriated 100 CBA slots for individuals at immediate risk of entering a nursing facility.

**Balancing Incentive Program**

Texas is seeking federal approval and funding to make further improvements in the ways people access and use the Medicaid LTSS system. If the funding is approved, Texas will build on the ADRC system and develop new assessment tools to simplify eligibility care planning.

In June 2012, DADS submitted an application to the Centers for Medicare and Medicaid Services (CMS) to participate in the Balancing Incentive Program (BIP). If the application is approved, Texas will be eligible to receive approximately $82 million per year (freed up general revenue) for community-based long-term services and supports (LTSS) in exchange for making certain structural changes. These include:

• No Wrong Door/Single Entry Point System – statewide coordinated system for streamlined eligibility and enrollment.
• Core Standardized Assessment Instrument(s) – assessments that determine eligibility, identify service and support needs, and inform care plan development. Assessments must address activities of daily living (ADLs); instrumental ADLs; medical conditions/diagnoses; cognitive functioning/memory; and behavior concerns.
- Conflict Free Case Management – separation of case management and eligibility determination from service provision.
SECTION VI: OTHER STATES’ EFFORTS TO IMPROVE ACCESS TO HCBS

Other states have used various strategies to improve access to HCBS. Two groups of strategies are described below.

Single Point of Entry and Expedited Enrollment

Some states use ADRCs or similar mechanisms to ensure that individuals and families seeking LTSS have access to HCBS and institutional care. The state of Washington requires a pre-admission assessment for anyone planning to enter an NF and use Medicaid services. The assessment identifies community-based services that could be used and helps families plan for them. In Oregon, people entering a NF under any payment method must undergo a simplified assessment and be informed of the feasibility of HCBS.

At least three states (Washington, Pennsylvania and Nebraska) use expedited financial eligibility for HCBS services. Individuals seeking services are asked basic screening questions about their income and assets. If it appears they are eligible, the state will establish a temporary service plan and begin paying for services immediately. Financial eligibility for Medicaid is determined within 45 days. If the individual is not found eligible for Medicaid, state or other non-Medicaid funds are used to pay for the temporary services.

Washington

Washington’s assessment and information system, Comprehensive Assessment and Reporting Evaluation (CARE), provides care planning and access not only to Medicaid waiver services but also to Medicaid state plan personal care and state-funded services. The state uses an expedited eligibility determination system that makes HCBS available as quickly as NF services. Data from the CARE system provides a preliminary eligibility financial eligibility determination. If the individual appears to be financially eligible, they can begin receiving services immediately. A full determination is made within 45 days. Washington began using this approach in 1996. State staff estimate that only about 1 percent of persons approved for expedited eligibility are later found ineligible and that the financial risk to the state is negligible.

Washington uses a combination of agency-based and consumer-directed services to provide in-home care. Usually, expedited services are arranged through a Medicare certified home health agency, and the consumer-directed services may be arranged later. Home health agencies, which provide services to individuals being discharged from a hospital, are normally prepared to provide immediate services.

Oregon

In addition to requiring pre-admission screening for all of its Medicaid long-term care services, Oregon also requires a less comprehensive pre-admission screen for any individual, regardless of financial resources, seeking admission into a Medicaid certified NF, regardless of payment source. This policy aims to educate all individuals with long-term care needs, whether they are
private pay or receive public funds, about home and community-based services and to help them decide whether their needs are more appropriately met in a less restrictive environment.

**Pennsylvania**

Applicants or agencies making referrals for Pennsylvania’s Community Choice program can call a state hotline that operates seven days a week, 24 hours a day, to request assessment for long-term care services. The hotline operator contacts an “on call” assessor who talks with the caller to determine the urgency of the situation. Assessment interviews can be conducted within 24 hours of the call for people in the community who are at risk of immediate admission to a NF. Assessors are employed by Area Agencies on Aging or other subcontractors. Assessors use a four-page form to make determinations about the level of care needed and to create an interim service plan. Subsequently, a more comprehensive plan of care is developed. The initial application asks for basic information about income and assets. The assessor faxes the completed form to the Medicaid office using a dedicated fax number. At the office, a caseworker makes a preliminary determination about eligibility and enters information about the individual into the system if it appears that he or she will be eligible. Services can be arranged within a few days; the information submitted must be verified in 45 days.

**Policy Commitment and Systems Change**

Some state Medicaid programs that are successful in keeping people in the community do not operate separate “transition” or “diversion” programs. Instead, they have made systemic changes to increase the capacity for community-based care, to inform consumers about options for care, and to assist consumers as they make choices about care. A 2005 report by the Georgetown University Health Policy Institute for the Kaiser Commission on Medicaid and the Uninsured, entitled “Strategies to Keep Consumers Needing Long-Term Care in the Community and Out of Nursing Facilities” described key strategies used in other states. Some examples are listed below:

- Expediting HCBS program eligibility determination to allow HCBS to be as available as NF placement during a crisis.
- Ensuring that sufficient numbers of community-based service providers are willing and able to provide immediate care.
- Using standardized assessment tools to allow simultaneous eligibility determination for multiple services.
- Providing support to maintain residences.
- Informing people about options for care including publicly and privately paid services.
- Fostering partnerships among NFs, state agencies, AAAs, hospitals, HCBS providers, and rehabilitation facilities to ensure that local arrangements can be made quickly.
- Strategic placement of diversion staff at key junctures in service delivery, including at the point of hospital discharge and at points of care crisis for families.
- Using public information campaigns to encourage people to plan for their own future long-term care (LTC) needs (e.g., personal financial planning, LTC insurance, etc.).
• Making successful community discharges a factor in reporting on the quality of nursing facility services.

• Modifying the reimbursement system to offer financial incentives to NF providers to encourage prompt and well-planned discharges.
SECTION VII: RECOMMENDATIONS TO EXPEDITE ACCESS TO HCBS

SB222 directs HHSC and DADS to “identify ways to expedite recipients’ access to community-based services and supports…for which interest lists or other waiting lists exist.” This section identifies some options that the state could consider to accomplish this goal. In some cases, further analysis is required to identify ways to minimize net cost to the state and maximize savings from avoiding unnecessary NF services.

Offer Time-Limited Personal Assistance Services for People in Crisis

Texas could offer time-limited personal assistance services (PAS) to people who are in a crisis situation and who appear to be eligible for Medicaid. At least three other states use this presumptive eligibility method (see page 57). Services could be coordinated with Medicare Home Health, privately paid services, AAA services, and informal caregivers, as needed. The two Community Living Options projects in Texas offer some models for this approach. (See page 49) Some elements of such a program would include the following:

- **Quick Eligibility Screen**: Staff would be assigned to ask basic questions about income, assets, functional status, medical status, and available supports. Screening questions can be adapted from those used in other states. Staff could be based at major hospitals, work by telephone, or both. Individuals and families would be given instructions about submitting a complete application and the time limits on services.

- **Quick Temporary Service Plan and Authorization**: Staff could develop a short-term service plan, limited to two months, for appropriate hours of PAS services. During that time, a full formal assessment could be conducted to develop a long-term service plan, assuming that the individual was found financially eligible. The short-term plan would reflect crisis needs (hospital discharge, for example); while the long-term plan would reflect the individual’s stabilized needs.

- **Contract Requirements for Rapid Service Availability**: DADS would need to work with providers to develop the contracts for services with short notice. Options should be available for service provision through agencies as well as consumer directed services. Other states may have experience that could help DADS structure the services.

- **Controls to Prevent System Abuse**: Eligibility might be limited to defined crises (e.g., hospital discharge and Adult Protective Services interventions.) Providers might not be permitted to initiate services without DADS authorization. A time limit on services would prevent abuse.

- **Funding Flexibility**: States that have implemented presumptive eligibility for HCBS have assumed the risk when individuals turn out not to be eligible for Medicaid. That is, when an individual fails the financial eligibility test, the state uses non-Medicaid funds to pay for the cost of services and does not expect reimbursement from the individual or family. Other states have found the risk to be small and the increased costs more than offset by decreases in
the use of NF services. Since two months of PAS services would cost less than $2,500, the amount at financial risk would be small.

- **Coordination with Other Services**: In a crisis or hospital discharge situation, individuals are likely to need services other than PAS. Medicare Home Health services, services from Area Agencies on Aging and support from volunteer and community groups may be required. Presumptive eligibility may operate best in an environment of enhanced community cooperation and hospital discharge planning, such as that discussed below.

**Offer Short-Term Waiver Services for People in Crisis**

Currently, CBA services are not available for crisis situations for people who are not already Medicaid-eligible. While there has been a marked decrease in wait times for individuals seeking CBA services, there continues to be some delay in access to services until a waiver slot is available and then must pass eligibility assessments. One approach to correcting this situation would be to offer short-term (e.g., two-month) waiver services under presumed Medicaid eligibility for people in crisis who appear likely to be Medicaid-eligible. Unlike the time-limited PAS, these waiver services could be more comprehensive, helping to meet needs that are more complex. Inclusion of durable medical equipment and medical supplies may be especially important.

These services would be strictly limited to two months. At the end of that time, if determined financially eligible, the individual would qualify for continuing PAS services, and be assigned to the interest list for waiver services.

Waiver services are designed to substitute for NF services. Although eligibility is reviewed annually and upon change of condition, services are generally expected to be a permanent part of the individual’s life, just as NF placements were generally presumed to be permanent. In practice, however, NF placements, especially those admissions for skilled nursing care paid by Medicare, are often short-term. When the individual’s condition is stabilized, or rehabilitation has progressed well, the individual leaves the facility. Short-term waiver services could operate on the same model.

The screening, authorization, and contracting process would be similar to those described for PAS services. The state would be at risk if the individual were found financially ineligible. Services could be capped to contain the risk.

Care planning and service authorization for short-term waiver services should take advantage of any services available from Medicare or other sources. Caregiver support and training may make it easier for families to provide care after the two-month period is over. Case management staff may need smaller caseloads to handle the complex needs of people in crisis situations. Federal authorization for a short-term waiver program may require some negotiation.

**Other Means of Expediting Access to HCBS**

Most people who receive Medicaid NF services are not eligible for Medicaid until they enter the facility. If their needs could be met in the community, without Medicaid, this would help control
state costs while increasing independence. Texas could employ several strategies to help individuals and families avoid Medicaid LTSS services.

**Enhance and Expand ADRCs**

Texas is making significant progress with Aging and Disability Resource Centers (ADRCs). Fourteen are now operating and a statewide system is planned. In particular, if federal funds for the BIP are approved, the state will have both an obligation and more resources to expand the ADRC system.

Furthermore, the centers could be supported in improving services, sharing best practices, and increasing local community cooperation. As ADRCs become entrenched in their communities and known to local providers, they will have increasing opportunities to help individuals and families receive services in the community.

**Enhance Hospital and NF Discharge Planning and Measurement**

As a result of the Affordable Care Act, hospitals face fiscal sanctions when too many discharged patients are re-admitted. As a result, they are working to improve their discharge planning and implementing programs to ensure that patients and families are able to arrange proper care at home. This emphasis offers an opportunity for synergy with HCBS services.

DADS could develop cooperative relationships between ADRCs and local hospitals, building on the model of the Community Living Options projects in Central Texas and Tarrant County (see page 54). The projects will need funding, and can share techniques and best practices to enhance hospital discharge practices. Projects should implement tools with strong evidence of effectiveness.

DADS could also develop and offer training on HCBS options (with and without Medicaid) for use by hospital discharge staff and medical professionals. The training could be made available at conferences or online, and could be structured to fulfill the continuing education requirements of relevant professional groups.

DADS could develop formal NF quality measures related to discharge practices. Such measures might include the number of people discharged to the community and the stability of those discharges. Over time, information about effective discharge practices can be developed. Reimbursement policies could also be modified to provide incentives for high-quality community discharges.

**Enhance Caregiver Support**

DADS has begun to implement programs to support caregivers. The Life Span Respite program, the Take Time Texas website, and programs implemented by the AAAs are helping families provide care longer and with less stress. These programs could be significantly expanded. Some possible approaches include:

- Develop and publicize internet resources for caregivers, building on the Take Time Texas website.
• Fund AAAs and local organizations to implement evidence-based caregiver support programs.
• Encourage faith-based and voluntary groups to provide evidence-based caregiver support activities to their members.
• Develop internet resources to guide families who need to arrange services and are able to do so with their own resources.

Encourage the Availability of Suitable Housing for an Aging Population

If people are not living in a nursing facility, they need affordable, accessible and integrated housing to remain in a community setting. Texas can help ensure that people who need LTSS have suitable housing in two major ways.

First, Texas can continue existing efforts under the Promoting Independence (PI) initiative to work with the Texas Department of Housing and Community Affairs and local public housing authorities to provide housing vouchers to meet the needs of people with very low income who are leaving NFs. The public housing system is complex, has limited funds, and does not routinely have sufficient vouchers for individuals with SSI-level incomes. The PI initiative works with housing agencies to adjust those priorities.

Second, Texas can encourage homeowners to plan and modify their homes to support aging in place. Texas could work with the building and remodeling industries to encourage designs that are both attractive and barrier-free. Internet and print resources for individuals could encourage baby boomers to build homes that will be easy to live in for many years.

Require Screening and Provision of HCBS Information Prior to NF Admission

Texas could act to ensure that everyone who enters a nursing facility is aware of the fact that other options are available. Building on the Oregon model, Texas could require that all potential and new NF residents undergo a brief screening questionnaire and be provided information about HCBS options. The screening and information could be provided in person or by telephone, with either the individual or a family member. The process should be conducted by a person employed or contracted to the state or to a hospital, but not by NF staff.

As part of the pre-admission screening, the individual or family member could be provided information and planning tools to assist in returning home or moving to the community when ready.

Improve Knowledge of the Reasons People Use Medicaid NF Services

The shortage of recent research on the use of NF services in Texas hampers the development of good policy. There is significant overlap between people using HCBS and people using NF services, but little information about the specific characteristics or circumstances that cause individuals to choose one service over the other. Texas could, at little cost, support additional research into NF use.
Texas could fund a survey of people newly admitted to NFs, or people newly eligible for Medicaid NF services, or their families, to identify the specific factors that caused the NF admission. The survey design would be based upon a small number of focus groups held with such individuals. The survey would be conducted by individuals not associated with NFs. To control costs, Texas may be able to work with university programs in social work and/or allied health fields. These survey elements could also be incorporated into other surveys conducted for quality control and improvement.

Existing data sources, such as the MDS and DADS Quality Assurance and Improvement Data Mart could also be used to further develop information about the characteristics of people who use NF services, whether under Medicaid or otherwise. The involvement of a university research team could bring additional resources and expertise into the analysis process.

With more information about the specific triggers for NF use, Texas could more carefully tailor HCBS programs, caregiver support activities, and alliances with hospitals to target resources to those at the greatest risk of using NF services.
APPENDIX A: SENATE BILL 222

S.B. No. 222

AN ACT

relating to access to certain long-term care services and supports under the medical assistance program.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.0515 to read as follows:

Sec. 531.0515. RISK MANAGEMENT CRITERIA FOR CERTAIN WAIVER PROGRAMS. (a) In this section, "legally authorized representative" has the meaning assigned by Section 531.051.

(b) The commission shall consider developing risk management criteria under home and community-based services waiver programs designed to allow individuals eligible to receive services under the programs to assume greater choice and responsibility over the services and supports the individuals receive.

(c) The commission shall ensure that any risk management criteria developed under this section include:

(1) a requirement that if an individual to whom services and supports are to be provided has a legally authorized representative, the representative be involved in determining which services and supports the individual will receive; and

(2) a requirement that if services or supports are declined, the decision to decline is clearly documented.

SECTION 2. Section 533.0355, Health and Safety Code, is amended by adding Subsection (h) to read as follows:
(h) The Department of Aging and Disability Services shall ensure that local mental retardation authorities are informing and counseling individuals and their legally authorized representatives, if applicable, about all program and service options for which the individuals are eligible in accordance with Section 533.038(d), including options such as the availability and types of ICF-MR placements for which an individual may be eligible while the individual is on a department interest list or other waiting list for other services.

SECTION 3. Subchapter D, Chapter 161, Human Resources Code, is amended by adding Sections 161.084 and 161.085 to read as follows:

Sec. 161.084. MEDICAID SERVICE OPTIONS PUBLIC EDUCATION INITIATIVE. (a) In this section, "Section 1915(c) waiver program" has the meaning assigned by Section 531.001, Government Code.

(b) The department, in cooperation with the commission, shall educate the public on:

(1) the availability of home and community-based services under a Medicaid state plan program, including the primary home care and community attendant services programs, and under a Section 1915(c) waiver program; and

(2) the various service delivery options available under the Medicaid program, including the consumer direction models available to recipients under Section 531.051, Government Code.

(c) The department may coordinate the activities under this section with any other related activity.

Sec. 161.085. INTEREST LIST REPORTING. The department shall post on the department's Internet website historical data, categorized by state fiscal year, on the percentages of individuals who elect to receive services under a program for which the department maintains an interest list once their names reach the top of the list.

SECTION 4. (a) In this section:
(1) "Long-term care services" has the meaning assigned by Section 22.0011, Human Resources Code.

(2) "Medical assistance program" means the medical assistance program administered under Chapter 32, Human Resources Code.

(3) "Nursing facility" means a convalescent or nursing home or related institution licensed under Chapter 242, Health and Safety Code.

(b) The Health and Human Services Commission, in cooperation with the Department of Aging and Disability Services, shall prepare a written report regarding individuals who receive long-term care services in nursing facilities under the medical assistance program. The report should use existing data and information to identify:

(1) the reasons medical assistance recipients of long-term care services are placed in nursing facilities as opposed to being provided long-term care services in home or community-based settings;

(2) the types of medical assistance services recipients residing in nursing facilities typically receive and where and from whom those services are typically provided;

(3) community-based services and supports available under a Medicaid state plan program, including the primary home care and community attendant services programs, or under a medical assistance waiver granted in accordance with Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n(c)) for which recipients residing in nursing facilities may be eligible; and

(4) ways to expedite recipients' access to community-based services and supports identified under Subdivision (3) of this subsection for which interest lists or other waiting lists exist.

(c) Not later than September 1, 2012, the Health and Human Services Commission shall submit the report described by Subsection (b) of this section together with the commission's recommendations to the governor, the Legislative Budget Board, the Senate Committee on Finance, the Senate Committee on Health and Human Services, the House Appropriations
Committee, and the House Human Services Committee. The recommendations must address options for expediting access to community-based services and supports by recipients described by Subdivision (3), Subsection (b) of this section.

SECTION 5. As soon as practicable after the effective date of this Act, the executive commissioner of the Health and Human Services Commission shall apply for and actively pursue amendments from the federal Centers for Medicare and Medicaid Services, or any other appropriate federal agency, to the community living assistance and support services waiver and the home and community-based services program waiver granted under Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n(c)) to authorize the provision of personal attendant services through the programs operated under those waivers.

SECTION 6. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

SECTION 7. This Act takes effect September 1, 2011.

______________________________    ______________________________
President of the Senate               Speaker of the House

I hereby certify that S.B. No. 222 passed the Senate on April 7, 2011, by the following vote: Yeas 31, Nays 0; and that the Senate concurred in House amendment on May 27, 2011, by the following vote: Yeas 31, Nays 0.

______________________________
Secretary of the Senate

I hereby certify that S.B. No. 222 passed the House, with amendment, on May 20, 2011, by the following vote: Yeas 142, Nays 7, one present not voting.
Chief Clerk of the House

Approved:

__________________________
Date

__________________________
Governor
APPENDIX B: ADDITIONAL INFORMATION REQUESTED

Information Requested by Senator Nelson’s staff:

“Background Data:

Profile of NF residents - demographics (i.e., age, race/ethnicity, gender); number who are Medicaid only vs. dual eligibles (some of this is discussed in the DADS 2011 Reference Guide).

Average amount of individual income applied to the cost of care for Medicaid NF residents (I believe this is captured in the DADS 2011 Reference Guide)

How Individuals Wind up in a NF:

Compare RUGS levels in NFs with LOC in CBA to determine the levels of services needed among these two groups and identify whether any NF residents have RUGS levels of individuals more typically served in CBA (community or ALF).

How many NF residents have spent down assets to be eligible for Medicaid?

Available Community Supports:

Service arrays in community based entitlement and waiver programs and most commonly utilized services in each.

Average number of attendant hours associated with each community based entitlement or waiver program.

How to Expedite Access to Community Services:

Number of NF residents who have expressed a desire to relocate to the community.

State's efforts to divert individuals from NFs and serve them in community based entitlement and waiver programs.

Other state's best practices to divert individuals to community care.”
APPENDIX C: SPECIAL POPULATION GROUPS

Among people receiving Medicaid nursing facility services, some small groups have unusual characteristics. If they receive services in the community (under Medicaid or otherwise) their needs are different and solutions that will work for “typical” residents of NFs may not work for them.

**Children**

In 2011, about 100 people under age 22 received Medicaid NF services in Texas each month (comprising 0.02 percent of the total Medicaid NF population). Of these, about half were legally adults (ages 18-21) but were classified as children for purposes of Medicaid eligibility.

People under age 22 who receive Medicaid NF services are unusual in a number of ways. Most importantly, they have severe disabilities and medical problems that allow them to qualify for medical necessity. Their care needs are severe enough that families are willing to consider NF, rather than home, care. Some specific characteristics of this population in 2011:

- About 80 percent had a RUG classification for Special Care or Extensive Services, placing them in the highest RUG cluster and indicating severe impairment and complex medical needs.
- Just over 60 percent were male, which may reflect the fact that certain types of developmental disabilities are more common in males than females.
- About three quarters were on SSI, more than in any other age group, reflecting the existence of serious and lasting disabilities.

The Medicaid service options available to people under age 22 in the community are somewhat different from those available to adults. Children do not qualify for the Community Based Alternatives waiver but can qualify for the Medically Dependent Children Program waiver (MDCP) which includes services that assist families in caring for a child with severe disabilities. While there is a long wait on the interest list for MDCP services (in April 2012, 1,036 children had been on the interest list for 5-6 years), children already in a NF can immediately qualify for MDCP services without an interest list waiting period. If the child qualifies for SSI, up to 24 hours per day of private duty nursing may also be available.

Many children who qualify for NF services may also qualify for services in waiver programs for people with intellectual and developmental disabilities—they may have intellectual disability plus serious medical needs, paralysis, or similar problems. Services under IDD waivers have interest lists, but special access can be arranged for a child at imminent risk of entering a NF.

**Conditions Identified by the Preadmission Screen and Resident Review (PASARR)**

Under Federal law, persons entering a Medicaid nursing facility who have a history of serious mental illness, intellectual disability, or a related condition (such as cerebral palsy, autism, or
many other early onset disabilities) must have their records reviewed to determine if they should receive special services relevant to their disability. This is intended to ensure that NF services do not overlook the special needs of such individuals.

In the spring of 2010, 5,043 individuals, or about 8 percent of the total Medicaid NF population had such conditions.\(^ {35} \)

![Figure 26. Special Needs Groups In NFs](image)

As Figure 29 above shows, about 45 percent of people (2,248 individuals) with PASRR-identified conditions had serious mental illness, about 30 percent (1,496 individuals) had intellectual disability, 7 percent (371 individuals) had related conditions and 18 percent (928 individuals) had two or more conditions.

### Intellectual and Developmental Disabilities and Related Conditions

People with intellectual and developmental disabilities and related conditions (IDD) in nursing facilities are younger than the general population of NF residents. Only about 30 percent are over age 75. About 22 percent of people with IDD who receive Medicaid NF services are age 50 or less, and comprise about 18 percent of all people in the same age group who are receiving Medicaid NF services.

People with intellectual and developmental disabilities and related conditions (IDD) in NFs may also qualify for other DADS services, such as the Home and Community Services (HCS) or Community Living Assistance Services and Support (CLASS) waivers, Intermediate Care Facility for Intellectual Disability (ICF/ID) or State Support Living Center (SSLC) services.

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\(^ {35} \) Data from the Preadmission Screening and Resident Review (PASARR) screening tool, spring 2010.
Some have received those services in the past, and then transferred to a NF. The reasons that individuals with IDD or their families choose NF services rather than waiver or ICF/ID services are not well documented. Increasing age, increasing medical problems, and the loss of family caregivers to illness or death have all been suggested as reasons. Other factors that likely encourage the use of NF services rather than those designed specifically for people with IDD include:

- The HCS and CLASS waivers both have long interest lists. In April 2012, 2,333 individuals had been on the HCS interest list for 9 years or more; 780 had been on the CLASS interest list for 8-9 years. Unlike CBA and MDCP, the HCS and CLASS waivers do not allow individuals in nursing facilities to access waiver services without spending time on the interest list.

- Nursing facilities in Texas are more likely than ICFs/ID to have available beds.

**Behavioral Health Issues**

People receiving Medicaid NF services may have a variety of mental health and substance abuse issues, but there is little available data. As noted above, some individuals in NFs have been identified by the PASARR process as having a need for mental health services. These individuals typically have a history of major mental illness such as schizophrenia or major depression. They may have a history of service in the state mental health system.

People receiving NF services in Texas (including all payment sources) receive medications related to mental health. More than half receive an anti-depressant, 20 percent receive an anti-anxiety drug and about 30 percent receive and anti-psychotic medication. The use of anti-depressant and anti-anxiety drugs may be related to mental distress resulting from illness or being in a nursing facility. Certain anti-psychotics are used to treat behavior problems in individuals with dementia.

There is no data about the existence of substance abuse issues among people receiving Medicaid NF services.
APPENDIX D: MAP OF TEXAS HEALTH AND HUMAN SERVICES REGIONS
APPENDIX E: RESOURCE UTILIZATION GROUPS CLASSIFICATION SYSTEM

RUGs are mutually exclusive categories that reflect levels of resources need in long-term care settings, primarily to facilitate Medicare and Medicaid payment. They are assigned to individuals based on data elements derived from the Minimum Data Set (MDS). There is a standard order, or hierarchy, and each RUG is associated with relative weighting factors. Each person receiving NF services is classified in one of 34 RUG groups, based on medical and functional needs, diagnoses, and care plans. Each RUG has an assigned value that represents the amount of resources (primarily staff time) a NF will utilize to care for an individual in that group. The values are used in the calculation of reimbursement rates.

Some services in a NF are provided to all residents. Cooking, cleaning, laundry, routine health monitoring and medication management are basic services that vary little from one individual to another. Assistance with some activities of daily living, known as “early loss” ADLs (e.g., bathing, dressing, walking) is so common that it is not considered in the RUG system. If an individual needs assistance with the “late loss” ADLs (e.g., toileting, transfer from bed to chair, bed mobility, eating), the amount of assistance needed will affect the RUG score. Medical, technological, and other special needs will also affect the RUG score.

The RUGs and related cost weights of each cluster are presented below:

### Table 5 RUG Clusters

<table>
<thead>
<tr>
<th>Cluster 1. Special Care or Extensive Services</th>
<th>Weight</th>
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<tbody>
<tr>
<td>RUG</td>
<td>Description</td>
</tr>
<tr>
<td>SE1</td>
<td>Extensive Services 1/ADL &gt; 6</td>
</tr>
<tr>
<td>SE2</td>
<td>Extensive Services 2/ADL &gt; 6</td>
</tr>
<tr>
<td>SE3</td>
<td>Extensive Services 3/ADL &gt; 6</td>
</tr>
<tr>
<td>SSA</td>
<td>Special Care/ADL 4 - 14</td>
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<tr>
<td>SSB</td>
<td>Special Care/ADL 15 - 16</td>
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<tr>
<td>SSC</td>
<td>Special Care/ADL 17 - 18</td>
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<table>
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<tr>
<th>Cluster 2. Rehabilitation</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>RUG</td>
<td>Description</td>
</tr>
<tr>
<td>RAA</td>
<td>Rehabilitation All Levels /ADL 4 - 9</td>
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<tr>
<td>RAB</td>
<td>Rehabilitation All Levels/ADL 10 - 13</td>
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<tr>
<td>RAD</td>
<td>Rehabilitation All Levels/ADL 17 - 18</td>
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<table>
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<tr>
<th>Cluster 3. High ADL Needs</th>
<th>Weight</th>
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</thead>
<tbody>
<tr>
<td>RUG</td>
<td>Description</td>
</tr>
<tr>
<td>PE1</td>
<td>Physical Function/ADL 16 - 18</td>
</tr>
<tr>
<td>PE2</td>
<td>Physical Function with Nursing Rehab/ADL 16 - 18</td>
</tr>
<tr>
<td>CC1</td>
<td>Clinically Complex/ADL 17 - 18</td>
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<tr>
<td>CC2</td>
<td>Clinically Complex With Depression/ADL 17 - 18</td>
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### Cluster 4. Low ADL Needs

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<th>RUG</th>
<th>Description</th>
<th>Weight</th>
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<tr>
<td>BB1</td>
<td>Behavior Problem/ADL 6 - 10</td>
<td>0.7509</td>
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<td>BB2</td>
<td>Behavior Problem with Nursing Rehab/ADL 6 - 10</td>
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<td>CA1</td>
<td>Clinically Complex/ADL 4 - 11</td>
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<tr>
<td>CA2</td>
<td>Clinically Complex with Depression/ADL 4 - 11</td>
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<td>Cognitive Impairment/ADL 6 - 10</td>
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### Cluster 5. Very Low ADL Needs

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<td>BA1</td>
<td>Behavior Problem/ADL 4 - 5</td>
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<td>Physical Function with Nursing Rehab/ADL 4 - 5</td>
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### Cluster 6. All Others

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<td>PC1</td>
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<tr>
<td>PC2</td>
<td>Physical Function with Nursing Rehab/ADL 9 - 10</td>
<td>0.8142</td>
</tr>
<tr>
<td>PD1</td>
<td>Physical Function/ADL 11 - 15</td>
<td>0.854</td>
</tr>
<tr>
<td>PD2</td>
<td>Physical Function with Nursing Rehab/ADL 11 - 15</td>
<td>0.9485</td>
</tr>
</tbody>
</table>
APPENDIX F. CHARACTERISTICS OF TEXANS WHO RECEIVED MEDICAID NF SERVICES WITHIN TWO YEARS OF ADMISSION

Among people in a NF, there is little difference between men and women in their receipt of Medicaid NF services within two years of admission. As Figure 30 below illustrates, for both genders, the likelihood of receiving Medicaid NF services within two years decreases with age.

The likelihood of receiving Medicaid NF services within two years of admission varied by race/ethnicity and educational attainment. At all educational levels, Anglos were less likely to receive Medicaid NF services than people in other racial and ethnic groups. Regardless of race or ethnicity, people with less education were more likely to receive Medicaid NF services.

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Figure 27. Medicaid Receipt within Two Years of NF Admission, by Age and Gender

Figure 28. Medicaid Receipt within Two Years of NF Admission, by Race/Ethnicity and Education
People who were married when they entered the NF were less likely to receive Medicaid NF services within two years than people of other marital statuses.

**Figure 29. Receipt of Medicaid NF Services within Two Years of NF Admission, by Marital Status**

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Medicaid (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never Married</td>
<td>51.7%</td>
</tr>
<tr>
<td>Married</td>
<td>24.5%</td>
</tr>
<tr>
<td>Widowed</td>
<td>31.1%</td>
</tr>
<tr>
<td>Separated</td>
<td>49.7%</td>
</tr>
<tr>
<td>Divorced</td>
<td>46.7%</td>
</tr>
</tbody>
</table>

Approximately 82 percent of new admissions to a NF in 2011 were from an acute care hospital. People admitted from acute and rehab hospitals were the least likely to receive Medicaid within two years of admission while people admitted from facilities for psychiatric care or for people with intellectual disabilities were the most likely to receive Medicaid NF services within that time frame.

**Figure 30. Receipt of Medicaid NF Services within Two Years of NF Admission, by Source of Admission**

<table>
<thead>
<tr>
<th>Source of Admission</th>
<th>Medicaid (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>54.0%</td>
</tr>
<tr>
<td>Asstd living, etc</td>
<td>43.9%</td>
</tr>
<tr>
<td>Acute Hospital</td>
<td>29.5%</td>
</tr>
<tr>
<td>Psych or IDD facility</td>
<td>70.0%</td>
</tr>
<tr>
<td>Rehab Hosp</td>
<td>27.6%</td>
</tr>
<tr>
<td>Other</td>
<td>48.4%</td>
</tr>
</tbody>
</table>
APPENDIX G: NON-MEDICAID HCBS PROGRAMS AND OTHER LONG TERM SERVICES AND SUPPORTS

Non-Medicaid HCBS

Texas offers several types of HCBS with Title XX Block Grant funds. Generally, these programs and services are designed for individuals whose income or resources are too high to qualify for Medicaid or to provide non-medical services like home delivered meals and Emergency Response Services (personal “ beepers” used to summon help in case of a fall).

Eligibility Requirements

Individuals receiving HCBS services via Title XX Block Grant funds must:

- be at least 18 years old;
- have a monthly income of no more than three times the standard SSI payment level ($2,094*);
- have resources of no more than $5,000; and
- meet the functional assessment score requirements of the specific service.

Availability

All non-Medicaid services have legislatively established enrollment limits. In most cases, interest lists are used, and wait times vary by service and region.

Specific Services

Adult Foster Care (AFC): provides a 24-hour living arrangement with supervision in an adult foster home for individuals who, because of physical, mental, or emotional limitations, are unable to continue independent functioning in their own homes. Providers of AFC must live in the household and share a common living area with the individual. Providers may serve no more than three adults in a DADS-enrolled AFC home unless the home is licensed by DADS as a Type C Assisted Living Facility or licensed as a Type A Small Group Home. Services available include help with ADLs and provision or arrangement of transportation. Individuals receiving AFC services pay the provider for room and board.

Client Managed Personal Attendant Services (CMPAS): provides personal attendant services to individuals with physical disabilities who are willing and able to supervise their attendant or who have someone who can supervise the attendant. Individuals receiving Client Managed Personal Attendant Services interview, select, train, supervise, and release their attendants. The CDS option is available for this service.

Day Activity and Health Services (DAHS): provides adult daycare services in licensed facilities Monday through Friday to individuals residing in the community as an alternative to placement in NFs or other institutional settings. Services are designed to address individual physical, mental, medical, and social needs.
**Emergency Response Services (ERS):** provides a 24-hour, seven days per week, electronic monitoring system for functionally impaired adults who live alone or are socially isolated in the community. In an emergency, the individual can press a call button to signal for help.

**Family Care (FC):** provides attendant care to eligible adults who are functionally limited in performing ADLs. Services include assistance with personal care activities, home management tasks, meal preparation, and help with errands. The CDS option is available, and in some areas of the state, the Service Responsibility Option is also available.

**Home-Delivered Meals (HDM):** provides nutritious noontime meals delivered by community-based provider agencies to the individual’s home.

**Assisted Living and Residential Care (ALRC):** provides a 24-hour living arrangement in licensed assisted living facilities in which personal care, home management, escort, social and recreational activities, 24-hour supervision, supervision of/assistance with or direct administration of medication, and transportation are provided. The individual pays the provider for room and board and may also have co-payment liability.

**Special Services for Persons with Disabilities (SSPD):** Services designed to help individuals develop the skills needed to remain in the community as independently as possible are provided in a variety of settings. Services are available only in the Austin, Metroplex, and Tyler Regions.
### Table 6. Title XX Program Statistics

<table>
<thead>
<tr>
<th>Service</th>
<th>FY 2010</th>
<th>FY 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult Foster Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average number served per month</td>
<td>69</td>
<td>57</td>
</tr>
<tr>
<td>Average monthly cost per individual</td>
<td>$438.84</td>
<td>$440.71</td>
</tr>
<tr>
<td><strong>Client Managed Personal Attendant Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average number served per month</td>
<td>466</td>
<td>430</td>
</tr>
<tr>
<td>Average monthly cost per individual</td>
<td>$1,122.61</td>
<td>$869.38</td>
</tr>
<tr>
<td><strong>Day Activity and Health Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average number served per month</td>
<td>2,571</td>
<td>2,688</td>
</tr>
<tr>
<td>Average monthly cost per individual</td>
<td>$497.88</td>
<td>$511.55</td>
</tr>
<tr>
<td><strong>Emergency Response Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average number served per month</td>
<td>17,442</td>
<td>16,412</td>
</tr>
<tr>
<td>Average monthly cost per individual</td>
<td>$23.60</td>
<td>$23.44</td>
</tr>
<tr>
<td><strong>Family Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average number served per month</td>
<td>6146</td>
<td>6,044</td>
</tr>
<tr>
<td>Average monthly cost per individual</td>
<td>$534.22</td>
<td>$545.50</td>
</tr>
<tr>
<td><strong>Home Delivered Meals</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average number served per month</td>
<td>16,648</td>
<td>16,412</td>
</tr>
<tr>
<td>Average monthly cost per individual</td>
<td>$101.62</td>
<td>$101.62</td>
</tr>
<tr>
<td><strong>Residential Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average number served per month</td>
<td>556</td>
<td>491</td>
</tr>
<tr>
<td>Average monthly cost per individual</td>
<td>792.22</td>
<td>796.37</td>
</tr>
<tr>
<td><strong>Special Services to Persons with Disabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average number served per month</td>
<td>104</td>
<td>93</td>
</tr>
<tr>
<td>Average monthly cost per individual</td>
<td>$802.82</td>
<td>$869.38</td>
</tr>
<tr>
<td><strong>Total (Unduplicated) Non-Medicaid Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average number served per month</td>
<td>36,746</td>
<td>35,684</td>
</tr>
<tr>
<td>Average monthly cost per individual</td>
<td>$211.37</td>
<td>$215.72</td>
</tr>
</tbody>
</table>

### Services from Area Agencies on Aging

DADS Access and Intake and the 28 Area Agencies on Aging (AAA) with which it contracts support a
statewide system of services funded through the Older Americans Act (OAA).

**Nutrition services**

These services include congregate meals, home delivered meals, nutrition education, nutrition counseling, and nutrition consultation.

In FY 2011, 52,237 individuals received 3,891,953 congregate meals at a cost $5.09 per meal. A total of 41,293 individuals received home-delivered 4,879,050 meals at a cost of $4.91 per meal.

**Services to Assist Independent Living**

DADS Access and Intake, and the 28 AAAs with which it contracts, support a statewide system of supportive and in-home services under the OAA. In-home and other support services include the following:

- adult day services;
- caregiver respite care – in-home, institutional, non-residential, or voucher-based;
- chore maintenance;
- emergency response services (ers);
- health maintenance;
- health screening/monitoring;
- homemaker;
- hospice;
- instruction and training;
- personal assistance;
- residential repair;
- senior center operations; and
- transportation – assisted, demand/response and fixed route.
**Medicare Home Health**

Under certain circumstances, Medicare covers Home Health Services, which include:

- skilled nursing care provided by a Registered Nurse (RN) or a Licensed Professional Nurse (LVN);
- physical therapy, speech-language therapy, and occupational therapy that is prescribed by a physician;
- durable medical equipment (e.g., a wheelchair or walker);
- medical social services to help with social and emotional concerns related to illness (may include counseling or help finding resources in the community);
- certain medical supplies (e.g., wound dressings); and
- home health aide services (similar to personal care services but more limited).

Medicare home health aide services are only available in conjunction with professional nursing services. If no professional care is needed, Medicare does not cover home health aide services. Medicare aides provide assistance with ADLs (e.g., bathing, dressing, toileting), but do not assist with IADLs (e.g., laundry, shopping, cleaning).

**Eligibility**

To receive Medicare home health services, an individual must:

- have a physician’s authorization and care plan;
- need skilled nursing care, physical therapy, speech-language therapy, or occupational therapy;
- use a Medicare-certified home health agency; and
- be homebound, or normally unable to leave home without help.

**Availability**

Generally, Medicare Home Health Services are only available during recuperation from an illness or injury, or when an ongoing condition becomes unstable. They are not usually available on an ongoing, long-term basis.
Table 7. Medicare Home Health Statistics, CY 2010

<table>
<thead>
<tr>
<th></th>
<th>Calendar Year 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Patients</td>
<td>368,722</td>
</tr>
<tr>
<td>Total Visits</td>
<td>22,074,537</td>
</tr>
<tr>
<td>Average visits per patient</td>
<td>60</td>
</tr>
<tr>
<td>Average payment per patient</td>
<td>$8,339</td>
</tr>
<tr>
<td>Total Payments</td>
<td>$3,074,853,160</td>
</tr>
</tbody>
</table>

**Private Pay Services**

Individuals and families may purchase various types of long-term services and supports (LTSS) using private funds. At one extreme, luxury continuing care retirement communities may provide independent living, assisted living, and NF care on the same campus, sometimes with costly amenities. Entry fees may exceed $400,000 for a life care option and monthly costs may exceed $10,000 for SNF services. At the other extreme, individuals or families may pay a friend or neighbor a few dollars for help with grocery shopping or housecleaning.

There is limited data about private pay services. The variability of the services, and in some cases, the absence of regulation or governmental involvement, means there is no organization that collects information, counts the number of providers, or describes the consumers. Following are some examples of private pay services.

**Assisted Living**

Assisted living is a long-term care option that combines housing, supportive services, assistance with ADLs, and limited health care and is licensed by the state. Some assisted living facilities provide specialized services for people with dementia. Assisted living units may be offered in freestanding communities or as a separate wing or building on a campus with other types of care. Nearly all assisted living in Texas is private pay, with only 4 percent of people in the CBA program living in ALFs.

In Fiscal Year 2011, Texas had 1,664 assisted living facilities with over 53,000 beds and over 33,000 residents. A recent national study by a group of provider organizations found that ALF residents nationally were older and more likely to be female than NF residents. Nearly three-fourths of ALF residents are female (compared to two-thirds of people receiving Texas Medicaid NF services) and the median age is over 87 years. Among people receiving Texas Medicaid NF services, only one-third are over age 85.

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**Private Duty Home Care**

Private duty home care services are provided in the home to help people live safely and independently. They are similar to Personal Care Services provided under various Medicaid and Area Agencies on Aging (AAA) programs. Services may be provided by certified nurse aides or by unlicensed assistants. Typical services may include:

- assistance with ADLs such as bathing and grooming;
- assistance with IADLs such as light housekeeping, meal preparation, or medication reminders; and
- errands and transportation to appointments.

Private duty home care services may be purchased through licensed agencies or from individuals. In Texas, the licensed agencies are called Home and Community Support Services Agencies (HCSSAs). Texas has over 5,000 HCSSAs. There is no information on the demographics of people using private HCSSA services.

Private home care services from a HCSSA cost about $20-25 per hour. Many organizations have an 8-hour daily minimum.

**Day Care**

Adult day care facilities provide services on a daily or regular basis, but not overnight, to four or more elderly people or people with disabilities. An Adult Day Care program is a structured, comprehensive program with health, social, and related support services in a protective setting.

**Respite Care**

Respite can take many forms and occur in many settings. Respite care is short-term, temporary care designed to help a caregiver who is responsible for the primary care of a loved one. Respite care allows caregivers to take a little time away from their responsibilities so that they can rest, recharge, and come back refreshed. Respite care is included in the CBA waiver and in other DADS waivers.

Respite care can last from a few hours to a few days, depending on the caregiver’s needs. In the home, respite may take the form of personal or medical, or my provide homemaker services to lighten the caregiver’s overall workload. Respite may also be provided in adult day care centers, assisted living facilities, or nursing facilities.

The Texas Lifespan Respite Care Program (LRCP) was created in 2009 by state legislation. The program established a statewide respite care system to enhance and expand the coordination and availability of respite services for family caregivers caring for individuals of any age and with any chronic health condition or disability. The LRCP seeks to increase Texas caregiver’s knowledge of the role of caregiving, and the options, services and resources existing in their communities. Key program elements to help and support caregivers include:

- development of a Statewide Respite Coalition;
• creation of the Texas Respite Coordination Center;
• activities to increase public awareness activities and develop a statewide process to identify caregivers and assess their needs; and
• funding through the Lifespan Respite Care Program to assist family caregivers. Funding is currently available in three local areas.

**Informal Caregivers**

The Behavioral Risk Factor Surveillance Survey (BRFSS) is a telephone survey/online of a sample of Texans aged 18 and older. In 2010, a special segment of the survey focused on unpaid caregivers and the people for whom they provided care. Following is a summary of the findings.

About **three million** adult Texans provided “…regular care or assistance to a family member or friend who is elderly, has a long term illness, or disability…” in the previous month.

While most people who were helped by caregivers were older, many were not.

- About half were age 70 or older.
- About 23 percent had three or more medical conditions

Most people receiving care were related to the caregiver; most often as parent (32 percent), spouse (14 percent), or parent in-law (11 percent). However, 17 percent were not related to the caregiver.

The most common areas where caregivers provided assistance were:

- IADLs such as cleaning, managing money, preparing meals (31 percent);
- ADLs such as bathing and dressing (21 percent) and
- transportation (19 percent).

The time commitment of caregivers varied; 38 percent gave five hours or less of care per week; 18 percent gave 40 or more.
APPENDIX H: DEMOGRAPHIC DETAILS

The following figures refer to the usage rate of Medicaid NF services. That is, they show the percentage of people in the general population who use Medicaid NF services.

Figure 31. Usage Rate for Medicaid NF Services, by Gender and Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Medicaid NF Female</th>
<th>22-64</th>
<th>65-74</th>
<th>75-84</th>
<th>85+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug. 2011</td>
<td>0.09%</td>
<td>0.10%</td>
<td>0.80%</td>
<td>2.63%</td>
<td>8.55%</td>
</tr>
</tbody>
</table>

Figure 32. Usage Rate for Medicaid NF Services by Race/Ethnicity and Age, 2010

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Age</th>
<th>Medicaid NF Anglo</th>
<th>22-64</th>
<th>65-74</th>
<th>75-84</th>
<th>85+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug. 2011</td>
<td>0.11%</td>
<td>0.18%</td>
<td>0.68%</td>
<td>0.68%</td>
<td>2.00%</td>
<td>6.50%</td>
</tr>
<tr>
<td></td>
<td>0.04%</td>
<td>0.04%</td>
<td>0.60%</td>
<td>0.60%</td>
<td>2.12%</td>
<td>6.41%</td>
</tr>
<tr>
<td></td>
<td>0.13%</td>
<td>0.13%</td>
<td>1.06%</td>
<td>1.06%</td>
<td>3.52%</td>
<td>15.34%</td>
</tr>
<tr>
<td></td>
<td>0.18%</td>
<td>0.18%</td>
<td>1.57%</td>
<td>1.57%</td>
<td>3.98%</td>
<td>10.08%</td>
</tr>
</tbody>
</table>
Figure 33. Usage Rate for Medicaid NF Services, by Age and Region

<table>
<thead>
<tr>
<th></th>
<th>Aug. 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Lubbock</td>
<td>Medicaid NF 65-74</td>
</tr>
<tr>
<td>2-Abilene</td>
<td>Medicaid NF 75-84</td>
</tr>
<tr>
<td>3-Metropolis</td>
<td>Medicaid NF 85+</td>
</tr>
<tr>
<td>4-Tyler</td>
<td>Medicaid NF 65-74</td>
</tr>
<tr>
<td>5-Beaumont</td>
<td>Medicaid NF 75-84</td>
</tr>
<tr>
<td>6-Houston</td>
<td>Medicaid NF 85+</td>
</tr>
<tr>
<td>7-Austin</td>
<td>Medicaid NF 65-74</td>
</tr>
<tr>
<td>8-San Antonio</td>
<td>Medicaid NF 75-84</td>
</tr>
<tr>
<td>10-El Paso</td>
<td>Medicaid NF 85+</td>
</tr>
<tr>
<td>11-Edinburg</td>
<td>Medicaid NF 65-74</td>
</tr>
</tbody>
</table>