

Addressing Shifts in Care from State Schools to Community Settings



LEGISLATIVE BUDGET BOARD

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Legislative Budget Board
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ADDRESSING SHIFTS IN CARE FROM STATE SCHOOLS TO COMMUNITY SETTINGS

Nationwide, the census in large state facilities serving persons with intellectual and developmental disabilities decreased by 71.7 percent from fiscal years 1980 to 2006. This decline reflects the desire of individuals to live in the least restrictive environment, integrated in the community; federal legislation and a U.S. Supreme Court ruling support that choice. The census decline in large state facilities in Texas (52.5 percent) has not been as steep as the national decline. However, several state initiatives are contributing to further decline in the census at state schools.

About 95 percent of the 1,083 state school residents who moved from a state school in Texas from fiscal year 2000 to December 2007 transitioned to the Home and Community-based Services Medicaid waiver program. This report analyzes the fiscal implications of this shift in care by comparing the acute and long-term care costs of supporting an individual in each setting, describes the challenges of providing adequate services in the community, and outlines potential strategies for addressing the shift in care.

CONCERNS

- ◆ The Texas Department of Aging and Disability Services anticipates that over the next five years approximately 100 fewer clients will be served in state schools each year. Initiatives focused on community alternatives may result in further declines in the state school census. However, the legislature has not directed the agency to downsize state schools. Without a long-term plan, cost efficiencies may be ignored and opportunities to redirect funds from institutional care to community care may be overlooked.
- ◆ The average annual cost of providing care to state school residents is considerably higher than the average annual cost of providing Home and Community-based Services to clients residing in group homes through the Medicaid waiver program (\$125,507 per person compared to \$63,529 per person, including medical costs).
- ◆ Client care costs account for 28.2 percent of the cost difference (13.3 percent related to care and 14.9 percent related to employee benefits). Another 31.9 percent is attributable to higher administrative expenses at the state schools. The balance of the cost

difference is related to comprehensive medical costs (14.6 percent), the Quality Assurance Fee (10.6 percent), and other costs (14.7 percent).

- ◆ Compared to clients now receiving care through the Home and Community-based Services waiver, state school residents are more medically fragile, have higher levels of need, and exhibit more severe behavioral problems.
- ◆ While the average cost for state school residents exceeds the average cost for clients served in the Home and Community-based Services program, it can be expected that as residents with higher levels of need transition to the community, costs of services in the community will rise. Accurate estimates of the fiscal impact of the shift in care between the two care settings are difficult due to the inability to identify costs for state school residents by Level of Need, Level of Care, or behavioral health status.
- ◆ Modest savings may be realized initially if residential units within a state school are closed, primarily due to staff reductions. However, fixed costs at the facilities would be shared by a smaller population, resulting in an increase in the average cost per resident. Substantial savings could be realized over the long term if entire state schools close. However, some administrative overhead costs currently charged to care at state schools would shift to other programs, potentially without the benefit of federal matching funds.
- ◆ The total value of state school land was estimated to be \$27.2 million in September 2005, with 43.4 percent of the total value attributable to Austin State School. The total value of state school buildings was \$142.7 million, for a total market value of \$169.9 million. However, in fiscal year 2008 the state was obligated to fulfill \$151.3 million in indebtedness for state school assets. Alternative best uses for the property at three state schools could be limited due to deed restrictions. Parcels of state school property have been listed for sale for years.
- ◆ The Department of Aging and Disability Services requested \$80.1 million (primarily in General Obligation bonds) for the 2010–11 biennium to

address life safety code requirements related to facility roofs, heating, ventilation and air conditioning, plumbing and electrical, and to replace old and damaged equipment and furniture. The agency has also requested use of \$29.6 million in unexpended balances from the 2008–09 biennium for capital repairs and renovations.

- ◆ The Quality Assurance Fee generated \$49.5 million in Federal Funds for the support of state school residents in fiscal year 2007. This method of finance is not available to support clients in the Home and Community-based Services program.
- ◆ Systemwide, 60.3 percent of state school residents' primary correspondents or legally authorized representatives live more than 40 miles from the state school and 44 percent of state school residents have a county of residence outside their state school's area.
- ◆ Barriers to transitioning state school residents include a lack of community providers willing and able to serve medically fragile clients or clients with severe behavioral problems, limited housing alternatives, and insufficient resources for serving individuals in the community.
- ◆ Given the demand for medical and behavioral specialists in community settings, retention of specialists at state schools to care for clients with developmental disabilities is crucial. Without a retention strategy, these professionals may migrate to other areas of healthcare.
- ◆ Currently, the Department of Aging and Disability Services conducts annual reviews of Home and Community-based Services providers. However, the agency lacks the resources for regulatory staff to visit all group homes and foster homes on an annual basis.

RECOMMENDATIONS

- ◆ **Recommendation 1:** Amend Rider 40, Cost Comparison Report, in the bill pattern of the Department of Aging and Disabilities, 2008–09 General Appropriations Act, to require the agency to distinguish the costs associated with state school residents and clients participating in the Home and Community-based Services program by Level of Need, Level of Care, and behavioral health status.

- ◆ **Recommendation 2:** Amend the Texas Health and Safety Code, Chapter 533, Powers and Duties, Sec. 533.032, Long-range Planning, to require the Department of Aging and Disability Services to include in its biennial Long-range Plan specific strategies for downsizing state schools and transitioning more state school residents to community-based care. The Long-range Plan should describe initiatives for achieving cost efficiencies and estimate the fiscal impact of each initiative.

- ◆ **Recommendation 3:** To achieve cost efficiencies in downsizing state schools, the Department of Aging and Disability Services should consider the following actions: (1) limiting admissions of clients to state schools in the process of eliminating residential units; (2) eliminating residential units with significant deferred maintenance costs; and (3) enhancing community services to assist in the transition of residents, such as development of affordable housing options, alternatives for serving children, safety net/emergency services, and improved monitoring of community providers.

- ◆ **Recommendation 4:** Contingent on amendment of the Texas Health and Safety Code to require a Long-range Plan to downsize state schools, adopt an appropriations rider to the 2010–11 General Appropriations Bill allowing the Department of Aging and Disability Services to transfer savings from Strategy A.8.1, MR State School Services, to any of the following strategies:

- A.3.2, Home and Community-based Services;
- A.3.3, Community Living Assistance;
- A.3.7, Texas Home Living Waiver;
- A.4.1, Non-Medicaid Services;
- A.4.2, MR Community Services;
- A.4.3, Promoting Independence Plan;
- A.4.4., In-home and Family Support;
- A.4.5, Mental Retardation In-home Services; or
- B.1.1, Facility/Community-based Regulation.

Before the transfer of such funds, the agency must obtain certification from the Health and Human Services Commission of the amount of savings related to the downsizing of state schools and approval of the transfers from the Legislative Budget Board and the Governor's Office.

DISCUSSION

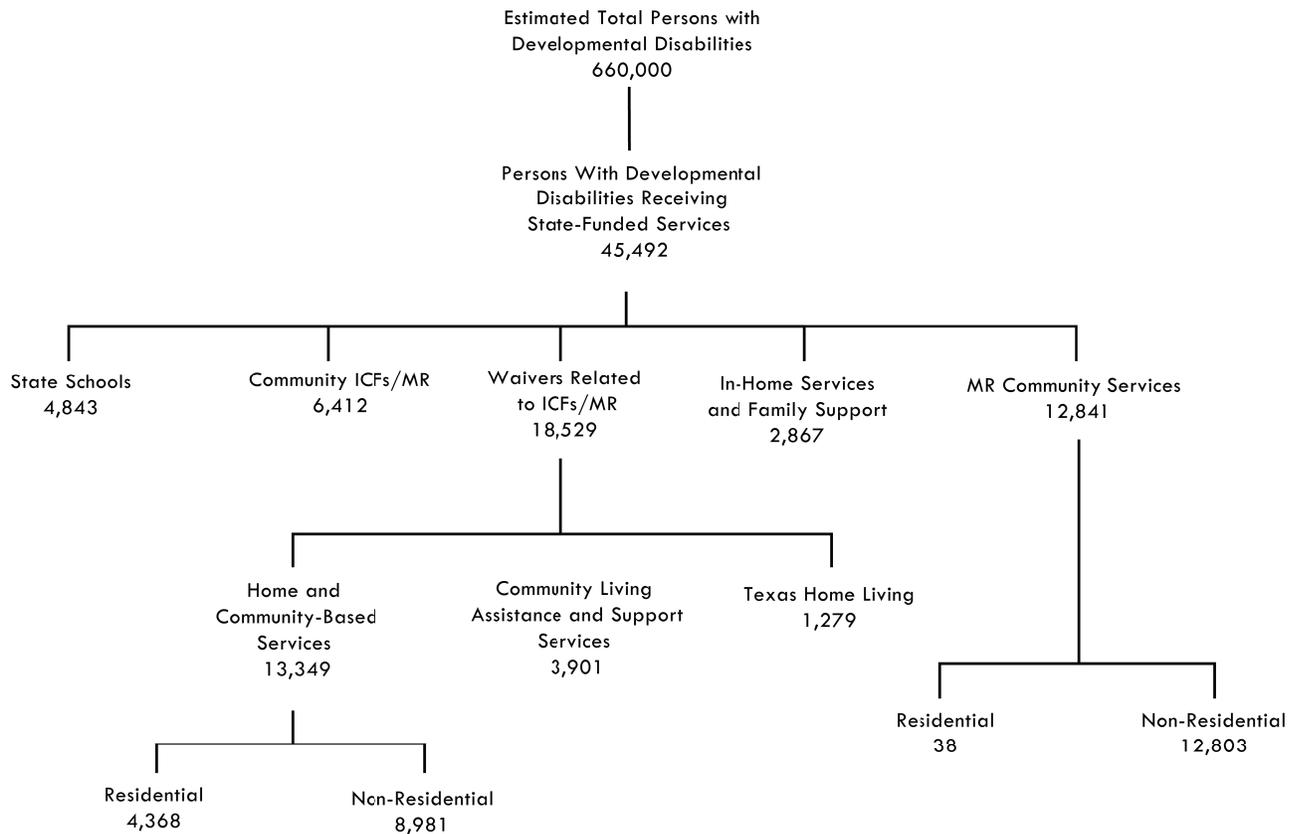
Approximately 660,000 Texans have developmental disabilities, and in fiscal year 2008, 45,492 persons received some type of related state-funded service. **Figure 1** shows a schematic of the number of individuals in each program. The Texas Department of Aging and Disability Services (DADS) operates several Medicaid programs that include residential services for individuals with developmental disabilities. There are 11 state schools and two state centers operating as Intermediate Care Facilities for Individuals with Mental Retardation (ICFs/MR). Throughout this report the term “state schools” will encompass the state schools and the state centers. These facilities are large institutional settings, with average daily census ranging from 76 residents (Rio Grande State Center) to 638 residents (Denton State School) as of December 31, 2007.

Clients also receive services in community ICFs/MR (mostly privately operated). As **Figure 2** shows, over 90 percent of community ICFs/MR are small (8 beds or less). At the end of

fiscal year 2008, approximately 70 percent of community ICFs/MR residents were living in small facilities.

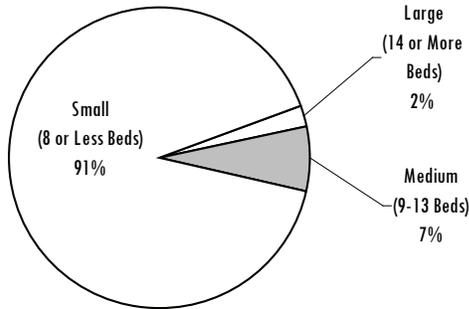
Through the Medicaid Program, the federal government can waive certain requirements and grant states the flexibility to offer customized benefits to particular populations. States must demonstrate that federal expenditures under a waiver program will not be greater than if the state continued regular Medicaid benefits. There are several waiver programs in Texas that provide care to clients eligible for ICF/MR services, including Home and Community-based Services (HCS), Community Living Assistance and Support Services (CLASS), and Texas Home Living. However, of the 1,083 individuals that moved from a state school from fiscal year 2000 to December 31, 2007, 95 percent transitioned to the HCS program, which served 13,349 clients in fiscal year 2008. Most residents in an ICF/MR or participating in these waiver programs meet the financial criteria for Medicaid based on the Supplemental Security Income (SSI) limit (74 percent of the Federal Poverty Level) or the special institutional

**FIGURE 1
SERVICES TO PERSONS WITH DEVELOPMENTAL DISABILITIES IN TEXAS, FISCAL YEAR 2008**



*Individuals with moderate, severe, or profound mental retardation who are likely to be functionally eligible for ICF/MR Services.
SOURCE: Texas Department of Aging and Disability Services.

FIGURE 2
COMMUNITY INTERMEDIATE CARE FACILITIES FOR
INDIVIDUALS WITH MENTAL RETARDATION BY SIZE
OF FACILITY, JULY 2007



NOTE: Excluding state mental retardation facilities.
 SOURCE: Texas Department of Aging and Disability Services.

limit established in Texas (220 percent of the Federal Poverty Level).

To be eligible for ICF/MR services or HCS, a person must have a determination of mental retardation or documentation from a physician of a related condition. The term “related condition” refers to a severe, chronic disability such as cerebral palsy, epilepsy or autism, that manifests before the person reaches age 22, is expected to continue indefinitely, and results in substantial functional limitations. Clients must meet a certain level of care criteria. For ICF/MR services, individuals must be in need of and able to benefit from active treatment provided in a 24-hour supervised setting. ICF/MR services include habilitation, medical services, skills training, as well as room and board.

The HCS program, however, provides an array of services supporting clients living in their own homes, family homes, foster homes or in settings with no more than four residents. Room and board is the responsibility of individuals in HCS, but Medicaid benefits include case management, adaptive aids, minor home modifications, counseling and therapies, nursing, dental treatment, day habilitation, supported employment, and residential assistance such as supported home living, foster/companion care, supervised living, and residential support services. As of October 2008, DADS was contracting with 315 HCS providers. Almost half (47.3 percent) of providers serve fewer than 20 clients, while larger providers (100+ clients) deliver care to about half (49.4 percent) of HCS clients.

State schools are an option only for individuals with severe or profound mental retardation and those with mental retardation who are medically fragile or who have significant behavioral problems. Evidence must be presented, however,

showing that individuals are at substantial risk of physical impairment or injury to themselves or others; are unable to provide for the most basic personal physical needs; and cannot be adequately and appropriately habilitated in an available, less restrictive setting. DADS contracts with 39 Mental Retardation Authorities (MRAs) in Texas, which serve as the points of entry for individuals with mental retardation or related conditions. MRAs determine if an individual is eligible for services and assist individuals enroll in Medicaid programs.

Individuals committed under the state’s Persons with Mental Retardation Act for long-term placement represent the largest category of admissions to state schools. Individuals can be admitted voluntarily for respite, emergency services, or long-term placement. Adults found incompetent to stand trial may be involuntarily committed for evaluation or for long-term placement under the Texas Code of Criminal Procedure. Minors may be involuntarily committed for evaluation or long-term placement under the Texas Family Code. Competency evaluations for juvenile males are conducted at the Mexia State School; evaluations of juvenile females are conducted at the San Angelo State School. In fiscal year 2007, about one-quarter of involuntary admissions at state schools were related to Texas Criminal Code or Texas Family Code commitments.

STATE SCHOOL AND HCS RESIDENTIAL CLIENT DEMOGRAPHICS

Because almost all clients who have moved from state schools since fiscal year 2000 transitioned to the HCS program and because state school residents are likely to require residential care, this report focuses primarily on comparing state school residents with HCS clients living in three- or four-bed group homes (referred to as HCS Residential). **Figure 3** shows a comparison of the population residing in state schools with clients enrolled in HCS Residential, based on December 31, 2007 data. Children (age 0 to 21) comprise 6.7 percent of state school residents, but the age breakdown varied by site. Mexia State School, which provides specialized treatment for male juvenile offenders, served 38.8 percent of all male youths in state schools. San Angelo State School, which provides services to girls committed by juvenile courts, was serving 26.7 percent of all female youths in state schools. The HCS Residential population is younger than the state school population. Children comprise 13.2 percent of the HCS residential population. Older individuals (age 55 and over) comprise 25.3 percent of the state school population, yet only 14 percent of the HCS Residential population.

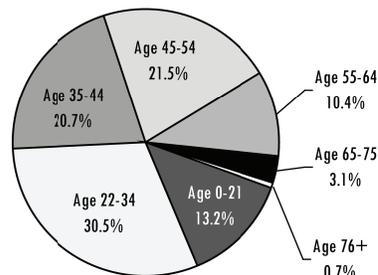
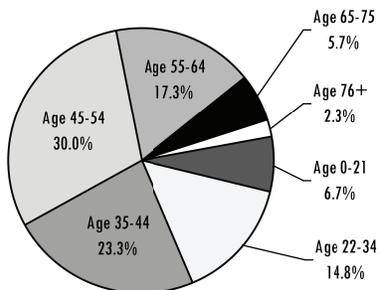
Data on the level of retardation shows dramatic differences between the two populations. As **Figure 3** shows, 72.7

FIGURE 3
DEMOGRAPHIC COMPARISON BETWEEN STATE SCHOOL RESIDENTS AND CLIENTS RECEIVING
HOME AND COMMUNITY-BASED SERVICES WITH RESIDENTIAL SERVICES, DECEMBER 31, 2007

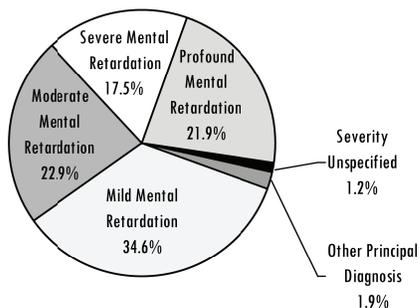
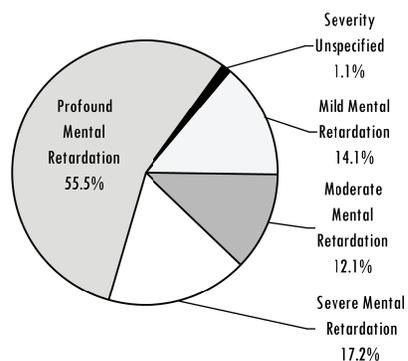
State School Residents

HCS Residential Clients

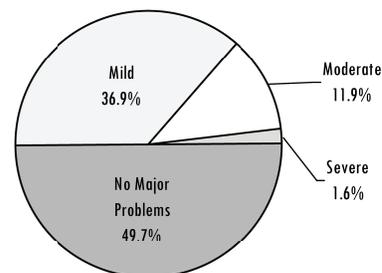
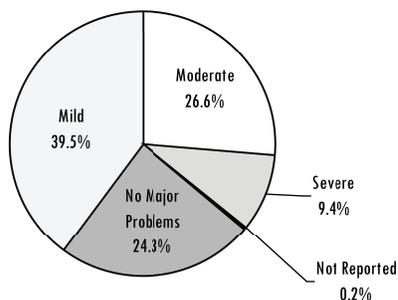
Age Distribution



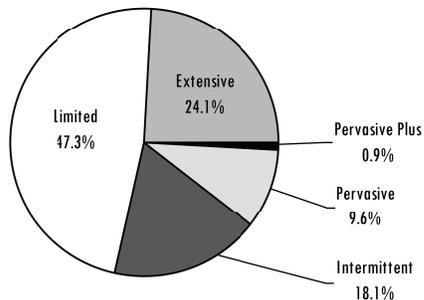
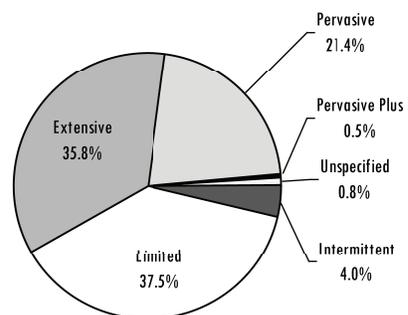
Level of Mental Retardation



Health Status



Level of Need



SOURCE: Texas Department of Aging and Disability Services.

percent of state school residents had profound or severe mental retardation, compared to 39.4 percent of HCS Residential clients. Conversely, 26.2 percent of state school residents had mild or moderate retardation, compared to 57.5 percent of HCS Residential clients. Although residents at most of the state schools are similar to the statewide figures, there are significant variances. For example, the number of residents with profound mental retardation was much higher at Richmond State School (68.8 percent), with fewer clients considered mild or moderate (14.2 percent). The lowest levels of retardation are seen at Mexia and San Angelo State Schools, with mild or moderate levels of 42.2 percent and 66.3 percent, respectively.

Regarding general health status, data demonstrate that HCS Residential clients are healthier than state school residents; no major health problems were indicated for half of HCS Residential clients, compared to approximately one-quarter of the state school population. Only 13.5 percent of HCS Residential clients had moderate or severe health problems, compared to 36 percent of state school residents. Furthermore, 78.5 percent of HCS Residential clients had no mobility impairments, compared to 41.2 percent of state school residents. Non-ambulatory clients comprise 13.8 percent of HCS Residential clients, compared to 31.9 percent of state school residents.

Significant distinctions exist among the state schools on general health status. Statewide, 63.8 percent of state school residents had mild or no major problems. However, the percentage of residents with mild or no major health problems was much higher at Mexia (80.5 percent) and San Angelo State Schools (78.7 percent), as well as Corpus Christi State School (76.6 percent). Conversely, 54.1 percent of Abilene State School residents had moderate or severe health problems.

Clients with developmental disabilities are assigned a Level of Need (LON) by DADS, based on individual assessments. LON statistics are indicative of clients' functional capabilities and further demonstrate differences between the state school and HCS Residential populations. **Figure 4** shows the characteristics of each LON. The LON for 65.4 percent of HCS Residential clients is characterized as intermittent or limited, compared to 41.5 percent of state school residents.

Data on behavioral health status of clients at state schools show that 26.9 percent of residents have severe or profound problems. These statewide figures obscure differences at individual facilities. Once again, the profile is very different at Mexia and San Angelo State Schools, with severe or profound behavior management problems noted for 73.8 percent and 61.2 percent of clients (respectively), compared to less than 15 percent of clients at a majority of other state facilities. DADS indicates that in fiscal year 2007, 58 percent of state school residents had a dual diagnosis of both intellectual and developmental disabilities and mental illness, with 51 percent of individuals served receiving psychotropic medications. Behavioral health status is not a required data item reported for HCS clients, so comparisons are more difficult. However, 36.1 percent of HCS clients had a behavioral management plan established, compared to 62 percent of state school residents. The vast majority (83 percent) of HCS clients with behavior management plans demonstrate maladaptive behavior, as opposed to self-injurious, aggressive, sexually aggressive, or disruptive behavior.

REGULATION OF SERVICE SETTINGS IN TEXAS

In August 2008, the Governor's Office confirmed the U.S. Department of Justice (DOJ) Civil Rights Division, Special Litigation Section, had begun its investigation into civil rights violations at 11 Texas state schools. The DOJ had

**FIGURE 4
LEVEL OF NEED CHARACTERISTICS**

LEVEL OF NEED	DESCRIPTION
Intermittent (LON 1)	Individuals do not demonstrate significant maladaptive behaviors and require limited personal assistance and/or regular to infrequent supervision.
Limited (LON 5)	Individuals have skills ranging from fairly independent to some personal care with reminders or guidance required. Staff support to individuals ranges from close supervision and guidance to direct assistance in accomplishing personal care.
Extensive (LON 8)	Individuals have skills ranging from no self-help skills (due to physical limitations) to demonstrating some basic self-help skills. Staff intervention includes personal care assistance utilizing hands-on techniques.
Pervasive (LON 6)	Individuals may have some basic self-help skills but demonstrate challenging behavior requiring intervention. One-on-one supervision or care may be required for safety reasons, but for less than 16 hours a day.
Pervasive Plus (LON 9)	Individuals require one-on-one staff supervision within arm's length during all waking hours (at least 16 hours per day) due to life-threatening or extremely dangerous behavior.

SOURCE: Texas Department of Aging and Disability Services.

previously investigated allegations of abuse and neglect at the Lubbock and Denton State Schools. In addition to the DOJ, there are several state entities that perform regulatory functions related to providers of services to individuals with developmental disabilities, including state schools, ICFs/MR, and HCS providers. **Figure 5** shows a summary of the regulatory functions performed by state and federal entities across care settings and the source of their statutory authority. Additional oversight is provided locally by MRAs.

SHIFTS IN CARE SETTING

According to an annual report produced by the Institute on Community Integration at the University of Minnesota, from 1980 to 2007, the national average daily population in large state facilities serving persons with intellectual disabilities and related developmental disabilities (ID/DD) decreased by 71.7 percent. In Texas, the average daily population in large state facilities serving persons with ID/DD decreased by 52.5 percent. In 2007, there were 20 Texans per 100,000 of the general population living in large state ID/DD facilities, compared to 12 persons per 100,000 in the U.S. Ten states have closed all large state ID/DD facilities. The number of children in large state ID/DD facilities declined more rapidly than the general population in these facilities, and at least 21 states had no large state facility residents younger than age 15.

PROMOTING INDEPENDENCE INITIATIVE

Several initiatives were developed over the last decade in response to the 1990 Americans with Disabilities Act and the 1999 Olmstead decision by the U.S. Supreme Court. The Americans with Disabilities Act requires that services be provided in the most integrated setting appropriate to the needs of a person. Public entities have to make reasonable modifications to avoid discrimination based on disability. The Olmstead decision further addressed unnecessary institutionalization of persons with disabilities. In Texas, legislation enacted by the Seventy-seventh Legislature, Regular Session, 2001, requires the Health and Human Services Commission (HHSC) to report on the status of an implementation plan to ensure appropriate care settings for people with disabilities. This legislation charged the Promoting Independence Advisory Committee (PIAC) to advise HHSC on methods to identify and assess each person who resides in an institution but would like to live in the community and for whom a transfer from an institution to the community is appropriate. PIAC also advises HHSC on community services and support options needed to address barriers to implementation of the Promoting Independence Plan (submitted every two years to the Governor and the Legislature), as well as funding options.

**FIGURE 5
STATE AND FEDERAL REGULATION OF LONG-TERM CARE SETTINGS FOR PERSONS WITH DEVELOPMENTAL DISABILITIES**

	DEPARTMENT OF AGING AND DISABILITY SERVICES, REGULATORY SERVICES	DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES, ADULT PROTECTIVE SERVICES	U.S. DEPARTMENT OF JUSTICE, CIVIL RIGHTS DIVISION, SPECIAL LITIGATION SECTION
State Schools Locally Operated ICFs/MR	<ul style="list-style-type: none"> As the State Survey Agency, certifies state mental retardation facilities as Medicare and Medicaid providers, in compliance with federal and state law. DADS certifies the number of beds available for Medicaid clients in state schools. Investigates complaints (reported by someone other than a provider) and incidents (self-reported) except in cases involving abuse, neglect, and exploitation. Tracks state employees that commit abuse, neglect, and exploitation in the state schools and state hospitals. The information is kept in the Client Abuse and Neglect Reporting System. <p>Statutory and other regulatory authority: 42 CFR 40 TAC §96.2 and §96.4</p>	<p>Investigates reported incidents of abuse, neglect, and exploitation, and issues findings.</p> <p>Statutory authority: Human Resources Code 48.252 and 48.352</p>	<p>Conducts investigations and litigation related to violations of the constitutional and federal rights of residents of state or locally operated institutions, monitors compliance, and enforces settlement agreements.</p> <p>Statutory authority:</p> <ul style="list-style-type: none"> Civil Rights of Institutional Persons Act, 42 USC §1997 Americans with Disabilities Act, 42 USC §12131 Individuals with Disabilities Education Act, 20 USC §400 Rehabilitation Act of 1974, 29 USC §794

**FIGURE 5 (CONTINUED)
STATE AND FEDERAL REGULATION OF LONG-TERM CARE SETTINGS FOR PERSONS WITH DEVELOPMENTAL DISABILITIES**

	DEPARTMENT OF AGING AND DISABILITY SERVICES, REGULATORY SERVICES	DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES, ADULT PROTECTIVE SERVICES	U.S. DEPARTMENT OF JUSTICE, CIVIL RIGHTS DIVISION, SPECIAL LITIGATION SECTION
ICFs/MRs (private)	<ul style="list-style-type: none"> • Licenses and certifies private ICFs/MRs as Medicare and Medicaid providers based on state and federal law, and certifies the number of Medicaid beds per facility. ICFs/MRs must pass a Life Safety Code survey, an initial program survey, and an annual program resurvey. • Investigates complaints (reported by someone other than a provider), and incidents (self-reported), including allegations of abuse, neglect, and exploitation. • Maintains Employee Misconduct Registry which contains names of employees permanently unable to work in DADS-regulated facilities. • Imposes enforcement remedies. • The State Office of Administrative Hearings conducts reviews and appeals relating to an employee sanction if it rises to the level in which the employee is listed on the Employee Misconduct Registry. <p>Other regulatory authority: 40 TAC §96.2 and §96.4</p>		
HCS Providers	<p>Monitors HCS program compliance using contractual agreements and annual reviews.</p> <p>Investigates complaints (reported by someone other than a provider) and incidents (self-reported) except in cases involving abuse, neglect, and exploitation.</p> <p>Other regulatory authority: 40 TAC §96.2 and §96.4</p>	<p>Investigates reported incidents of abuse, neglect, and exploitation.</p> <p>Statutory authority: Human Resources Code 48.252 and 48.352</p>	

SOURCE: Legislative Budget Board.

Regarding state schools, PIAC resolutions have recommended HHSC give consideration to rebalancing the system design and moving funds from institutional care to community services. Under the Promoting Independence Plan, individuals in state schools or in large community ICFs have expedited access to HCS waiver services. State school residents can access HCS waiver services within six months of referral; individuals residing in large community ICFs can access waiver services within 12 months. From fiscal year 2001 to December 2007, 1,083 state school residents moved from a state school to a community-based setting.

MONEY FOLLOWS THE PERSON POLICY

Texas’ original “Money Follows the Person” (MFP) policy was implemented September 1, 2001, allowing individuals residing in nursing facilities to relocate into a community setting, with related Medicaid entitlement funding transferring to community-based settings. A waiver slot is available to clients who make the transition without affecting the waiting list for community-based waiver services. Legislation enacted by the Seventy-ninth Legislature, Regular Session, 2005, codified this practice.

In January 2007, the Centers for Medicare and Medicaid Services (CMS) approved Texas’ MFP Rebalancing Demonstration. This demonstration project includes several

strategies to increase the use of community care versus institutional care. An enhanced Federal Funds match rate is available over 12 months for each person who resided in an inpatient facility for at least six months, then relocates to a residence where no more than four unrelated individuals reside. To promote the transition of clients from ICFs/MR, funds will be available to certain medium (9 to 13 beds) or large (14 beds or more) ICFs/MR that voluntarily agree to close. As part of the MFP demonstration, DADS anticipated that 84 state school residents would transition from institutional care.

COMMUNITY LIVING OPTIONS INFORMATION PROCESS AND PERMANENCY PLANNING

Another initiative to ensure that clients are served in the most appropriate setting is the Community Living Options Information Process (CLOIP), implemented January 2, 2008. Senate Bill 27, Eightieth Legislature, 2007, requires service coordinators at MRAs to conduct an annual, face-to-face meeting with state school residents (and their legally authorized representatives (LARs) if appropriate) to educate and inform them about community alternatives. DADS allocated \$2.6 million in General Revenue Funds to the 13 MRAs with state schools in their regions for fiscal year 2008; \$3.6 million is budgeted for fiscal year 2009. As of May 2008, a date for discussing living options had been set for over 99 percent of state school residents, and MRA service coordinators had contacted 1,455 adult residents. The CLOIP is expected to increase the number of individuals with developmental disabilities who transition to the community.

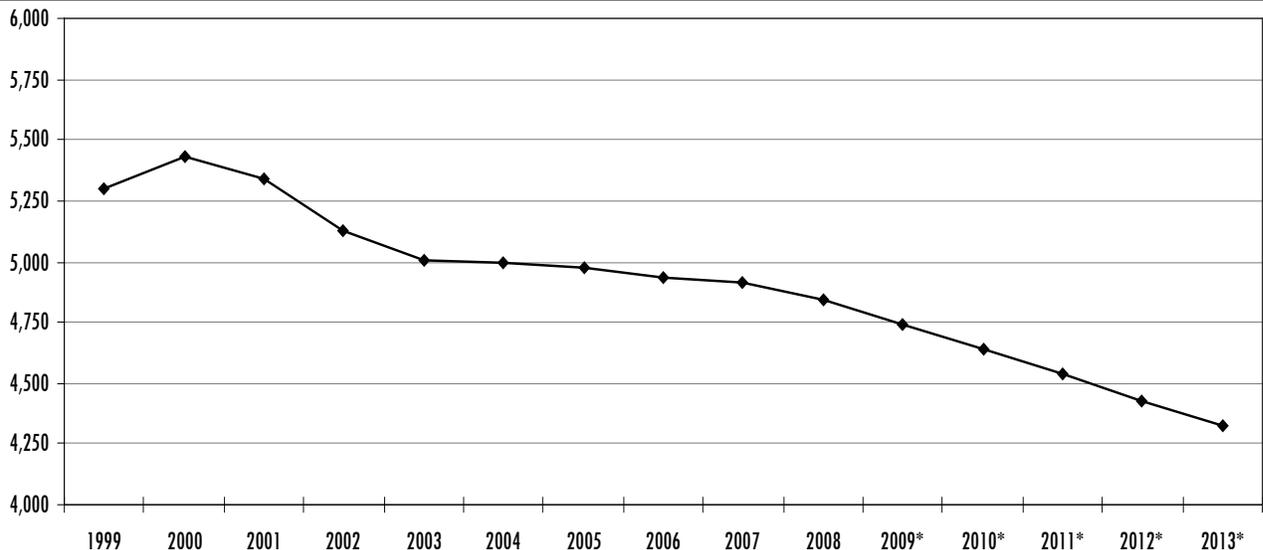
Interdisciplinary Teams (IDTs), which include clients, families, LARs, MRA staff, and professionals specified by the state school, assess an individual's treatment, training, and habilitation needs annually and make recommendations for services. If the IDT determines that a community living option is most appropriate, the IDT is responsible for developing an action plan with timelines to address the transition process, as well as supports and services needed by the individual to reside in the community. If there is not consensus by the IDT regarding the most appropriate living option, the head of the state school appoints a review team to evaluate the situation and make a recommendation within 21 days. Within three days of the team's recommendation, the head of the facility will issue a decision. Clients or actively involved persons may request further review by the ombudsman in the DADS state office.

Legislation enacted by the Seventy-ninth Legislature, Regular Session, 2005, strengthened permanency-planning activities for children, which focus on supporting an enduring, nurturing parental relationship. Provisions included a transfer of the responsibilities for permanency planning from providers to independent entities. MRAs are responsible for permanency planning for individuals under age 22 who live in an ICF/MR, nursing facility, or a residential setting of the HCS program. Approval for a child to reside in an institution must be obtained every six months.

STATE SCHOOL CENSUS PROJECTIONS

The population served at state schools is declining (Figure 6). Despite Texas' total population growing 10

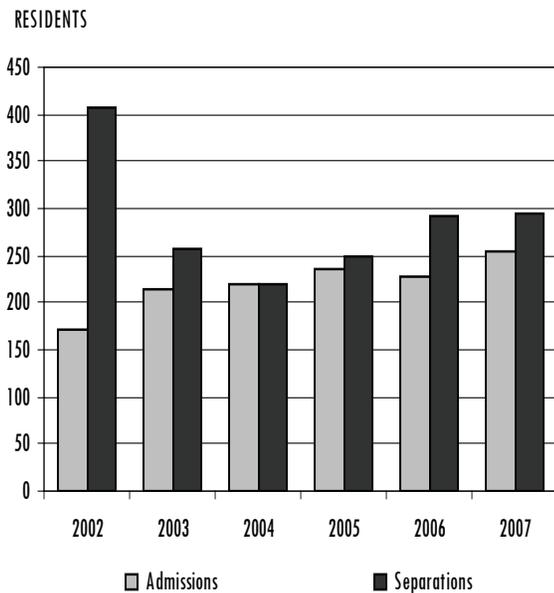
FIGURE 6
STATE SCHOOL CENSUS, FISCAL YEARS 1999 TO 2013



*Projected.
SOURCE: Texas Department of Aging and Disability Services.

percent between 2002 and 2007, the average enrollment at state schools over the past five years dropped 4.4 percent. **Figure 7** shows that each year the number of separations (which includes movement to the community, discharges and deaths) exceeded the number of admissions.

**FIGURE 7
ADMISSIONS AND SEPARATIONS AT STATE SCHOOLS
FISCAL YEARS 2002 TO 2007**



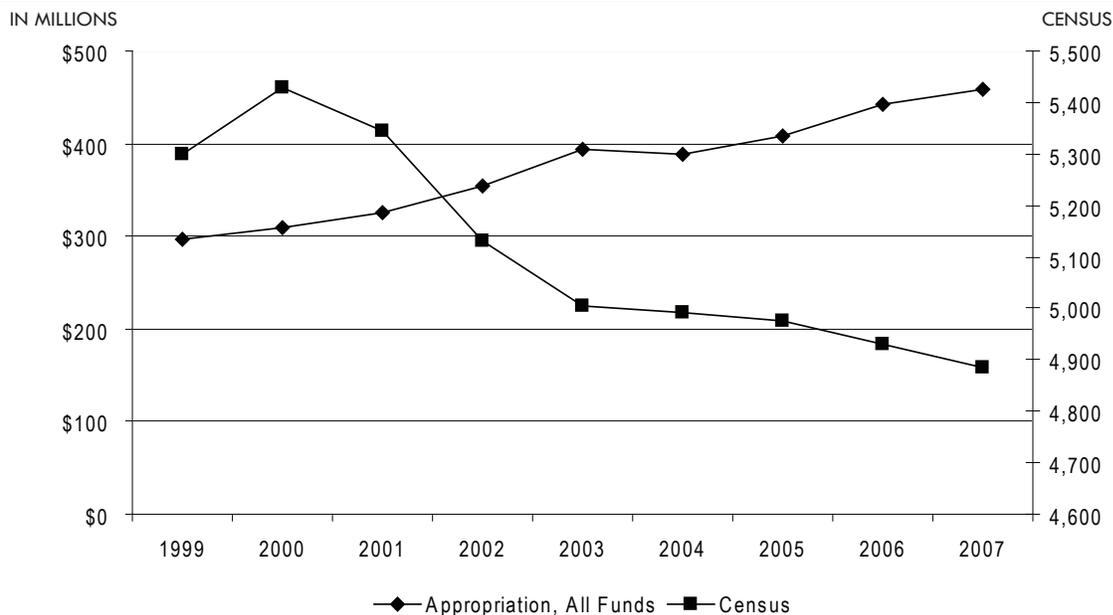
SOURCE: Texas Department of Aging and Disability Services.

Over the past decade, the average monthly enrollment in state schools declined from 5,673 residents in fiscal year 1997 to 4,909 residents in fiscal year 2007. As of June 30, 2008, the state school enrollment was 4,817, compared to a certified bed capacity of 5,985. DADS projects 21 admissions to state schools per month and 30 separations per month from September 2008 through September 2013. Consequently, a net decline in the state school census between 99 and 108 people per year is anticipated from fiscal years 2008 to 2013. Based on these estimates, state school enrollment in September 2013 will be approximately 4,260 residents, a 13 percent drop from the fiscal year 2007 average. In addition to existing initiatives that account for a decline in the state school population, DADS has requested \$4.6 million in General Revenue Funds for the 2010–11 biennium to prevent 196 individuals in emergency and crisis situations from entering institutions by providing HCS waiver slots. HHSC’s Consolidated Budget proposal includes a request for \$224 million in General Revenue Funds for the 2010–11 biennium to serve clients waiting on interest lists for Medicaid waiver services. If funded, these items could divert further admissions into state schools. DADS should develop a long-term plan to address these shifts in care settings.

ANALYZING THE COST OF CARE

Texas has invested a significant amount of funds in state schools and the HCS waiver program. As shown in **Figure 8**, state school appropriations increased by \$161.7 million (54.5 percent increase), while the state school census declined by

**FIGURE 8
STATE SCHOOL APPROPRIATIONS AND CENSUS, FISCAL YEARS 1999 TO 2007**



SOURCE: Texas Department of Aging and Disability Services.

413 persons (7.8 percent decrease) between fiscal years 1999 and 2007. The Eightieth Legislature, 2007, appropriated an additional \$124.9 million (All Funds) for state schools in the 2008–09 biennium.

The state investment in the HCS waiver program has also increased over time, as shown in **Figure 9**. Since fiscal year 1999, the Legislature has increased appropriations by \$218.2 million (All Funds), or 91.6 percent, while enrollment in the waiver has increased by 6,818 persons (136.9 percent).

Given the amount of the appropriations and the increased needs of the programs each biennium, an understanding of the complete costs of the operation of each program is needed. The changing state school census and the increased number of persons the HCS waiver serves also invite comparison of the program costs to understand the implications of the changing number of clients served in each setting.

COMPARING STATE SCHOOL COSTS

To understand the total costs related to the operation of state schools, there must be a consideration of the activities conducted by several agencies in addition to DADS. **Figure 10** shows a description of the functions each agency performs.

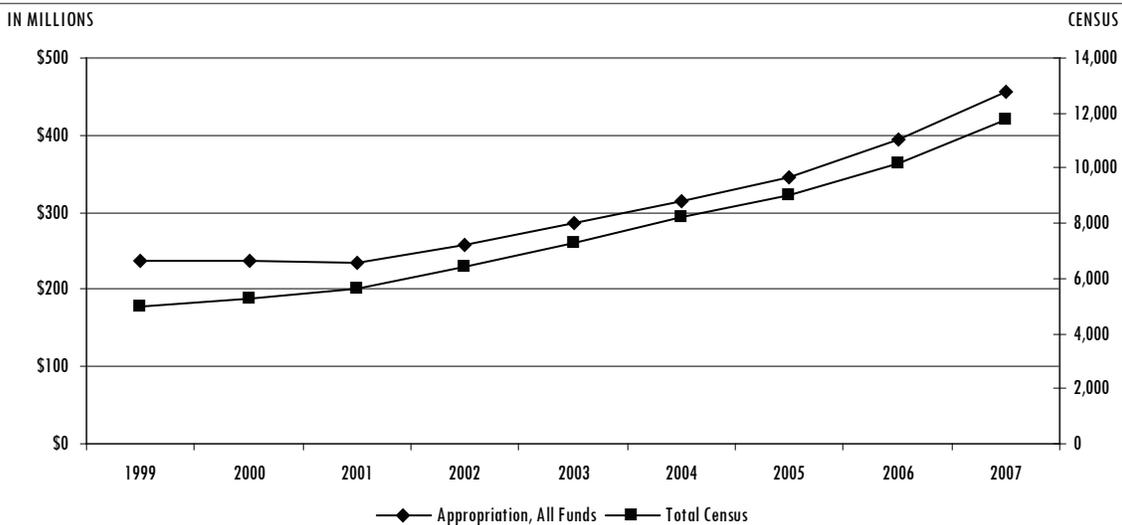
State schools are funded primarily through the Medicaid program with state and federal funds. In Texas, the Federal Medical Assistance Percentage (FMAP) for fiscal year 2007 was 60.8 percent, and the state share was 39.2 percent. For

reimbursement purposes, DADS establishes a standard daily rate for state schools that does not vary by the client’s LON or Level of Care (LOC) (i.e., medical fragility). The rate reflects the average cost of serving state school residents at all schools, including all direct, indirect, and overhead expenses.

Annual cost reports for each school provide the basis for development of rates. DADS staff members complete the reports for each school and submit them to the Rate Analysis Department at HHSC. Office of Inspector General at HHSC audits these reports. HHSC uses past audited cost reports to develop a single interim rate for all state schools for a given year, which means current rates are based on costs from prior fiscal years, with some adjustment for inflation. For example, cost reports from fiscal year 2005 were used to develop the interim rate for fiscal year 2007. When final expenditure data are available for a given fiscal year, HHSC determines the total allowable expenditures for Medicaid-eligible clients only. HHSC uses the data to calculate the final rate for the year, determine the federal and state shares of expenses, and identify the additional state funds owed or federal funds to recover.

The cost reports are used to determine expenses allowed by Medicaid for generating matching federal funds. The cost reports do not reflect the total cost for operation of the schools because there are costs incurred that are “unallowable” for Medicaid reimbursement. Federal and state regulations define allowable expenses as those that are reasonable and necessary in the normal conduct of operations relating to

**FIGURE 9
HOME AND COMMUNITY-BASED SERVICES APPROPRIATIONS AND CENSUS, FISCAL YEARS 1999 TO 2007**



SOURCE: Texas Department of Aging and Disability Services.

FIGURE 10
AGENCIES PERFORMING FUNCTIONS RELATING TO THE OPERATION OF STATE SCHOOLS

AGENCY	FUNCTION
Department of Aging and Disability Services (DADS)	Operates state schools and performs regulatory functions. Contracts with Mental Retardation Authorities to perform the eligibility determination for publicly funded MR services, enroll eligible persons in Medicaid programs, engage in permanency planning, and educate clients through the Community Living Options Information Process. Pays the Health and Human Services Commission for consolidation expenses including Enterprise Information Technology, Human Resources, Civil Rights, Procurement, and other expenses including legal support.
Employees Retirement System	Administers health insurance and retiree benefits to current and former state school employees.
Comptroller of Public Accounts	Pays the Social Security taxes for state school employees.
Texas Public Finance Authority (TPFA)	Services DADS General Obligation bond debt on behalf of the state schools.
Texas Facilities Commission	Disperses Master Lease Payments to TPFA on behalf of DADS.
Department of Family and Protective Services, Adult Protective Services	Investigates reported incidents of abuse, neglect, and exploitation in state schools.
Health and Human Services Commission, Rate Analysis Department	Determines the interim and final rates for state schools.

SOURCE: Legislative Budget Board.

recipient care. Allowable costs exclude expenditures for personal or other activities not related to the provision of long-term care. HHSC adopts rules on allowable and unallowable costs across the long-term care settings for which it sets rates. For the state schools, unallowable expenses include grant-funded positions and expenses associated with the operation of revolving fund services that are sustained with client funds, such as canteens and sheltered workshops. Rider 35 of DADS’ bill pattern of the 2006–07 General Appropriations Act appropriated balances in the revolving fund accounts for canteens and sheltered workshops to DADS and provided DADS with the authority to expend these Appropriated Receipts.

To determine the costs eligible for federal reimbursement, HHSC begins with the total expenditures, which include operational costs in addition to DADS central office expenditures, HHSC consolidation expenses, the Statewide Cost Allocation Plan, employee benefits, inactive retiree insurance, depreciation, lump sum terminations, Workers’ Compensation, and state unemployment costs. From these expenditures, HHSC audits reported costs to determine the total allowable, Medicaid-eligible reimbursement costs, which are reflected in Medicaid-billed days. Non-Medicaid clients include private pay clients that do not meet Medicaid’s eligibility criteria and residents placed at state schools through court commitments. A combination of grants, General

Revenue Funds, and client contributions finance unallowable items.

Figure 11 shows how the total expenditures are reduced to allowable expenses for federal reimbursement, using data from fiscal year 2007.

FIGURE 11
STEPS FOR CALCULATING FISCAL YEAR 2007
STATE SCHOOL EXPENDITURES FOR FEDERAL
REIMBURSEMENT PURPOSES

CALCULATION	TOTAL STATE SCHOOL EXPENDITURES (IN MILLIONS)
Pre-Allocation Total Expenditures	\$647.1
Step 1: Subtract Unallowable Expenditures	(\$36.6)
Total Allowable Expenditures	\$610.5
Step 2: Subtract Expenditures from non-Medicaid Days	(\$15.6)
Total Allowable Expenses, Medicaid Days Only	\$594.8

SOURCES: Legislative Budget Board; Health and Human Services Commission.

DADS’ Central Office budgets for each school separately, as costs vary by school. In the budget process, DADS considers the following factors:

- overhead costs assigned to each school such as cost pools, HHSC oversight, Workers' Compensation, and Master Lease Payments;
- staffing costs which include costs all schools incur regardless of size (administrative and managerial staff) and costs for direct and indirect care workers based on the facility size and required staffing ratios; and
- other historical expenditures. In recent years, cost drivers included food, utilities, prescription drugs, and travel.

The cost per resident, per day by state school is shown in **Figure 12**. The average annual cost was \$125,507 per person. The per diem cost is based on the allowable expenses and the adjusted census, which reflects the total number of days of care for all state school residents.

FIGURE 12
COSTS BY STATE SCHOOL, FISCAL YEAR 2007

STATE SCHOOL	TOTAL ALLOWABLE EXPENSES (IN MILLIONS)	ADJUSTED CENSUS (IN DAYS)	AVERAGE CENSUS	PER DIEM COST
Lufkin State School	\$46.9	153,002	419	\$306.52
Brenham State School	45.3	146,496	401	\$308.89
Corpus Christi State School	43.0	134,043	367	\$321.08
Denton State School	76.2	233,781	640	\$326.05
San Antonio State School	34.7	105,389	289	\$329.06
El Paso State Center	17.2	52,217	143	\$329.19
Austin State School	52.7	157,335	431	\$334.65
Abilene State School	64.6	187,941	515	\$343.95
Richmond State School	66.0	185,123	507	\$356.69
San Angelo State School	39.5	107,798	295	\$366.81
Mexia State School	67.5	179,698	492	\$375.78
Lubbock State School	44.5	107,400	294	\$414.48
Rio Grande State Center	12.3	27,561	76	\$445.41
TOTAL	\$610.5	1,777,784	4,871	\$343.39

NOTE: The total allowable expenses include allowable expenses for all state school residents (including Medicaid and non-Medicaid eligible persons).

SOURCE: Health and Human Services Commission.

To analyze the expenditures per school and compare these expenditures with the HCS Residential program in greater detail, Legislative Budget Board (LBB) staff subdivided expenditures into four categories, as shown in **Figure 13**.

Figure 14 shows additional information about the expenditures per school including resident care (direct and indirect care), comprehensive medical, administrative, and other expenditures from the cost reports by school (fiscal year 2007). Slight differences exist between the total cost values reported in **Figures 12 and 14** because **Figure 12** data was adjusted after the audit and before federal settlement.

Although state school costs varied from the statewide average, the difference was not statistically significant except in the case of the Rio Grande State Center. Rio Grande's daily cost is \$101.81 above the statewide average of \$343.62, and the difference is statistically significant at the 95 percent level. The Department of State Health Services operates the Rio Grande State Center, which serves residents with both mental health needs and developmental disabilities. Rio Grande's administrative and comprehensive medical costs exceeded the statewide average, and it is possible these costs vary because of the unique administrative situation and the relatively small number of residents receiving services at the center compared to other schools.

A school's census and resident mix influence costs. Client care staffing costs comprise a large share of state school costs as referenced in **Figure 14** and are based on required staffing ratios that vary according to the school census and in some cases, the LON and LOC of residents. For example, residents with a LON 9 or "Pervasive Plus" designation require one-on-one supervision for all waking hours (up to 16 hours per day), and residents with a LON 6 or "Pervasive" designation may require one-on-one supervision but for fewer than 16 hours. **Figure 14** also shows a variance in medical costs by resident, suggesting that different resident mixes at each school could result in differing medical expenses.

In addition to these factors which influence state school costs, the state schools have utilized various measures to contain or reduce operating costs. For example, all the schools recently implemented various energy efficiency initiatives. Some schools have consolidated their laundry and accounting operations.

More information comparing costs among state schools and the economic effects of state schools on their surrounding communities can be found in a 2005 HHSC report entitled *Study of Feasibility of Facility Closures and Consolidations*—

**FIGURE 13
LEGISLATIVE BUDGET BOARD EXPENDITURE CLASSIFICATION METHODOLOGY, SEPTEMBER 2008**

EXPENDITURE TYPE	EXPENSES INCLUDED FOR STATE SCHOOLS	EXPENSES INCLUDED FOR HCS RESIDENTIAL PROGRAM
Client Care	Includes direct and indirect costs. <ul style="list-style-type: none"> • Day habilitation services • Supported employment • Dietary services • Social workers • Nursing • Therapy services • Residential services 	Includes direct and indirect costs. <ul style="list-style-type: none"> • Day habilitation services • Supported employment • Dietary services • Social workers • Nursing • Therapy services • Residential services (3- or 4-bed group homes) • Case management services
Comprehensive Medical	<ul style="list-style-type: none"> • Acute care • Prescription drugs • Direct medical staff costs • A portion of indirect expenses allocable to comprehensive medical including salary and fringe for administrators, professional administrative staff, clerical staff, medical records and central supply staff, laundry and housekeeping staff, dietician and food service staff, maintenance staff, utilities, maintenance and repair supplies, equipment expense, depreciation expense for buildings and depreciable equipment, interest/mortgage expense, and office and miscellaneous supplies. 	<ul style="list-style-type: none"> • Acute care • Prescription drugs
Administrative	<ul style="list-style-type: none"> • Central office administration including supplies and allocated expenses including Insurance State Contribution, Statewide Cost Allocation Plan, lump sum terminations, DADS Central Office expenses, and HHSC Consolidation Expenses • Program administration 	<ul style="list-style-type: none"> • Central office/supplies • Program administration • DADS indirect allocation to HCS program
Quality Assurance Fee	<ul style="list-style-type: none"> • Provider tax 	
Other	<ul style="list-style-type: none"> • Transportation • Payroll taxes • Total facility and operation costs • Workers Compensation expenses for Transportation, Maintenance, and Administration Staff 	<ul style="list-style-type: none"> • Transportation • Payroll taxes • Total facility and operation costs • Workers Compensation expenses for Transportation, Maintenance, and Administration Staff

SOURCE: Legislative Budget Board.

Fiscal Year 2005 (State Schools), relating to Rider 55 of the 2004–05 General Appropriations Act.

COMPARING COSTS OF SERVICES DELIVERED BY STATE SCHOOLS AND THE HCS RESIDENTIAL PROGRAM

Comparison of costs between the state schools and HCS providers is difficult due to the differences in rate methodologies for the programs. The state schools operate using a cost-based reimbursement methodology. Although an interim rate exists, a legislative appropriation determines the spending limit. An objective of the rate methodology is to capture all costs for maximizing federal reimbursement. Regardless of the amount spent, as long as the expenditures

are allowable for Medicaid purposes, the state can receive matching Federal Funds for whatever it spends. The HCS program uses a different reimbursement process. Cost limitations per client exist and are based on institutional costs (200 percent of the rate for ICF/MR services). Providers are reimbursed on a fee-for-service basis which limits program costs. Together, these differences in how costs and rates are defined and calculated result in different constraints for the programs, making cost comparisons difficult.

To estimate the cost implications of the shift of residents from state schools to the HCS Residential program (group homes) more accurately, data on the average costs of serving

FIGURE 14
CLIENT CARE, COMPREHENSIVE MEDICAL, ADMINISTRATIVE, AND OTHER COSTS BY STATE SCHOOL
FISCAL YEAR 2007

STATE SCHOOL	CLIENT CARE	COMPREHENSIVE MEDICAL	ADMINISTRATIVE	QUALITY ASSURANCE FEE	OTHER	TOTAL
Lufkin State School	\$155.91	\$37.15	\$65.59	\$18.18	\$29.97	\$306.80
Brenham State School	\$164.12	\$20.44	\$72.72	\$19.58	\$32.16	\$309.03
Corpus Christi State School	\$156.33	\$45.31	\$69.85	\$17.97	\$31.81	\$321.27
Denton State School	\$163.97	\$45.94	\$65.26	\$17.98	\$32.96	\$326.11
San Antonio State School	\$174.35	\$36.11	\$70.73	\$19.08	\$28.94	\$329.20
El Paso State Center	\$161.45	\$33.48	\$82.03	\$18.38	\$34.01	\$329.35
Austin State School	\$179.55	\$30.38	\$72.13	\$18.92	\$33.97	\$334.95
Abilene State School	\$161.76	\$61.81	\$66.78	\$17.30	\$36.57	\$344.23
Richmond State School	\$182.59	\$42.93	\$70.48	\$17.85	\$42.98	\$356.83
San Angelo State School	\$181.86	\$32.22	\$87.00	\$18.91	\$47.36	\$367.35
Mexia State School	\$197.50	\$35.64	\$82.63	\$15.95	\$44.50	\$376.21
Lubbock State School	\$208.28	\$68.55	\$84.69	\$17.44	\$35.83	\$414.79
Rio Grande State Center	\$178.04	\$103.30	\$93.83	\$15.78	\$54.49	\$445.43
STATEWIDE AVERAGE COST PER DAY	\$173.71	\$42.46	\$73.07	\$17.99	\$36.40	\$343.62

SOURCE: Legislative Budget Board.

clients by LON, LOC, and behavioral health status in both service settings should be analyzed. Rates for private ICF/MR services and some HCS services vary based on the client's LON, suggesting that service delivery to higher needs clients is more expensive. However, due to limitations in available data, this analysis cannot be completed for state schools and the HCS program. The state schools do not track service provision at the individual client level for the purposes of cost reimbursement. Aggregate costs are used to create an average daily rate.

Unlike state schools, the HCS program operates as a "fee-for-service" program. Costs are based on utilization of services, which vary by client. Most services have quarter-hour reimbursement rates; some have a daily or monthly rate. However, HCS providers report on the costs incurred for all of the clients they serve in the aggregate on the annual cost reports. These practices prevent assignment of the costs to an individual or group with the same LON or LOC in both care settings. In addition, because community providers are not required to capture the behavioral health status or health status code (which reflects the LOC) for all clients, limited data are available preventing analysis of costs by resident needs. Recommendation 1 would require DADS to distinguish the costs associated with state school residents and clients participating in the Home and

Community-based Services program by LON, LOC, and behavioral health status.

Given limitations of available data, LBB staff developed a methodology that accounts for expenditures incurred in state schools and the HCS Residential program (group homes) in a consistent manner to enable a comparison of the settings. Because of the data limitations, expenditures reflect existing average costs associated with each setting, not the marginal costs for a client transitioning into or out of a care setting. Using audited 2007 cost reports from state schools and 2007 data from all HCS providers (the HCS data was unaudited at the time of the research), LBB staff categorized expenditures into five groups: (1) client care, (2) comprehensive medical, (3) administrative, (4) Quality Assurance Fee, and (5) other, and identified a list of expenditures for inclusion in each group. This process allows an accurate comparison of costs between the settings and highlights where areas of difference exist. **Figure 13** details this classification system for expenditures. Using this methodology, LBB staff identified the costs for the program overall and for each expenditure category. The findings are shown in **Figure 15**.

The average annual cost of providing HCS Residential services was \$63,529 per person in fiscal year 2007. The difference in the average daily cost for fiscal year 2007 between state schools and HCS Residential services was

FIGURE 15
AVERAGE DAILY COSTS IN STATE SCHOOLS COMPARED TO STATE COSTS FOR HOME AND COMMUNITY-BASED SERVICES RESIDENTIAL CARE, FISCAL YEAR 2007

	CLIENT CARE			COMPREHENSIVE MEDICAL			ADMINISTRATIVE	QUALITY ASSURANCE FEE	OTHER	TOTAL
	CARE	BENEFITS	TOTAL CLIENT CARE	ACUTE CARE/ PRESCRIPTION	DIRECT MEDICAL STAFF AND INDIRECT ALLOCATIONS	TOTAL COMPREHENSIVE MEDICAL				
State Schools	\$140.76	\$32.95	\$173.71	\$10.47	\$31.99	\$42.46	\$73.07	\$17.99	\$36.40	\$343.62
HCS- Residential waiver	\$118.15	\$7.62	\$125.77	\$17.72	\$0.00*	\$17.72	\$18.96	\$0.00	\$11.49	\$173.93
Difference	\$22.61	\$25.33	\$47.94	(\$7.25)	\$31.99	\$24.74	\$54.11	\$17.99	\$24.91	\$169.69

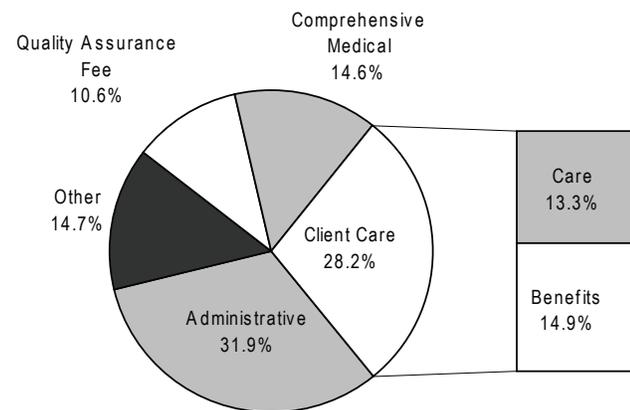
*Administrative costs, including claims processing, are not included.

NOTE: HCS data from fiscal year 2007 was unaudited at the time of the analysis. Numbers may not add due to rounding.

SOURCE: Legislative Budget Board.

\$169.69. The HCS program cost is 49.4 percent lower than the state school cost per day. An analysis of each expenditure category explains some of the cost differences between the programs. **Figure 16** shows the proportions attributable to different categories of cost.

FIGURE 16
EXPENDITURE CATEGORIES AS A PERCENTAGE OF THE DIFFERENCE BETWEEN STATE SCHOOL AND HOME AND COMMUNITY-BASED SERVICES RESIDENTIAL CARE COSTS, FISCAL YEAR 2007



SOURCE: Legislative Budget Board.

Client care includes staffing costs for contracted and state employees who provide care and services to state school residents, HCS staff and contracted workers, and the benefit costs for employees. The overall client care costs differ between the settings by \$47.94. Of this difference, \$25.33 (14.9 percent of the total cost difference) can be attributed to employee benefit costs. All state employees receive a state benefit package, whereas the benefits offered by HCS providers are not as robust. The remaining difference is likely

due to the higher LON, LOC, and behavioral health needs of state school residents, and the resulting implications for staffing ratios.

One of the primary differences between costs for state schools and the HCS program is room and board. Medicaid reimbursement for state schools covers room and board, as well as basic personal items, but does not cover room and board or personal items in the HCS program. Most state school residents and HCS clients are eligible for the cash assistance program called Supplemental Security Income (SSI), which is 100 percent federally funded. In 2007, monthly SSI payments were \$623. However, when an individual resides in a state school, these federal payments are reduced to a \$30 per month Personal Needs Allowance (which the state supplements with \$30 per month using General Revenue Funds). HCS program participants remain eligible for the full monthly SSI payment, but are responsible for room and board. HCS clients use approximately 90 percent of their SSI payments for room and board. Therefore, the state pays for approximately 40 percent of room and board costs in state schools, while a 100 percent federal payment covers room and board costs in the HCS program, thus maximizing the use of Federal Funds for the care of the individual. If included in the daily living expenses of clients, room and board would add \$18.42 to the HCS client care cost.

The difference in comprehensive medical costs between the settings is \$24.74 per day, with state schools costing more than the HCS Residential program. This analysis assumes that acute care medical costs for the HCS program are the same for all clients including residential and non-residential due to the availability of data. However, it is likely that the

costs are higher for HCS Residential clients. The costs for state schools and the HCS Residential program include acute care and prescription drug costs, but state schools also include direct medical staff costs (e.g., physicians and nurses working in the state school campus infirmaries) and an indirect allocation for many administrative and overhead expenses (see **Figure 13**) on the cost reports. The state school includes these items because they relate to the provision of medical services, and are allowable for drawing federal funds. The inclusion of direct staff costs and some indirect costs accounts for the majority of the difference in cost. Medicare Part D prescription drug costs are excluded from the comprehensive medical costs for both settings.

Some of the cost differences could relate to the way care is provided. In the HCS program, medical providers are not available on the premises of residential settings; clients receive care in physician offices and hospitals and fill prescriptions at pharmacies. The costs HHSC incurs to pay its claims processing contractor to process the claims for HCS clients are not included.

Administrative costs are a large source of variance between state school costs and HCS program costs (\$54.11 per day). Many sources of overhead and administrative costs that do not exist in the HCS program are included in the cost reports for state schools, such as HHSC consolidation expenses, DADS Central Office expenses, the Statewide Cost Allocation Plan, lump sum terminations, and insurance contributions for inactive retirees. These costs are included in the cost reports because they can be matched with federal funds. Administrative costs for HCS residential include some of DADS' indirect costs to operate the waiver program and costs incurred by providers.

ICF/MR providers pay a provider tax called the Quality Assurance Fee (QAF), which is an allowable cost under Medicaid. The QAF is levied on community ICFs/MR, as well as the state schools. QAF is included in the cost of services for state school residents, yet is not a cost incurred for HCS services; this fee accounts for 10.6 percent of the difference in costs between the two settings (\$17.99 per day).

The cost reports identify \$32 million in QAF paid by state schools for fiscal year 2007. States may use such healthcare provider fees as the state share of Medicaid spending and these fees generated \$49.5 million in federal Medicaid reimbursement. The state sought implementation of a QAF for the HCS program but did not receive federal approval. As

the state school census declines, the ability to rely on QAF to support the care of clients diminishes.

Other costs vary by \$24.91 per day and reflect differences in transportation, facility, and staffing costs for maintenance and other staff. The state school costs are likely to be higher because of higher maintenance costs associated with state school buildings and vehicles and because of higher payroll taxes paid by state schools relative to HCS providers (due to the larger relative number of employees and higher wages).

PROPERTY VALUES AND DEFERRED MAINTENANCE COSTS

As **Figure 17** shows, the value of land at state schools was estimated to be \$27.2 million in September 2005. Of this, 43.4 percent (\$11.8 million) was attributable to Austin State School, which is located in a highly desirable development area with rising land values. The land value at six other state schools ranged from \$1 million to \$4 million, with the remaining six valued at less than \$1 million. Acreage at each state school ranges from 20 acres at El Paso State Center to 1,031 acres at San Angelo State School. There are 880 buildings containing 5.4 million square feet, valued at \$142.7 million. The total market value (land plus buildings) was \$169.9 million.

Certain factors, however, hamper the marketability of some state school properties. Some parcels of property at state schools have been listed for sale for several years. Three of the state schools (Corpus Christi, El Paso, and Lubbock) have deed restrictions that limit the alternative best use of the property. Corpus Christi and Lubbock State Schools must be used for care of the mentally disabled. El Paso State Center must be used for human development or public purposes. Costs related to asbestos abatement may also restrict the sale of property.

Indebtedness is another significant consideration. The total payoff amount for indebtedness at the state schools was \$151.3 million in fiscal year 2008. Amounts ranged from \$5.1 million at El Paso State Center to \$25.5 million at Richmond State School.

The amount of deferred maintenance bolsters the argument to downsize state school facilities. According to data from the Computer Aided Facility Management System maintained by HHSC, deficiency costs for critical needs, potentially critical needs, and necessary—but not yet critical—needs total \$159.6 million in fiscal year 2009. More than one-quarter of the total deficiency costs are related to San Angelo

**FIGURE 17
STATE SCHOOL PROPERTY VALUES, INDEBTEDNESS, AND DEFICIENCY COSTS**

STATE SCHOOL	LAND		BUILDINGS			2005 MARKET VALUE (IN MILLIONS)	2008 INDEBTEDNESS (IN MILLIONS)	2009 DEFICIENCY COSTS (IN MILLIONS)
	ACRES	2005 VALUE (IN MILLIONS)	NUMBER	2005 VALUE (IN MILLIONS)	SQUARE FEET			
Abilene	338	\$1.2	99	\$16.0	626,936	\$17.2	\$20.9	\$14.5
Austin	93	\$11.8	113	\$6.4	681,694	\$18.2	12.8	14.4
Brenham	198	\$1.3	33	\$8.0	371,099	\$9.3	8.2	3.0
Corpus Christi	104	\$1.1	52	\$6.2	299,787	\$7.4	7.6	11.1
Denton	188	\$3.9	73	\$24.9	491,644	\$28.8	13.7	12.7
El Paso	20	\$0.4	19	\$3.4	119,128	\$3.8	5.1	1.0
Lubbock	226	\$0.7	41	\$9.4	320,786	\$10.0	8.1	10.6
Lufkin	159	\$0.3	72	\$9.5	364,603	\$9.8	9.8	3.3
Mexia	842	\$0.5	176	\$10.6	707,808	\$11.1	19.8	6.9
Richmond	242	\$1.5	51	\$10.6	506,844	\$12.1	25.5	32.8
Rio Grande	78	\$0.7	28	\$4.4	230,157	\$5.0	NA	1.8
San Angelo	1,031	\$0.5	84	\$5.5	492,044	\$6.0	13.7	42.1
San Antonio	473	\$3.2	39	\$27.9	235,250	\$31.1	6.0	5.2
TOTAL	3,992	\$27.2	880	\$142.7	5,447,780	\$169.9	\$151.3	\$159.6

NOTES: Indebtedness includes General Obligation Bonds, Master Lease Purchase Payments, and State Energy Conservation Office Loans. Deficiency costs represent total facility costs for Priority 1 (critical), Priority 2 (potentially critical) and Priority 3 (necessary, but not critical) needs. SOURCES: Legislative Budget Board; Health and Human Services Commission; Texas Department of Aging and Disability Services; General Land Office.

State School (\$42.1 million), but costs in excess of \$10.0 million exist at six other state schools. DADS has requested \$80.1 million (primarily in General Obligation bonds) for the 2010–11 biennium to address life safety code requirements related to roofs, heating, ventilation and air conditioning, plumbing and electrical, and to replace old and damaged equipment and furniture. The agency has also requested use of \$29.6 million in unexpended balances from the 2008–09 biennium for capital repairs and renovations.

IMPLICATIONS OF COST ANALYSIS

As more state school residents leave state schools for community settings, there will be complicated cost implications. LBB staff analysis found that the average cost difference per day between the state schools and the HCS program was \$169.69 in fiscal year 2007. If multiplied by the number of total state school resident bed days, the difference in care settings totals \$301.5 million. However, for many reasons this amount does not represent the amount that would be saved if all state school residents were served in the HCS program.

Savings related to a change in the care setting are dependent on the closure of beds at the state school. Some savings may

be realized if residential units within a state school are closed, primarily due to staff reductions. However, residents transitioning to the community are scattered throughout the state schools, living in various residential units that are formed based on the age, gender, and functional ability of residents. Until the number of discharged residents is of a sufficient size, staffing reductions are not justified. At that point, there would be reductions in direct and indirect client care costs, employee benefits, and taxes. Paradoxically, to sustain the quality of care in state schools, there could be costs associated with staff retention during transition periods.

As discussed previously, state school residents have higher LON, LOC (medical fragility), and more behavioral health diagnoses than HCS residents. As the client mix in the HCS program changes, the average cost of service would increase, but predicting the fiscal impact is problematic. Refined analysis of the cost implications of decreasing state school populations would be possible through the collection of additional data. DADS should analyze client expenditures and patient identifying information, including LON, LOC, and behavioral health status, to distinguish costs per client group. This information will enable more accurate forecasting

of changes in costs with changes in client participation in different long-term care settings.

Inadequate reimbursement rates in the community are frequently cited as barriers to care. Increases in provider rates would narrow the gap between state school and HCS costs and reduce savings. Furthermore, the expertise of professionals employed at state schools would be needed in the community. Former state employees could become the workforce that provides care to the new HCS clients, applying pressure for better pay and employee benefits. Conversely, there could be an unintended consequence of replacing a state school workforce that has robust health insurance with a workforce with inadequate health insurance.

As the state school census declines, fixed costs at the facilities are shared by a smaller population, resulting in an increase in the average cost per resident. Many of the expenses at state schools, such as facility costs, operate on economies of scale. For additional savings to be realized, entire state schools would need to close. As mentioned previously, the state is facing significant deferred maintenance costs that could be averted. One-time revenue from the sale of state school property is possible, but the associated debt limits the net gain—particularly if the market value is limited to the value of the land. As noted previously, several parcels of state school land have been on the market for some time and deed restrictions limit the use of some property. If DADS were unable to sell the properties, it would incur costs to maintain the land and buildings, and such costs would not be shared with the federal government since the property would be vacant of residents.

Some administrative overhead costs currently charged to care at state schools exist regardless of whether state schools remain in operation. Other overhead costs are allocated based on the number of employees, so these costs could decrease. However, if all of the schools were closed, some of these overhead costs would shift to other programs at DADS or other state agencies, potentially without the benefit of federal matching funds. Some functions that exist to support state schools would be shifted to support the HCS program. Certain changes are not expected to increase costs because the total number of clients would remain constant. For example, the reduction in the need for DADS regulatory staff to certify and investigate complaints and incidents at state schools (except for abuse, neglect, and exploitation) would be offset by an increased need for DADS regulatory staff to manage HCS contracts. There would be reduced need for DFPS staff to investigate reported allegations of abuse,

neglect, and exploitation in state schools, but an increased need for DFPS staff to investigate these allegations in HCS settings. HHSC would have minor cost savings due to eliminating the need to set state school rates.

In summary, the overall fiscal impact of downsizing state schools is difficult to predict and will take some time to resolve. It is also unlikely that the capacity exists to absorb all state school residents immediately. The following section discusses issues faced in providing care for persons with developmental disabilities in the community.

CHALLENGES IN PROVIDING COMMUNITY-BASED CARE

In addition to serving as the points of entry for publicly funded programs for individuals with developmental disabilities and being responsible for the CLOIP, MRAs provide (or contract to provide) an array of community-based services and help arrange community services for individuals who want to move out of ICFs/MR, including state schools. In July 2008, LBB staff conducted a confidential on-line survey of MRAs in Texas to gather information from the MRAs' perspective on institutional and community services. Many MRAs indicate that few individuals choose to go to or to remain in a state school or a large ICF/MR if they believe appropriate services are available in the community. However, because HCS slots are not an entitlement under Medicaid, access is limited for persons residing in the community. General Revenue Funds for services in the community are limited to appropriated amounts, and inadequate funding levels were mentioned often as a reason individuals are served in state schools or large ICFs/MR. Also, many providers are unwilling to take Medicaid patients because of low reimbursement rates and onerous documentation requirements.

Behavior issues of some individuals, especially violent behavior, are often mentioned as creating obstacles to community placement, with difficulty finding professionals to work with these individuals. DADS recently obtained approval from the Centers for Medicare and Medicaid Services to add Board-certified Behavior Analysts to the list of qualified providers of behavioral support (effective September 1, 2008). A few MRAs cited difficulties getting approval from DADS for one-to-one supervision in the community for individuals with behavior problems and for individuals needing full-time nursing. They also indicated that behavior problems frequently return when an individual's condition stabilizes and one-to-one supervision is subsequently canceled.

Some MRAs mentioned that when individuals have been residing at state schools or large ICFs/MR for a long period, or when individuals' needs are being met at the larger facilities, there may be resistance to moving on the part of individuals, their families, or LARs. Difficulty adjusting to different routines and having fewer people around in the community living setting were also considerations. Instability of community providers was also cited as a concern of families.

Sixty-two (62) percent of MRAs serve predominantly rural counties, while 29 percent serve predominantly urban counties. The remaining 9 percent serve an even distribution of both rural and urban counties. Finding professional healthcare providers that accept Medicaid is particularly challenging for rural MRAs, but fewer providers of all types are available in rural areas. Some rural MRAs have access to a very limited number of small ICFs/MR or group homes and report that small ICFs/MR seldom have openings. Not surprisingly, transportation was one of the most important issues for MRAs serving rural areas.

Among many suggestions, several MRAs recommended that DADS have publicity campaigns about individuals who have had success in transitioning from state schools or large ICFs/MR into communities to encourage families who are thinking about community placement. They would also like to see intensive recruitment activities to increase the base of providers for individuals with severe behavior problems or medical needs.

A few MRAs recommended that priority be given to individuals in the community who need services to deter admission to state schools, rather than giving HCS slots to the individual at the top of the interest list. One MRA mentioned the possibility of having special funding set aside for emergency situations, while another suggested having additional funding to help with the costs of transitioning people into the community.

A few MRAs mentioned processes that could be improved. They noted that DADS' utilization review could be timelier when individuals transition to community residential settings and the need for medical or behavior supports are greater than anticipated. Without timely determinations, providers deliver the necessary services and are not reimbursed until the utilization review is complete. They also mentioned that small providers occasionally have difficulty remaining solvent because of delays in getting initial reimbursement from the

state. MRAs would also like the amount of documentation to be reduced.

STRATEGIES FOR ADDRESSING SHIFTS IN CARE SETTINGS

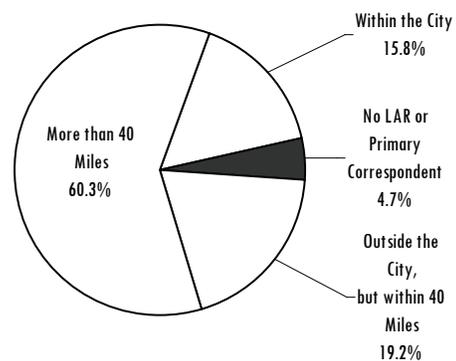
Faced with a declining census at state schools, there are various approaches DADS could take to achieve cost efficiencies. These include efforts to guide admissions, target deferred maintenance, and enhance alternative services in the community.

CONTROLLING ADMISSIONS

When an eligible individual seeks admission to a state school, preference for placement is given to the state school nearest to their home unless (1) space is unavailable; (2) the individual, parent of a minor, or guardian requests otherwise; or (3) there are other compelling reasons for placement elsewhere. DADS' state office participates in the determination of an alternate facility when necessary.

Figure 18 shows across all state schools, 60.3 percent of state school residents' primary correspondents or LAR lived more than 40 miles from the state school.

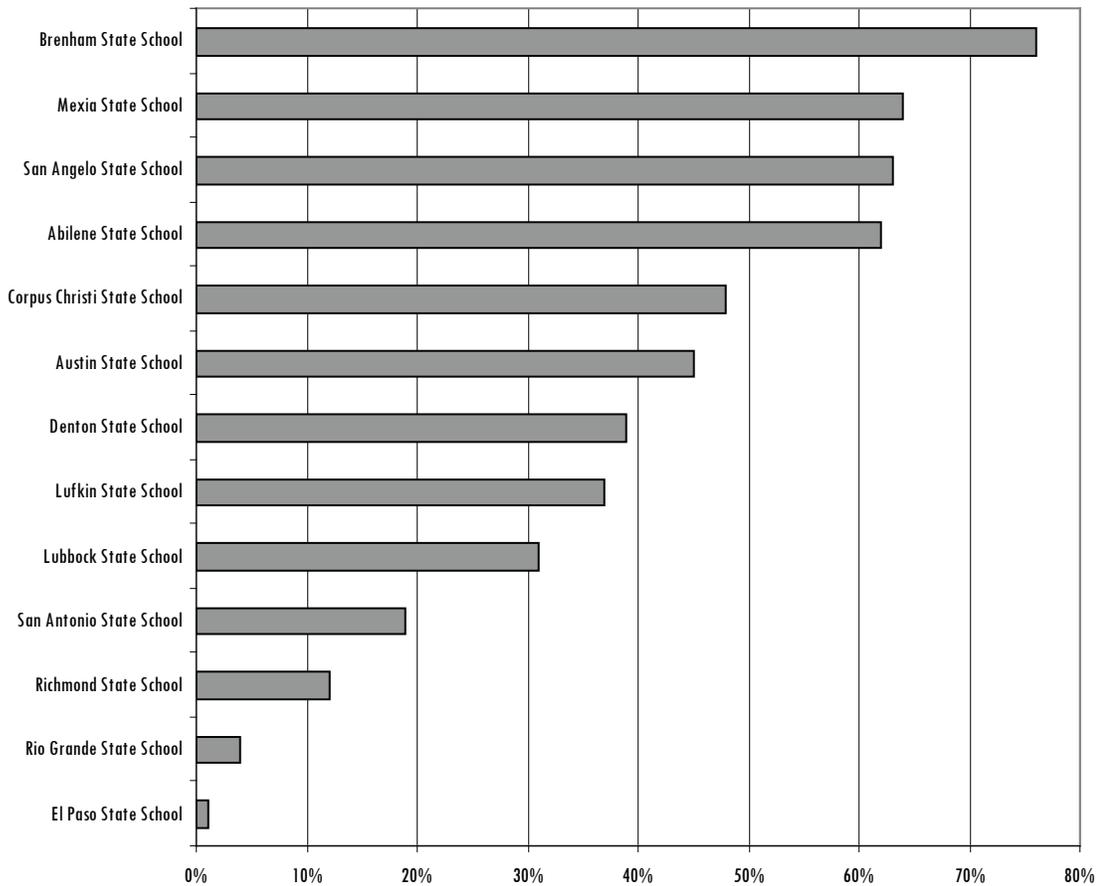
**FIGURE 18
DISTANCE OF LEGALLY AUTHORIZED REPRESENTATIVE OR
PRIMARY CORRESPONDENT FROM THE STATE SCHOOL,
DECEMBER 31, 2007**



SOURCE: Texas Department of Aging and Disability Services.

Figure 19 shows a significant range in the percentage of state school residents with a county of residence outside the state school's service area. For example, 76 percent of Brenham State School residents have a county of origin outside its service area. Excluding the two smaller state centers which serve single counties, the percentage drops to 12 percent of Richmond State School residents. There are valid explanations

FIGURE 19
PERCENTAGE OF STATE SCHOOL RESIDENTS WITH COUNTY OF RESIDENCE OUTSIDE THE SERVICE AREA, DECEMBER 31, 2007



SOURCE: Texas Department of Aging and Disability Services.

for the variance. Location near a major population center accounts for much of the variance, as does the capacity of each state school. In addition, given the roles of Mexia and San Angelo State Schools, higher percentages of residents from other areas of the state would be expected. Systemwide, 44 percent of state school residents had a county of residence outside their state school's area.

To achieve cost efficiencies, DADS has the ability to limit admissions to state schools, particularly those facilities in the process of eliminating residential units.

TARGETING DEFERRED MAINTENANCE

As mentioned previously, deficiency costs at state schools total \$159.6 million. In preparation of maintenance cost projections, DADS assumes that buildings will be maintained at current conditions and assigns priority to buildings based on their use and the need to comply with the Texas Life Safety Code. A long-term plan could identify older buildings

with high maintenance costs that are not cost-efficient to habilitate.

ENHANCING COMMUNITY SERVICES

In fiscal year 2007 the average wait for community placement of state school residents was 121 days. There are a number of strategies that could alleviate barriers to serving clients in the community, including the following examples.

Housing. The HCS program provides services to individuals who live in their own home, in their family's home, in a foster/companion care setting, or in a small group home that has no more than four residents. As mentioned previously, clients residing in the community typically rely on SSI payments to pay room and board (\$637 per month in fiscal year 2008).

Federal assistance from the U.S. Department of Housing and Urban Development programs—operated by the Texas

Department of Housing and Community Affairs and local public housing authorities—may be an option, but competition for accessible units is stiff. Finding appropriate housing can be a challenge for state school residents seeking transition to the community. An outreach program to recruit foster/companion care providers could relieve housing demands for persons transitioning from state schools. MRA survey responses supported such an approach.

Alternatives for Children. As mentioned previously, individuals less than age 22 make up 6.7 percent of the state school population. Almost half of these residents are at least 18 years old. The other half are mostly teenagers, but about 5 percent of the residents less than age 22 were age 8 to 12 as of August 31, 2007. Approximately one-third of the children age 0 to 17 were involuntary commitments under the Family Code. Admission of children to state schools increased in fiscal year 2007. Of the 152 individuals admitted, 77 percent had a diagnosis of mild or moderate mental retardation, but 57 percent had a co-occurring diagnosis of mental illness and 16 percent had a diagnosis of autism or pervasive developmental disorder. DADS has requested \$4.6 million in General Revenue Funds to provide HCS services to individuals at imminent risk of institutionalization in the event of emergencies or crisis situations. The request would provide services to 196 individuals, including 100 children.

Pursuant to a resolution passed by the Promoting Independence Advisory Committee and the Children's Policy Council, HHSC directed DADS to convene a workgroup to examine factors related to the admission of children to state schools and make recommendations for eliminating barriers to serving children in the community. Recommendations that could accelerate transition of children in state schools include creation of a centralized children's unit at DADS with responsibilities for overseeing the long-term services and support needs of children in state schools, as well as increased funding for the permanency planning function conducted by MRAs to assure an ongoing and proactive process, rather than a six-month review. Savings from downsizing state schools could be channeled into such initiatives.

Safety Net Services. The MRAs, community advocates and families stress the need for more safety net services to maintain individuals with developmental disabilities in the community. DADS has requested \$31.3 million in General Revenue Funds for the 2010–11 biennium to restore funding reductions made in fiscal year 2003 and to provide in-home services to 3,712 individuals. Additional funds for crisis

services, respite, specialized services for individuals with severe behavior problems, and other supports could sustain former state school residents in the community. Initiatives could induce medical professionals and direct care workers currently at state schools to remain in the field in the community and alleviate negative impacts to the local economy.

Regulation of Community Providers. DADS currently reviews each HCS provider annually. DADS lacks the resources, however, for regulatory staff to visit all group homes and foster homes in the HCS program on an annual basis. The agency has requested \$2.3 million in General Revenue Funds for the 2010–11 biennium for this purpose. More frequent monitoring of community providers could improve the quality of care. Also, a July 2008 report by the State Auditor's Office discusses issues and provides recommendations for strengthening processes for investigating allegations of abuse, neglect, and exploitation of people with developmental disabilities receiving state-funded services.

IMPLEMENT A LONG-TERM PLAN TO ADDRESS SHIFTS IN CARE

Chapter 533, Sec. 533.032 of the Texas Health and Safety Code, requires DADS to develop a long-term plan every two years for the provision of services in state-operated institutions. The agency must provide information and recommendations regarding the most efficient long-term use and management of state schools, and include a projection of future bed requirements, maintenance costs, and strategies for maximizing use of the facilities. Public input is solicited and the agency must consider the medical and behavioral needs of clients, as well as their program and service preferences.

Although the statute requires DADS to address the most efficient long-term use and management of campus-based facilities, there is not specific direction regarding downsizing of state schools. The Texas Health and Safety Code, Chapter 533, Powers and Duties, Sec. 533.032, Long-range Planning, should be amended to require DADS to develop a long-range plan for downsizing state schools and transitioning more state school residents to community-based care (Recommendation 2), with fiscal impacts included.

The long-range plan should include methods for achieving cost efficiencies. DADS should consider approaches such as: (1) limiting admission of clients from outside catchment areas to state schools approaching elimination of a residential unit; (2) eliminating residential units with significant deferred maintenance costs; and (3) enhancing community services,

such as the development of affordable housing options, alternatives for serving children, safety net/emergency services, and improved oversight of community providers (Recommendation 3).

The 2010–11 General Appropriations Bill should provide flexibility for DADS to transfer savings related to downsizing state schools into community supports and services (Recommendation 4). Funds could be transferred to the following strategies:

- A.3.2, Home and Community-based Services;
- A.3.3, Community Living Assistance;
- A.3.7, Texas Home Living Waiver;
- A.4.1, Non-Medicaid Services;
- A.4.2, MR Community Services;
- A.4.3, Promoting Independence Plan;
- A.4.4, In-home and Family Support;
- A.4.5, Mental Retardation In-home Services; or
- B.1.1, Facility/Community-based Regulation.

Transfers should be contingent on certification of the savings by HHSC and subject to approval by the Legislative Budget Board and the Governor's Office (Recommendation 4).

There are numerous factors that will determine the appropriate timeframes, locations and strategies for downsizing state schools. It is imperative that the quality of care is not jeopardized during the process. There are also many different approaches for enhancing community alternatives. The existing Texas Aging and Disability Services Council is responsible for making recommendations to the HHSC executive commissioner and the DADS commissioner regarding the management and operation of the agency, including policies and rules governing the delivery of services and the rights and duties of clients. The Promoting Independence Advisory Committee advises HHSC on services and support options needed to address barriers to persons with developmental disabilities living in the community. These two bodies are available to provide oversight and advice on downsizing the state schools.

