

A stylized graphic of the Texas state flag, featuring a blue field with five white stars and a red and white striped field, arranged in a geometric pattern.

Examining the Need for a Rate Increase to IDD Community-Based Providers

White Paper

Texas Conservative Coalition Research Institute

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The purpose of this paper is to examine Medicaid enrollees with intellectual or developmental disabilities in greater depth and whether state lawmakers should invest in rate enhancements for providers serving these individuals in community settings.

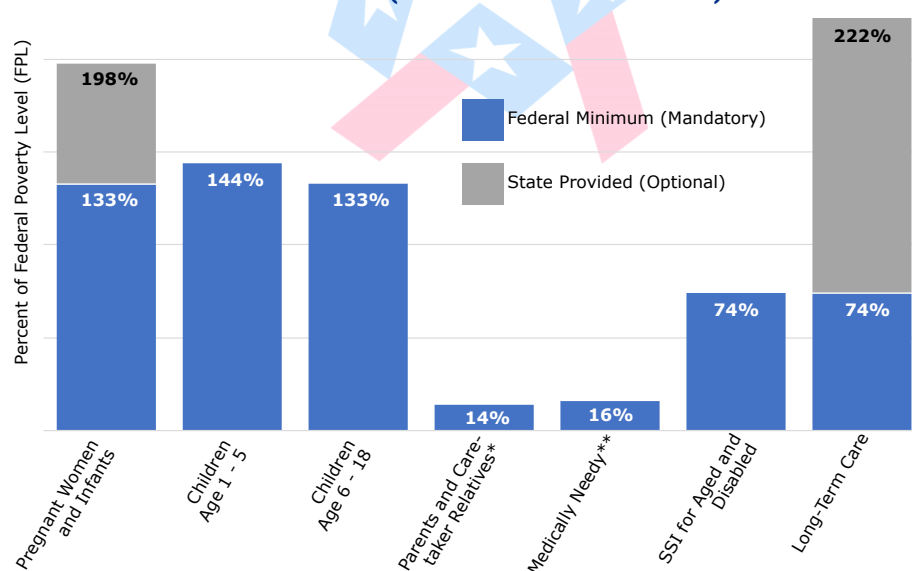
I. Background

Medicaid Overview

With a total FY 2018-2019 biennial appropriation of \$61.8 billion all funds (AF), the Medicaid program makes up just over 28% of the entire state budget.¹ And, because the program is an entitlement with open-ended funding, and is largely ruled by federal laws and regulations, the state has limited control in curbing Medicaid population growth and costs. In State Fiscal Year (SFY) 2017, Texas Medicaid served just over 4 million low-income, elderly, and individuals with disabilities.² The program funds about 53% of all births in Texas, and covers 62% of all nursing facility residents.³

Even though our state has one of the nation's largest Medicaid programs,⁴ Texas largely covers only mandatory populations required by the federal government. The table below shows the population groups that are covered by Texas' program, and which are mandatory versus optional.

**Texas Medicaid Income Eligibility Levels for Selected Programs,
March 2018 (as a Percent of the FPL)^t**

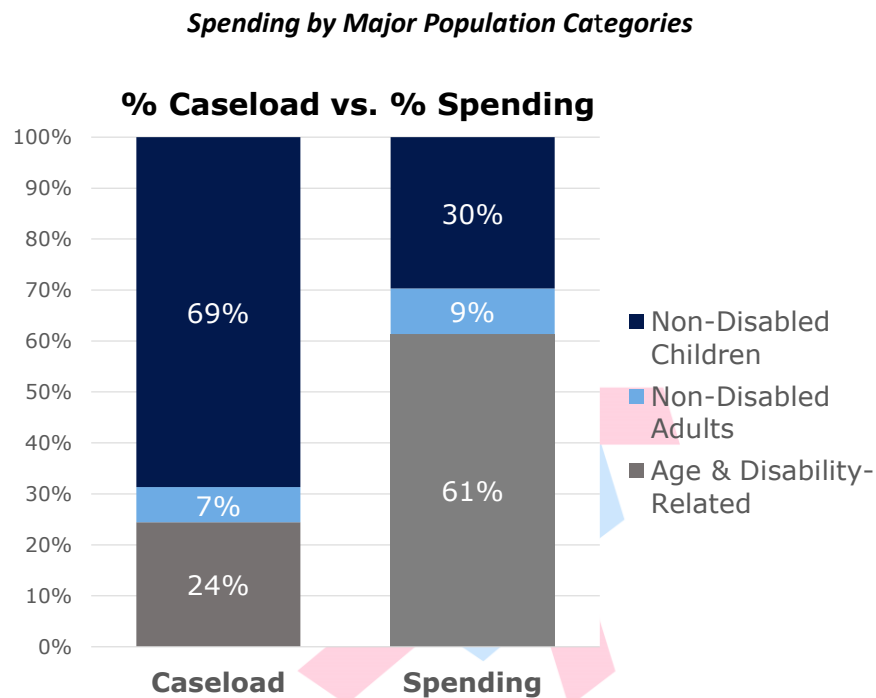


^tThis figure reflects eligibility levels as of March 2018. In 2014, the Affordable Care Act (ACA) required states to adjust income limits for pregnant women, children, and parents and caretaker relatives to account for Modified Adjusted Gross Income (MAGI) changes.

*For Parents and Caretaker Relatives, maximum monthly income limit in SFY 2018 was \$230 for a family of three, which is approximately 14 percent of the FPL. **For Medically Needy pregnant women and children, the maximum monthly income limit in SFY 2018 was \$275 for a family of three, which is approximately 16 percent of the FPL.

Source: Texas Health & Human Services Commission⁵

Although the majority of individuals covered by Medicaid are “acute” care populations (mostly children)- meaning they do not meet a functional need of ongoing long-term services and supports- this population does not make up the majority of program expenditures. Rather, the “age and disability-related population,” formerly referred to as the Aged/Blind/Disabled- or ABD- population comprises only about a quarter of Texas Medicaid’s population, but is responsible for more than 60 percent of total costs. The following graphic depicts how caseload and costs are spread across major population categories in the Texas Medicaid program.



Source: Health and Human Services Commission⁶




Age & Disability-Related Population

Within the “age & disability-related” category are different populations with distinct needs and challenges who may have physical, mental or developmental disabilities. Unlike acute care Medicaid, where individuals must meet a single set of linear eligibility criteria, age and disability-related individuals may qualify based on eligibility criteria for various programs, which contain a financial (means-tested) component and a functional (level of need) component. The same program may serve individuals of varying diagnoses, needs, and levels of acuity. The “age & disability-related” category includes:

- **Supplemental Security Income:** Supplemental Security Income (SSI) is a federal cash assistance program that, in Texas, is accompanied by automatic Medicaid enrollment. Eligibility criteria for this program is established and determined by the federal Social Security Administration (SSA). Low-income individuals with disabilities and low-income individuals age 65 and older may qualify for SSI.⁷

- **Medicaid for the Elderly and People with Disabilities (MEPD)**: Individuals with disabilities and individuals age 65 and older who do not qualify for SSI may be eligible for MEPD. MEPD enrollment is achieved through the facility serving these individuals and includes:
 - Nursing facilities (NF),
 - Intermediate care facilities for individuals with an intellectual disability or related condition (ICF/IID), and
 - Community programs serving individuals in their homes.⁸
- **Medicaid Buy-In Program**: This program allows two populations to “buy-in” to Medicaid coverage:
 - Children- The Medicaid Buy-In Program for Children (MBIC) allows the family of a child with a disability at or below 300% of the federal poverty level (FPL) to pay a monthly sliding scale premium to buy in to Medicaid coverage. The premium is waived for children at or below 150% FPL.⁹
 - Workers with Disabilities- This Medicaid Buy-In (MBI) program allows individuals with disabilities who are working to buy in to Medicaid coverage. To qualify for MBI these individuals must have incomes below 250% FPL and no more than \$5,000 in resources.¹⁰
- **People Eligible for Medicare and Medicaid**- These individuals, known as “dual eligibles,” are enrolled in both the Medicare and Medicaid programs. In general, Medicare covers acute care (i.e. physician services, hospital care, and prescription drug coverage) for these enrollees, while Medicaid is responsible for any wrap-around services and out-of-pocket costs not covered by Medicare, as well as long-term care services.¹¹

Although Medicaid caseloads have grown significantly over the past decade,¹² primarily due to mandatory eligibility changes brought about by the Affordable Care Act (ACA), the age & disability-related population has experienced the smallest growth rate. The table below displays the 10-year caseload growth trends of Medicaid client categories, as well as the average per member per month (PMPM) cost of each category.

Major Medicaid Client Categories				
		Non-Disabled Children	Non-Disabled Adults	Age & Disability-Related
% of Caseload		69%	7%	24%
10-year Growth		+49%	+39%	+20%
Cost per Client*		\$536	\$246	\$1,768

*Average cost per client per month is based on full benefit entitlement only.

Source: Health and Human Services Commission¹³

Medicaid Long-Term Services and Supports

Medicaid long-term services and supports (LTSS) may be provided in a home or community-based setting or in a long-term care facility, such as a nursing home or state supported living center. Federal Medicaid policy requires nursing facility care for individuals age 21 and over as a mandatory benefit, while other LTSS are provided through waivers.¹⁴

In Texas, home and community services are provided through waivers. Waivers allow the state to “waive” off of regular federal Medicaid laws and regulations and provide services that would not normally be covered by Medicaid (i.e. providing LTSS in the home or community instead of in an institution). Because a waiver service is not an entitlement, HHSC explains that “the demand for some waivers programs exceeds capacity, and therefore, the programs maintain interest lists. People who may require these services can add their name to the appropriate list at any time. Enrollment into the waiver is based on available [state] resources.”¹⁵ Moving off of the list into a waiver is often described as being given a “waiver slot,” and HHS budget decisions generally include discussion of reducing these interests lists by funding additional slots.

II. Individuals with Intellectual or Developmental Disabilities and Related Conditions

There is no universal definition for “IDD.” The term encompasses individuals with intellectual and developmental disabilities, as well as related conditions, and they can co-occur with behavioral health conditions as well. HHSC generally [defines](#) IDD as occurring at any time up to age 22 and most often lasting throughout a person’s life. An estimated 35 percent of individuals with IDD are reported to have a co-occurring behavioral health condition.¹⁶

Individuals with IDD usually need assistance with “major life activities” such as self-care, language, mobility, learning, and independent living.¹⁷ Currently, more than 500,000 individuals with intellectual and developmental disabilities and related conditions call Texas home.¹⁸ Many of these individuals will migrate across various programs and services throughout their lifetimes as their ages, needs, and availability of services change.

Historically, services for individuals with IDD focused on ensuring clients were safely housed. However, shifts in federal and state laws over the past decades have resulted in a system of care known as “person-centered planning,” which “represented a fundamental shift from service planning that required providers to keep people with disabilities safe to a service planning and service delivery system that provides supports necessary for individuals to achieve their desired outcomes.”¹⁹

Publicly-funded IDD services in Texas are accessed through regional Local Intellectual and Developmental Disability Authorities (LIDDAs). The state’s 39 LIDDAs²⁰ serve as the single point of access to IDD services in their respective areas, both institutional and community-based care. With a primary focus on service coordination, LIDDAs provide information about services to clients and their families,



conduct some eligibility testing, assist clients with enrolling in programs, and support residents transitioning out of institutions into the community.²¹

An individual's services are based on his or her determined level of need (LON). There are five LON categories ranging from "Intermittent," meaning the client does not require 24-hour care and usually only needs staff reminders and occasional guidance to "Pervasive Plus," the highest acuity level that necessitates one-on-one staff supervision within arm's length during all waking hours.²²

IDD Care Settings

In the past, individuals with IDD were primarily served in institutional settings. As the IDD client and stakeholder community began to focus on providing care to individuals with IDD in what is commonly referred to as "the least restrictive setting," more and more of these individuals sought to leave institutions and live and work in their communities. A recent HHSC report provides a brief overview of how services accessed by the IDD population have evolved over the years:

Historically, individuals with IDD in Texas accessed publicly-funded services in institutions. Over the past 40 to 50 years, Texas has made significant changes and investments to shift access to community-based services, including the development of IDD Waiver programs, a focus within the school system to provide appropriate education to children with disabilities and a recognition of the importance of employment training and opportunities for individuals with IDD. Today, services in Texas for individuals with IDD encompass an array of acute care and long-term services and supports (LTSS) that are provided throughout an individual's life. Services for individuals with IDD are intended to be individualized, foster self-determination, community inclusion, and focus on the individual's quality of life.²³

Individuals with IDD may be served in a larger institutional setting, in a smaller residential setting, or in their homes and community settings via various waiver programs:

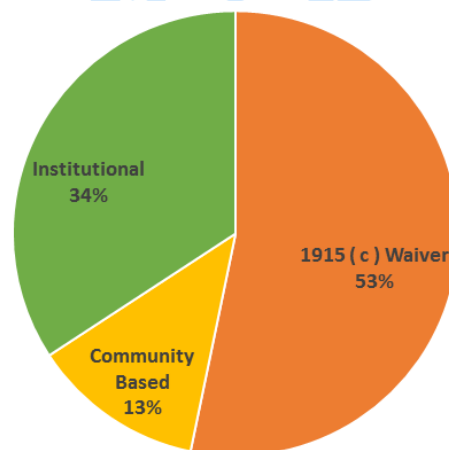
- Long-Term Care Facilities
 - Nursing facilities- provide 24-hour care to residents that meet a "level of medical necessity requiring nursing care on a regular basis,"²⁴ and, while they largely serve the elderly, they can also provide services to younger people with physical, intellectual, and/or developmental disabilities. If an individual is determined to have an intellectual or developmental disability or a mental illness, he or she is provided an opportunity for community placement in lieu of placement in a nursing facility.²⁵
 - State Support Living Centers (SSLCs)- formerly known as "state schools," these are state-run institutional facilities that provide 24-hour care to individuals with IDD and with those co-occurring behavioral health conditions. SSLCs fall under the category of intermediate care facilities for individuals with an intellectual disability or related condition (ICFs/IID). Texas' SSLCs are located in Abilene, Austin, Brenham, Corpus

Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, Rio Grande, San Angelo, and San Antonio. Collectively, they are home to about 3,000 total residents.²⁶

- Community-based ICF/IIDs- Defined as a “residential facility in a community setting,” the vast majority of ICFs provide 24-hour care in a smaller, more residential environment. With just under 800 of these facilities in the state, most serve a maximum of six residents.²⁷
- Home and Community-Based Settings- as an alternative to institutional care, individuals who qualify for services in a facility can be alternatively served through a Home and Community-Based Services (HCBS) 1915(c) waiver. The following HCBS waivers were designed to provide LTSS services for the IDD population:²⁸
 - Home and Community-based Services (HCS);
 - Community Living Assistance and Support Services (CLASS);
 - Texas Home Living (TxHmL); and
 - Deaf Blind with Multiple Disabilities (DBMD).

Today, the majority of IDD funding goes towards home and community-based services, with only about one-third of funding directed to institutional care. The following pie chart illustrates how funding for IDD services is allocated within the current budget cycle.

**HHSC Funding Percentages by Program Type
FY 18 and FY19 All Funds**



Source: Health and Human Services Commission²⁹

Although state lawmakers continue to make significant investments in helping individuals move off waiver interest lists and into home and community-based care, individuals can spend years awaiting a waiver slot. The following table represents the number of individuals served by IDD-related waivers versus those waiting on interest lists. It should be noted that these are *interest* lists, not true waiting

lists. Eligibility is not determined until a slot becomes open and individuals can sign up for multiple lists simultaneously. So, while these numbers are significant, not everyone will ultimately be determined eligible, and this is not an unduplicated count.

Waiver Program Enrollment and Interest Lists

Waiver	Current Enrollment*	Interest List**
HCS	27,689	93,284
CLASS	5,885	67,038
DBMD	381	416
TxHmL	6,540	73,388
TOTAL	40,495	234,126

* Enrollment data is reported by HHSC as of October 1, 2018.

** Interest list numbers are updated as of [January 2019](#)

Individuals may be on multiple interest lists, so this is not an unduplicated number

Source: Health and Human Services Commission^{30 31}

In its FY 2020-21 Legislative Appropriations Request (LAR), HHSC requested an exceptional item to fund additional slots “to support community transitions and reduce interest lists” for HCS, TxHmL, DBMD, and CLASS waiver programs.³²

III. Cost Comparisons in IDD Care Settings

As explained in the Introduction, this population is considerably more expensive than the acute care population because of the necessary comprehensive services, both acute and LTSS. Costs fluctuate depending on the acuity of the client and his or her level of need. But they can also vary greatly depending on the *type* of service a client receives.

The 2018-2019 General Appropriations Act (Article II, HHSC, Rider 5) directed HHSC to analyze the costs of certain government-funded residential and non-residential services for persons with IDD. For the purposes of this comparison, HHSC examined costs within the following facilities and programs:

- State Support Living Centers;
- Community-Based ICF/IIDs;
- Home and Community-based Services Waiver
 - In-home setting
 - Three-to- four bed residential group home setting; and
- Texas Home Living Waiver.

The following table is taken directly from HHSC's [Cost Comparison Report](#) showing average monthly cost per client served in each program and setting.

Cost Analysis Report - 2017

Monthly Average Cost per Individual Served by Setting

Program: State Operated ICF-IID/RC (State Supported Living Center [SSLC])	
Long-Term Care Costs - Average	19,081.26
Administrative/Overhead Costs	7,686.41
Total State Operated ICF-IID/RC Costs	26,767.67
Program: Non-State Operated ICF-IID/RC (Community ICF/IID)	
Long-Term Care Costs - Average	4,375.73
Acute Care Cost - Average	339.01
Total non-State Operated ICF-IID/RC Costs	4,714.74
Program: HCS Waiver: Residential	
Long-Term Care Costs - Average	5,244.16
Acute Care Cost - Average	764.97
Total HCS: Residential Costs	6,009.13
Program: HCS Waiver: Non-Residential	
Long-Term Care Costs - Average	2,785.97
Acute Care Cost - Average	659.94
Total HCS: Non-Residential Costs	3,445.91
Program: HCS Waiver: All Settings	
Long-Term Care Costs - Average	3,595.58
Acute Care Cost - Average	694.50
Total HCS: All Settings Costs	4,290.08
Program: Texas Home Living Waiver (TxHmL)	
Long-Term Care Costs - Average	1,801.23
Acute Care Cost - Average	770.31
Total TxHmL Costs	2,571.54

Source: Health and Human Services Commission³³

Perhaps the starkest comparison in this study is that of the two institutional settings examined- SSLCs, at an average monthly cost per resident of almost \$27,000, and community-based ICF/IIDs, costing an average \$4,700 per month for each resident. Although the SSLC census had been declining for several years, since 2016 there have been more admissions into than transitions out of these facilities.³⁴ According to the 2019 *Foundation for an IDD Strategic Plan* report, “[t]he majority of individuals admitted in recent years, including those on civil commitments, have complex behavioral health needs that can be difficult to meet.”³⁵

While there may well be some individuals that require the larger institutional setting of an SSLC, it is far more cost effective to serve any individuals that wish to be, and can be safely served, in community ICFs/IIDs and other home and community-based settings. As the Cost Comparison Report notes, SSLC

costs include “maintenance and construction costs, employee benefit costs and other federally allowable administrative, medical, and overhead costs.”³⁶ Even lower acuity individuals will be more expensive in an SSLC due to all of the additional costs needed to support their infrastructure.

IV. IDD Direct Care Workforce

Like any other area of the healthcare system, direct care workers, those who care for these clients on a daily basis, are the pillar of the IDD care and support system. Even if home and community-based care is more cost-effective and preferable, clients cannot be served, and interest lists cannot be reduced, if there is not adequate staff to fill the need.

The 2019 [Foundation for the IDD Strategic Plan](#) explains:

The IDD service system also relies on the availability and readiness of the direct service workforce to deliver services across all service systems. However, demand and competition for these frontline staff exceeds supply. Texas struggles with workforce capacity in part due to high levels of job stress, long hours, limited training, and low wages resulting in high turnover.³⁷

A national report examining the high rates of turnover in this field found that, because retail workers and stock clerks can make “several dollars” more per hour, and these jobs are often highly stressful, many leave to pursue other opportunities.³⁸ A survey completed as a part of the study said that 88 percent of respondents reported leaving their direct care job because of inadequate pay, and the average turnover rate for these positions is almost 50 percent.³⁹

Direct care workers in Texas, particularly those in community settings, are faced with very similar tough choices in deciding whether to stay with a low-pay high-stress job. According to information from IDD providers, the state will only recognize starting wages for an average direct care worker in these programs at \$8.76/ hour, while a similar starting position at the Austin SSLC pays \$13/ hour.⁴⁰ In comparison, a job at an area Rudy’s BBQ can start at an hourly wage of \$12,⁴¹ Buc-ee’s at \$12- \$14⁴², and HEB at \$10- \$11.⁴³ PPAT notes that some providers pay more than the \$8.76 in order to remain competitive; however, they may do so at a loss, since those additional costs are not recognized or reimbursed by the state.

One recent *Forbes* article examining this report describes how this constant turnover impacts the IDD population and better pay for these workers could improve the system:

Constant turnover is highly disruptive to people with I/DD. Most people can imagine how this affects a family, their health and well-being, whether that person needs assistance with basic tasks, such as hygiene and medication, or they require job coaching or help to prepare for an interview. A DSP [direct service professional] does all of that and more. Losing the backbone of

support, even with a very supportive family and community, can bring everyday life to a standstill....

Essentially, every aspect of an I/DD individual's life could very well change for the better if DSP wages improved. Still, many legislators lack an understanding of the crucial role of DSPs in the caregiving system, which can result in limited funding for them, which comes primarily from Medicaid.⁴⁴

V. Policy Recommendation and Conclusion

Include Appropriations to Increase Wages to Direct Care Staff

A budget rider to increase rates (including wages for direct support staff) for the ICF/IID program and the Home and Community-based Services (HCS) and Texas Home Living (TxHmL) waivers was included in the Committee Substitute for HB 1 and voted out of the full House Appropriations Committee on March 18, 2019. The rider directs \$42 million in General Revenue and \$68.1 million in federal funds in each year of the 2020 -2021 biennium to rebase reimbursement methodologies and update facility-based community services, including a seven percent factor.

Lawmakers should support increasing direct care staff wages at the newly proposed levels at a minimum. Raising these direct care wages of community-based providers to equal those earned by their counterparts in SSLCs would allow community providers to more effectively recruit and retain a skilled workforce, and that only stands to improve outcomes for these clients.

Taxpayer funds must be spent judiciously, and that rarely equates to investing millions of dollars into the Medicaid program. However, this instance is different. When the Medicaid program was first created in the 1960s, individuals with IDD were part of the population this program was intended to serve. The government decided it had a duty to ensure these individuals received quality care, and maintaining that responsibility will sometimes require additional investments. Increasing rates for direct care wages supports fulfillment of that responsibility by allowing additional individuals to be served in more cost-effective home and community-based settings. If Texas is ever going to transition residents out of costlier SSLCs and continue its mission to decrease waiver interest lists, the state must ensure a sufficient direct care workforce.

END NOTES

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