

**Department of State Health Services
Council Agenda Memo for State Health Services Council
August 28-29, 2013**

Agenda Item Title: New rules concerning a Home and Community-Based Services-Adult Mental Health Program

Agenda Number: 4.b

Recommended Council Action:

For Discussion Only

For Discussion and Action by the Council

Background:

The Mental Health and Substance Abuse (MHSA) Division, Program Services Section, develops and implements programs concerning the provision of mental health community services. The Division develops standards to ensure that the 37 local mental health authorities (LMHAs) and one managed care organization that contract directly with the Department of State Health Services (DSHS) provide appropriate, adequate mental health services to the citizens of Texas. The MHSA Division, State Hospitals Section, provides guidance and direction in the provision of evidence-based healthcare treatment and services for ten state mental health hospitals and one infectious diseases hospital.

A number of individuals have resided in state mental health facilities (SMHFs) for extended periods of time, in some cases, for years. These individuals no longer require an inpatient level of treatment, but need specialized supports that are not available through existing community-based mental health and disability programs. Characteristics of this population include:

- a history of unstable housing/homelessness;
- co-occurring physical health issues including hypertension, obesity, diabetes, high cholesterol, mobility impairment, and suspected developmental disabilities;
- cognitive issues including dementias, traumatic brain injuries, cognitive processing issues due to mental illness, and complex mental health diagnoses such as schizoaffective disorder; and
- less family support than mental health clients in general.

DSHS and the Texas Health and Human Services Commission (HHSC) plan to submit a Medicaid state plan amendment under Sec. 1915(i) of the Social Security Act, as amended by the Affordable Care Act of 2010, which, if approved by the Centers for Medicare and Medicaid Services, would allow the State to obtain federal matching funds to provide home and community-based services to Medicaid eligible clients in this population. Some individuals in the targeted population are not qualified for Medicaid. Services for these individuals will be provided using general revenue funds appropriated for this program. DSHS estimates that maximum of 106 individuals will be served during the 2014-2015 biennium.

Summary:

The purpose of the new rules is to implement a Home and Community-Based Services-Adult Mental Health (HCBS-AMH) Program that includes residential assistance, assisted living, cognitive rehabilitative services, supported employment, transition assistance from institution to community, specialized therapies, short term respite, peer support, specialized substance abuse treatment services, and medical/nursing assistance. DSHS will contract with HCBS-AMH provider agencies to provide the array of services included in the HCBS-AMH Program. The rules set forth the purpose, eligibility criteria, individual plan of care and assessment requirements, and provider qualifications for this program.

Title 25. Health Services
Part 1. Department of State Health Services
Chapter 416. Mental Health Community-Based Services
Subchapter B. Home and Community-Based Services--Adult Mental Health Program
New §§416.51 - 416.58

Proposed Preamble

The Executive Commissioner of the Health and Human Services Commission, on behalf of the Department of State Health Services (department), proposes new §§416.51 - 416.58, concerning home and community-based services for individuals with extended tenure in state mental health facilities.

BACKGROUND AND PURPOSE

The purpose of the Home and Community-Based Services--Adult Mental Health Program (HCBS-AMH program) is to provide home and community-based services to adults with extended tenure in state mental health facilities in lieu of their remaining long term residents of state facilities. The HCBS-AMH program would provide an array of services, appropriate to each individual's needs, which would enable these individuals to live in the community rather than residing in state mental health hospitals.

A number of adults have resided in Texas psychiatric facilities for extended periods of time, in some cases, for years. These individuals no longer require an inpatient level of treatment, but need specialized supports that are not available through existing community-based mental health and disability programs.

Characteristics of this population include: 1) a history of unstable housing/homelessness; 2) co-occurring physical health issues including hypertension, obesity, diabetes, high cholesterol, mobility impairment and suspected developmental disabilities; 3) cognitive issues including dementias, traumatic brain injuries, cognitive processing issues due to mental illness and complex mental health diagnoses such as schizoaffective disorder; and 4) less family support than individuals with mental illness in general.

In September 2010, the Continuity of Care Task Force, which was charged by the department with developing recommendations for resolving barriers to discharging individuals with complex needs from state psychiatric facilities, advised that the state consider implementing the HCBS-AMH program. The Continuity of Care Task Force, which included local mental health authority (LMHA) leadership, advocates, consumers, law enforcement, judges, inpatient providers and agency staff, conducted public meetings, key informant interviews, meetings with key professional groups and four public forums in various locations of the state. The department sought and obtained funding to implement this HCBS-AMH program during the 83rd Legislature, Regular Session, 2013, via Article II, Rider 81 of the General Appropriations Act for the 2014-2015 Biennium. Rider 81 requires that the department implement this HCBS-AMH program for individuals with extended tenure stays in state mental health facilities. The department would operate the HCBS-AMH program, contracting for services with provider agencies, approving the individual service plans, paying claims for home and community-based

services and performing quality assurance activities. The department estimates that a total of 106 individuals could be served during the biennium.

Home and community-based services could potentially include residential assistance options such as foster/companion care, supervised living, residential support services and assisted living; cognitive rehabilitative services; supported employment; transition assistance from institution to community; specialized therapies; short term respite; peer support; specialized substance use disorder treatment and medical/nursing assistance.

For Medicaid-eligible individuals within this population §1915(i) of the Social Security Act could enable Texas to obtain federal matching funds for this HCBS-AMH program via a Medicaid State Plan Amendment, if the amendment were approved by the federal Medicaid agency. The department is working closely with the Health and Human Services Commission to develop and obtain approval for the §1915(i) State Plan Amendment and to explore other options for obtaining federal Medicaid matching funds.

SECTION-BY-SECTION SUMMARY

The new rules set forth the basic requirements which would enable the department to implement a HCBS-AMH program. These include purpose and application; definitions of terms; eligibility criteria for individuals to participate in this HCBS-AMH program; copayment requirements for the HCBS-AMH program; assessment requirements consistent with federal Medicaid requirements; individual plan of care requirements consistent with federal Medicaid requirements; provider qualifications and contracting requirements which apply to providers seeking to participate in this program; and right to fair hearing and appeals process language, which delineates the rights of individuals to request an appeal and obtain a fair hearing and which is consistent with the processes used for the department and Medicaid services.

Section 416.51 sets forth the purpose for the subchapter and describes that the subchapter applies to people who have an agreement to provide home and community-based services, entities who have administrative responsibilities under this program, and individuals who are applicants for or recipients of services provided under this program.

Section 416.52 lists the terms and definitions used in the subchapter as follows: “assessor,” “activities of daily living,” “adult,” “department,” “designee,” “individual plan of care,” “legally authorized representative (LAR),” “provider,” “serious mental illness, and uniform assessment.”

Section 416.53 sets forth the eligibility criteria for receiving home and community-based services.

Section 416.54 acknowledges that certain home and community-based services may be dependent upon the individual's or LAR's ability to make a co-payment.

Section 416.55 stipulates that each individual determined eligible for home and community-based services must receive a uniform assessment, which is the basis for developing the individual plan of care (IPC).

Section 416.56 stipulates that the IPC must address the following elements to be approved: prepare for the individual's transition to the community; promote the individual's inclusion into the community; protect the individual's health and welfare in the community; supplement, rather than replace, the individual's natural support systems and resources; be designed to prevent or reduce the likelihood of the individual's admission to an inpatient psychiatric facility; be the most appropriate type and amount of services to meet the individual's needs; and prevent the provision of unnecessary or inappropriate care.

Section 416.57 sets forth the provider qualifications and provides information about contracting to provide home and community-based services.

Section 416.58 sets forth the right of Medicaid and non-Medicaid individuals to fair hearings and appeal process and provides references to those and processes.

FISCAL NOTE

Mike Maples, Assistant Commissioner for Mental Health and Substance Abuse Services, has determined that for each year of the first five years that the sections will be in effect there will be positive fiscal implications to state government as a result of enforcing and administering the sections as proposed Rider 81 appropriates \$2,655,006 in fiscal year 2014, and \$5,217,413 in fiscal year 2015 to the department to implement and operate the HCBS-AMH program. The department projects \$5,217,413 for each fiscal year from 2016 through 2019. There is no fiscal impact for local government as a result of administering the sections.

SMALL AND MICRO-BUSINESS IMPACT ANALYSIS

Mr. Maples, as required by Government Code, Chapter 2006, Agency Actions Affecting Small Businesses, §2006.002, Adoption of Rules with Adverse Economic Effect, has also determined that the proposed rules will not have an adverse economic effect on small businesses or micro-businesses. The program does not impose a regulatory burden on businesses of any size. The rules permit implementation of this program to provide services to adults who have extended tenure in state mental health facilities. There will be an enrollment process for providers who wish to participate in the program. Information about the program, including reimbursement rates, will be made available to the public prior to the enrollment process. Because community-based services will be reimbursed for individuals who were formerly in institutions, the sections may result in economic increase to home and community-based services providers.

ECONOMIC COST TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT

There is no economic cost to persons who are required to comply with the sections as proposed. There is no anticipated impact on local employment.

PUBLIC BENEFIT

In addition, Mr. Maples has determined that for each year of the first five years the section is in effect, the public will benefit from adoption of the section. The rules allow the department to enable individuals who would otherwise have extended stays in state mental health facilities to

live successfully in the community. This is consistent with a person-centered, recovery-focused approach to serving individuals with mental illness. Such an approach is generally recognized as a best practice and is consistent with federal guidance. Additionally, establishing the HCBS-AMH program for this population could free needed bed space in state mental health facilities to serve more individuals who need acute inpatient care.

REGULATORY ANALYSIS

The department has determined that this proposal is not a “major environmental rule” as defined by Government Code, §2001.0225. “Major environmental rule” is defined as a rule the specific intent of which is to protect the environment or reduce risk to human health from environmental exposure and that may adversely affect, in a material way, the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of a state or a sector of the state. This proposal is not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

TAKINGS IMPACT ASSESSMENT

The department has determined that the proposal does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Government Code, §2007.043.

PUBLIC COMMENT

Comments on the proposal may be submitted to Janet Fletcher, Adult Mental Health Program Services, Department of State Health Services, Mail Code 2018, P.O. Box 149347, Austin, Texas 78714-9347, telephone (512) 467-5425 or by email to MHSARules@dshs.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register*.

LEGAL CERTIFICATION

The Department of State Health Services General Counsel, Lisa Hernandez, certifies that the proposed rules have been reviewed by legal counsel and found to be within the state agencies' authority to adopt.

STATUTORY AUTHORITY

The new sections are authorized by Health and Safety Code, §533.0345, which requires the department to develop program standards for mental health services; and Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001.

The proposed new sections affect the Health and Safety Code, Chapters 533 and 1001; and Government Code, Chapter 531.

Legend: (Proposed New Rules)
Regular Print = Proposed new language

§416.51. Purpose and Application.

(a) Purpose. The purpose of this subchapter is to implement a program that provides home and community-based services to individuals with severe and persistent mental illness who have extended tenure in state mental health facilities.

(b) Application. The subchapter applies to:

(1) persons and entities that have an agreement to provide the home and community-based services, as described in this subchapter;

(2) entities that have administrative responsibilities under this program; and

(3) individuals who are applicants for or recipients of home and community-based services under this program.

§416.52. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Assessor--The person who conducts the uniform assessment must, at minimum, be a qualified mental health professional--community services as defined in Chapter 412, Subchapter G of this title (relating to Mental Health Community Services Standards).

(2) Activities of daily living--These actions include (but are not limited to) performing personal hygiene activities, dressing, meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, navigating public transportation and participating in the community.

(3) Adult--An individual who is 18 years of age or older.

(4) Department--The Department of State Health Services.

(5) Designee--An entity approved by the department to review the individual plan of care (e.g., local mental health authority).

(6) Individual plan of care (IPC)--A written, individualized plan, developed in consultation with the individual and LAR, if applicable, which identifies the necessary home and community-based services to be provided to the individual.

(7) Legally authorized representative (LAR)--A person authorized by law to act on behalf of the individual with regard to a matter described in this subchapter, including, but not limited to, a guardian or managing conservator.

(8) Provider--Any person or legal entity that has an agreement with the single state Medicaid agency and/or the department to provide the home and community-based services.

(9) Serious mental illness--An illness, disease or condition (other than a sole diagnosis of epilepsy, dementia, substance use disorder, intellectual or developmental disability) that:

(A) substantially impairs thought, perception of reality, emotional process, development or judgment; or

(B) grossly impairs and individual's behavior as demonstrated by recent disturbed behavior.

(10) Uniform assessment--A set of standardized assessment measures used by the department to determine level of need as set forth in this program.

§416.53. Eligibility Criteria.

To participate in the this program, the individual must be an adult and meet the needs-based eligibility criteria for home and community-based services as determined by an independent evaluation conducted by a designee approved by the department using the uniform assessment tool approved by the department (e.g., the adult needs and strengths assessment).

§416.54. Co-payments.

A co-payment for home and community-based services may be assessed as described in Chapter 412, Subchapter C of this title (relating to Charges for Community Services), concerning billing procedures.

§416.55. Uniform Assessment.

Each individual determined eligible to participate in this program must receive a uniform assessment as defined by the department, based on the needs of the individual. The uniform assessment will be the basis for the IPC. The assessor must consult with the individual, service providers and, where appropriate, the individual's LAR, family, spouse, facility treatment team or other responsible persons to conduct the uniform assessment and develop the IPC. The uniform assessment must:

(1) be conducted face-to-face;

(2) take into account the ability of the individual to perform two or more activities of daily living; and

(3) assess the individual's need for home and community-based services.

§416.56. Individual Plan of Care.

(a) The IPC, developed in accordance with Chapter 412, Subchapter D of this title (relating to Mental Health Service--Admission, Continuity, and Discharge), concerning discharge planning, must be reviewed by a designee approved by the department before forwarding to the department for approval. The IPC must be approved by the department before a provider may begin delivering home and community-based services. To be approved, the IPC must:

- (1) prepare for the individual's effective transition to the community;
- (2) promote the individual's inclusion into the community;
- (3) protect the individual's health and welfare in the community;
- (4) supplement, rather than replace, the individual's natural support systems and resources;
- (5) be designed to prevent or reduce the likelihood of the individual's admission into an inpatient psychiatric facility;
- (6) be the most appropriate type and amount of services to meet the individual's needs; and
- (7) prevent the provision of unnecessary or inappropriate care.

(b) The IPC must be reviewed by a designee approved by the department and submitted to the department for approval as part of the annual eligibility determination required under §416.53 of this title (relating to Eligibility Criteria) or more often as the individual's needs require. Any recommended changes to the assessment outside the annual review process must be approved by the department.

(c) The designee approved by the department must submit the following to the department with the IPC:

- (1) a uniform assessment of the individual that identifies the individual's needs and supports the home and community-based services included in the IPC; and
- (2) documentation that non-home and community-based services, support systems and resources are unavailable or are insufficient to meet the goals specified in the IPC.

(d) The department may conduct utilization review of an IPC and supporting documentation at any time to determine if the services specified in the IPC meet the requirements described in subsection (a) of this section. If the department determines that one or

more of the services specified in the IPC do not meet the requirements described in subsection (a) of this section, the department may deny, reduce, or terminate the service, modify the IPC, and send written notification to the individual, LAR, and the provider according to §416.58 of this title (relating to Fair Hearings and Appeal Processes).

(e) In addition to the utilization review conducted in accordance with subsection (d) of this section, the department may conduct utilization review of the provider and the provision of home and community-based services at any time.

(f) The cost of the IPC must be reasonable as determined by the single state Medicaid agency and/or the department.

§416.57. Provider Qualifications and Contracting.

A prospective provider may request and submit an application to provide home and community-based services to the department at any time. The application sets forth the qualifications to be a provider. In order to provide home and community-based services to:

(1) Medicaid-eligible individuals, a provider must be enrolled as an approved Medicaid provider in Texas and must enter into a contract with the department and the single state Medicaid agency.

(2) non-Medicaid-eligible individuals, a provider must be approved by, and enter into a contract with, the department.

§416.58. Fair Hearings and Appeal Processes.

(a) Right of Medicaid-eligible individual to request a fair hearing. Any Medicaid-eligible individual whose request for eligibility to receive home and community-based services is denied or is not acted upon with reasonable promptness, or whose services have been terminated, suspended, or reduced by the department, is entitled to a fair hearing in accordance with 1 TAC Part 15, Chapter 357, Subchapter A (relating to Uniform Fair Hearing Rules).

(b) Right of non-Medicaid-eligible individual to request an appeal. Any individual who has not applied for or is not eligible for Medicaid, whose request for eligibility to receive home and community-based services is denied or is not acted upon with reasonable promptness, or whose services have been terminated, suspended, or reduced by a provider, is entitled to notification and right of appeal in accordance with the department's rules concerning such matters for non-Medicaid-eligible individuals.