

**Department of State Health Services
Council Agenda Memo for State Health Services Council
May 18-19, 2016**

Agenda Item Title: Amendments to rules concerning local authority responsibilities

Agenda Number: 3.c.

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 (MCO) that contract directly with DSHS provide appropriate, adequate mental health services to the citizens of Texas.

Chapter 412 concerning Local Authority Responsibilities includes subchapters that address contracts management for local authorities; charges for community services; admission, continuity, and discharge; mental health community services standards; mental health case management; mental health prevention; and provider network development.

In FY 2015, LMHAs served 138,163 adults and 38,966 children (excluding the NorthSTAR service area). Funding for community services comes from the Mental Health Block Grant, General Revenue, and third-party payers such as Medicare, Medicaid, and private insurance.

Summary:

The purpose of the amendments is to provide a clear, concise process for determining cost sharing for individuals with non-Medicare third-party coverage; expand the licensed professionals who are authorized to determine medical necessity to include physician assistants with specialized psychiatric/mental health training; provide a reference to the criteria set forth in the subchapter for local mental health authorities to use in developing an alternative credentialing process for qualified mental health professionals – community services; and update references to the *Diagnostic and Statistical Manual* to a generic format so future amendments will be unnecessary.

Key Health Measures:

While the program does not collect data that would address these particular amendments, each one benefits consumers, providers, DSHS, and taxpayers in unique ways. The clarifying language added to §412.108(d) assists the LMHA in determining an individual's ability to pay if the individual has non-Medicare third-party coverage (e.g., insurance with a managed care organization, private insurance, or CHIP) that covers mental health services and implements the statutory requirement that DSHS is the payor of last resort.

The reference to the *Diagnostic Statistical Manual (DSM) of Mental Disorders* published by the American Psychiatric Association has been clarified by adding the phrase "that is approved for use by the department" so that when the DSM is revised, DSHS has the ability to switch to the most current version. Further, the LMHA's performance will prescribe which version of the DSM is to be used.

In the definition of the term "LPHA or licensed practitioner of the healing arts," physician assistant (PA) is added to the definition (at the request of the LMHAs. DSHS agrees that giving PAs the authority to document medical necessity will help alleviate the physician shortage in many areas of the state and is consistent with the federal

regulations related to PAs determining medical necessity.

The definition for the term “physician assistant” is revised to include the requirement that PAs have specialized psychiatric/mental health training in addition to being licensed in accordance with the Occupations Code. The specialized training ensures that PAs have the training necessary to meet the needs of the population being served.

In the definition of the term “QMHP-CS or qualified mental health professional-community services,” a reference to the criteria the LMHA is directed to use in developing an alternative credentialing process for QMHP-CSs is added. The alternative credentialing process will help alleviate the staff shortage in many areas of the state.

Annually, the Center for Health Care Statistics obtains data concerning the number licensed professionals from the respective licensing boards. This information will be reviewed by program staff to determine whether other actions can be taken to ease any staff shortages identified. Further, the Center for Health Care Statistics is interested in a collaborative effort between themselves, program staff, and LMHAs by way of the Texas Council of Community Centers to obtain similar data on unlicensed staff such as QMHP-CSs and community support specialists.

Summary of Input from Stakeholder Groups:

In December 2015, the miscellaneous amendments being proposed for Chapter 412 concerning Local Authority Responsibilities were distributed for informal comment to staff of the Texas Council of Community Centers, state mental health facilities, LMHAs, Disability Rights Texas, consumer advocates, and other members of the public who have asked to receive information related to rule actions.

Comments were received from MHMR of Tarrant County, Ft. Worth; Andrews Center, Tyler; Burke Center, Lufkin. All requested clarification on how to implement the rule provisions related to billing individuals with non-Medicare third-party coverage. DSHS program staff and staff from the Texas Council of Community Centers held a conference call with staff of the Department of Aging and Disability Services, Disability Rights Texas, and consumer advocates to discuss the need for additional rule revisions to further clarify billing procedures for individuals with non-Medicare third-party payor coverage. After a thorough discussion of the subchapter related to charges for community-based services, all participants agreed that no additional rule revisions were necessary. However, DSHS agreed to prepare and post on the Internet a “Frequently Asked Questions” document that would comprise the questions and related responses discussed during the call.

Proposed Motion:

Motion to recommend HHSC approval for publication of rules contained in agenda item # 3.c.

Approved by Assistant Commissioner/Director: Lauren Lacefield Lewis **Date:** April 12, 2016

Presenter: Lauren Lacefield Lewis **Program:** Mental Health and Substance Abuse Services **Phone No.:** 512-206-5345

Approved by CPEA: Carolyn Bivens **Date:** April 4, 2016

Title 25. HEALTH SERVICES
Part 1. DEPARTMENT OF STATE HEALTH SERVICES
Chapter 412. Local Mental Health Authority Responsibilities
Subchapter A. Charges for Community Services
Amendments §412.108
Subchapter G. Mental Health Community Services Standards
Division 1. General Provisions
§412.303
Division 3. Standards of Care
§412.322

Proposed Preamble

The Executive Commissioner of the Health and Human Services Commission, on behalf of the Department of State Health Services (department), proposes amendments to §412.108, §412.303 and §412.322, concerning local mental health authority (LMHA) responsibilities.

BACKGROUND AND PURPOSE

The purpose of the amendments is to clarify processes related to billing for community mental health services; expand the provider base authorized to determine medical necessity to include physician assistants with specialized psychiatric/mental health training; provide a reference to the criteria set forth in the subchapter for LMHAs to use in developing an alternative credentialing process for qualified mental health professionals – community services (QMHP-CS); and update specific references to the *Diagnostic and Statistical Manual* with a generic reference to eliminate the need to revise rules should the manual change in the future.

SECTION-BY-SECTION SUMMARY

In §412.108 concerning billing procedures, subsection (a) describes the process for determining the monthly account for each person; subsection (b) directs that the LMHA access all available funding sources before using department funds to pay for a person's services; subsection (c) directs the LMHA to bill the person's third-party coverage for the monthly account amount for covered services; subsection (d) sets the processes for billing the person (or parents) the monthly account amount when there is no third-party coverage, when there is Medicare third-party coverage, or when there is non-Medicare third-party coverage; and subsection (e) describes the information that must be included in monthly billing statements that are sent to individuals who have been determined as having an ability to pay for the services the individuals receive. The requirements and processes for payments, collections, and non-payment, including when a financial hardship exists are located in §412.109.

Section 412.108(d)(3) concerns non-Medicare third-party coverage and reflects separate billing scenarios depending on whether a person's cost sharing exceeds or is less than the person's maximum monthly fee (MMF). Subparagraph (A) requires that if all cost sharing exceeds the MMF, the person is billed all applicable co-payments, co-insurance, and deductibles for services listed in the monthly account as covered by the non-Medicare third-party coverage. Subparagraph (B) requires that if a person's cost sharing does not exceed the person's MMF, then the amounts described in new subsection (d)(3)(B)(i)(I) and (II) are added to equal the total amount applied toward the person's MMF. These fees when added together determine whether the account amount exceeds or is less than the person's MMF.

In §412.303(19), the definition of the term "DSM--The current edition of the *Diagnostic Statistical Manual of Mental Disorders* published by the American Psychiatric Association is clarified by adding the

phrase “that is approved for use by the department” so that when the DSM is revised the department's system has the ability to switch to the use of the most current version at the same time. Further, the local mental health authority performance will prescribe which version of the DSM is to be used.

In §412.303(35), the definition of the term “LPHA or licensed practitioner of the healing arts” is clarified by adding the acronyms for the respective clinical/clinical profession titles in subparagraphs (B), (C), and (G). In paragraph (D), the word “licensed” is deleted because the term “licensed psychologist” is not used as part of a psychologist’s clinical title as is the case when using the term “licensed clinical social worker.” The definition of each clinical/medical title sets forth the requirement that the professional be licensed according to the Occupations Code, Chapter 204. A new paragraph (F) is added to include "physician assistant (PA)" and the subsequent paragraph is re-lettered.

In §412.303(45), the following requirement that the PA "has specialized psychiatric/mental health training" was added in addition to being licensed in accordance with the Occupations Code, Chapter 204.

In §412.303(48), the definition of the term “QMHP--CS or qualified mental health professional--- community services,” paragraph (C) is revised to refer to the criteria in §412.316(c) and (d) that the LMHA or MCO must use to determine an alternative credentialing process for QMHPs.

The amendments to §412.322(b) and (g) is amended by deleting the language "all five axes of the current" because the current edition DSM V, no longer uses axes in the formulation of mental health diagnoses.

FISCAL NOTE

Lauren Lacefield Lewis, 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 no fiscal implications to state or local governments as a result of enforcing and administering the sections as proposed.

SMALL AND MICRO-BUSINESS IMPACT ANALYSIS

Lauren Lacefield Lewis has also determined that there will be no adverse impact on small businesses or micro-businesses required to comply with the sections as proposed. This was determined by interpretation of the rules that small businesses and micro-businesses will not be required to alter their business practices in order to comply with the sections. Therefore, an economic impact statement and regulatory flexibility analysis for small and micro-businesses are not required.

ECONOMIC COSTS TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT

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

PUBLIC BENEFIT

In addition, Mrs. Lacefield Lewis has also determined that for each year of the first five years the sections are in effect, the public will benefit from adoption of the sections. The public benefit anticipated as a result of enforcing or administering the sections will be clear, concise process for determining cost sharing for individuals with non-Medicare third-part coverage; expand the licensed professionals who are authorized to determine medical necessity to include physician assistants with specialized psychiatric/mental health training; provides a reference to the criteria set forth in the subchapter for local mental health authorities to use in developing an alternative credentialing process for qualified QMHP-

CS; and update references to the *Diagnostic and Statistical Manual* to a generic format so future amendments will be unnecessary.

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 to mean 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, Department of State Health Services, Mail Code 2018/552, P.O. Box 149347, Austin 78714-9347, or by email to mhsarules@dshs.state.tx.us with the phrase "Chapter 412 Misc. Changes – Formal Comment" in the subject line. 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 amendments are authorized by 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 amendments affect Government Code, Chapter 531; and Health and Safety Code, Chapter 1001.

Legend: (Proposed Amendments)

Single Underline = Proposed new language

[Bold, Print, and Brackets] = Current language proposed for deletion

Regular Print = Current language

(No change.) = No changes are being considered for the designated subdivision

§412.108. Billing Procedures.

(a) - (c) (No change.)

(d) Billing the person (or parents).

(1) No third-party coverage. If the monthly account amount for services not covered by third-party coverage:

(A) exceeds the person's maximum monthly fee (MMF), then the amount is reduced to equal the MMF and the LMHA bills person (or parent) the MMF; or

(B) is less than the person's MMF, then the LMHA bills the person (or parent) the monthly account amount for services not covered by third-party coverage.

(2) Medicare third-party coverage. Nothing in this paragraph is intended to conflict with any applicable law, rule, or regulation with which a LMHA must comply.

(A) The following amounts are added to equal the total amount applied toward the person's MMF:

(i) the amount of all applicable co-payments and co-insurance for services listed in the monthly account as covered by Medicare third-party coverage;

(ii) the amount Medicare third-party coverage was billed but did not pay because the deductible hasn't been met; and

(iii) the monthly account amount for services not covered by third-party coverage.

(B) If the total amount applied toward the person's MMF as described in paragraph (2)(A) of this subsection:

(i) exceeds the person's MMF, then the amount is reduced to equal the MMF and the LMHA bills person (or parent) the MMF; or

(ii) is less than the person's MMF, then the LMHA bills the person (or parent) the total amount applied toward the MMF.

(3) Non-Medicare third-party coverage.

(A) Cost-sharing exceeds MMF. If the amount of all applicable co-payments, co-insurance, and deductibles for services listed in the monthly account as covered by non-Medicare third-party coverage exceeds the person's MMF, then the LMHA bills the person (or parent) all applicable co-payments, co-insurance, and deductibles.

(B) Cost-sharing does not exceed MMF.

(i) If the amount of all applicable co-payments, co-insurance, and deductibles for services listed in the monthly account as covered by non-Medicare third-party coverage does not exceed the person's MMF, then the following amounts are added to equal the total amount applied toward the person's MMF:

(I) the amount of all applicable co-payments, co-insurance, and deductibles; and

(II) the monthly account amount for services not covered by third-party coverage.

(ii) If the total amount applied toward the person's MMF as described in paragraph (3)(B) of this subsection:

(I) exceeds the person's MMF, then the amount is reduced to equal the MMF and the LMHA bills person (or parent) the MMF; or

(II) is less than the person's MMF, then the LMHA bills the person (or parent) the total amount applied toward the MMF.

(C) Annual cost-sharing limit. If the person (or parent) has reached his/her annual cost-sharing limit (i.e., maximum out-of-pocket expense) as verified by the non-Medicare third-party coverage, then the LMHA will not bill the person (or parent) any co-payments, co-insurance, or deductibles, as applicable to the annual cost-sharing limit, for services covered by the non-Medicare third-party coverage for the remainder of the policy-year.

(4) Social Security work incentive provisions.

(A) If the person identified a payment amount for specific services in his/her approved plan utilizing Social Security work incentive provisions (i.e., *Plan to Achieve Self-Sufficiency; Impairment Related Work Expense*), then the LMHA bills the person the monthly account amount for the specific services up to the identified payment amount. If the monthly account amount for the specific services is greater than the identified payment amount, then the remaining balance is applied toward the person's MMF.

(B) The following amounts are added to equal the total amount applied toward the person's MMF:

subsection; and

(ii) the monthly account amount for services not covered by third-party coverage.

(C) If the total amount applied toward the person's MMF as described in paragraph (4)(B) of this subsection:

(i) exceeds the person's MMF, then the amount is reduced to equal the MMF and the LMHA bills person (or parent) the MMF; or

(ii) is less than the person's MMF, then the LMHA bills the person (or parent) the total amount applied toward the MMF.

(e) (No change.)

SUBCHAPTER G. MENTAL HEALTH COMMUNITY SERVICES STANDARDS.
DIVISION 1. GENERAL PROVISIONS.

§412.303. Definitions.

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

(1) - (18) (No change.)

(19) DSM--The current edition of the *Diagnostic Statistical Manual of Mental Disorders* published by the American Psychiatric Association that is approved for use by the department.

(20) - (34) (No change.)

(35) LPHA or licensed practitioner of the healing arts--A staff member who is:

(A) a physician;

(B) a licensed professional counselor (LPC);

(C) a licensed clinical social worker (LCSW);

(D) a [**licensed**] psychologist;

(E) an advanced practice nurse; [**or**]

(F) a physician assistant (PA); or

(G) [(F)] a licensed marriage and family therapist (LMFT).

(36) - (44) (No change.)

(45) Physician assistant--A staff member who has specialized psychiatric/mental health training and who is licensed as a physician assistant by the Texas State Board of Physician Assistant Examiners in accordance with Texas Occupations Code, Chapter 204.

(46) - (47) (No change.)

(48) QMHP-CS or qualified mental health professional-community services--A staff member who is credentialed as a QMHP-CS who has demonstrated and documented competency in the work to be performed and:

(A) has a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major (as determined by the LMHA or MCO in accordance with §412.316(d) of this title (relating to Competency and Credentialing)) in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention;

(B) is a registered nurse; or

(C) completes an alternative credentialing process as determined by the LMHA or MCO in accordance with §412.316(c) and (d) of this title relating to (Competency and Credentialing) [identified by the department].

(49) - (64) (No change.)

DIVISION 3. STANDARDS OF CARE.

§412.322. Provider Responsibilities for Treatment Planning and Service Authorization.

(a) (No change.)

(b) Diagnostics. The diagnosis of a mental illness must be:

(1) rendered by an LPHA, acting within the scope of his/her license, who has interviewed the individual, either face-to-face or via telemedicine;

(2) based on the [all five axes of the current] DSM;

(3) documented in writing, including the date, signature, and credentials of the person making the diagnosis; and

(4) supported by and included in the assessment.

(c) - (g) (No change.)

(h) Discharge Summary. Not later than 21 calendar days after an individual's discharge, whether planned or unplanned, the provider must document in the individual's medical record:

(1) a summary, based upon input from all the disciplines of treatment involved in the individual's treatment plan, of all the services provided, the individual's response to treatment, and any other relevant information;

(2) recommendations made to the individual or their LAR (if applicable) for follow up services, if any; and

(3) the individual's last diagnosis, based on the **[upon all five axes of the current]** DSM.