Next Steps: A Study of State Hospital Step-Down Services

As Required by
2022-23 General Appropriations Act,
Senate Bill 1,
87th Legislature, Regular Session, 2021
(Article II, HHSC, Rider 57)

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Executive Summary

The 2022-23 General Appropriations Act, Senate Bill (S.B.) 1, 87th Legislature, Regular Session, 2021 (Article II, Health and Human Services Commission (HHSC), Rider 57) directs HHSC to produce a study on step-down services that can be used to divert people from state mental health hospitals to the community. The study focuses on people who experience long or frequent stays in state hospitals. People who are admitted to state hospitals are primarily adult men under the age of 65 who are diagnosed with psychotic disorders. Seventy-four percent of people in state hospitals for over one year were admitted under forensic commitments in fiscal year 2021.

Barriers to discharge that prevent people from transitioning into the community vary by person but may include lack of suitable housing; a need for supportive medical, behavioral, or personal care services; limited financial resources; issues with daily living skills; involvement with the criminal justice system; and a lack of confidence or sense of purpose which impede the ability to live more independently. Some people also have cognitive challenges which make it difficult for them to address their own needs or unable to understand that they have mental illness. Past involvement with the criminal justice system can create additional barriers to leaving a state hospital, such as challenges with obtaining housing or seeking employment. Barriers to discharge are heightened in rural and remote regions where services, supports, and housing are more often difficult to obtain or access.

Effective step-down (transition) programs involve significant investments of time and resources. Best practices for diverting people from repeated or long-term hospitalization involve several key elements:

- A transition process including a dedicated team with clearly defined roles, which provides support to the person before, during, and after discharge;
- An approach to planning and service delivery that builds on a person's strengths and addresses their goals and preferences;
- A continuum of residential options with varying levels of support;
- Access to medical services, behavioral health services, substance use disorder services, long-term care services, home and community-based services (HCBS), peer and crisis services, and other supports, as needed;
- Training and technical assistance for people transitioning, state staff assisting in the transition, the local justice system, local healthcare providers,

behavioral health and long-term services providers, Local Mental Health or Behavioral Health Authorities (LMHAs/LBHAs) and other partners;

- A clear point of accountability for outcomes, with well-defined data collection, evaluation, and performance measures that are routinely collected and reported; and
- Sustainable financing for transition services, supports, and housing.

Elements of step-down programs may be financed through various sources including Medicaid, Medicare, the United States Department of Housing and Urban Development (HUD), local funds, grants or appropriations, and private sector funds from sources such as managed care organizations (MCOs) and foundations.

1. Introduction

The *Next Steps: A study of State Hospital Step-Down Services* report is submitted pursuant to Rider 57, which directs HHSC to study the efficacy and efficiency of step-down services in diverting people from the state mental health hospital inpatient system into the community.

Rider 57 requires HHSC to identify:

- Barriers to transitioning people from the state mental health hospital inpatient system;
- Best practices for providing step-down housing to people with complex psychiatric needs;
- Potential funding sources to continue and expand step-down services; and
- Strategies to establish step-down housing in rural or remote counties.

To complete this study, HHSC used several data sources, including interviews with state hospitals, LMHAs, LBHAs and other states' mental health authorities; consultation with HHSC subject matter experts; consultation with stakeholders, including people with lived experience of transitioning from an inpatient setting to the community; a survey of other state mental health authority systems; analysis of Texas Medicaid and state mental health system data; and consultation with national organizations representing mental health and state health policy perspectives.[1]

This study focuses on people who have experienced extended or frequent stays in a state hospital. The study includes people with a continuous inpatient stay of one year or more, and people who have repeated stays, defined as two or more admissions within the same fiscal year.

Transitioning (stepping-down) people from state hospitals is a process which begins upon admission to the hospital.

The transition process continues after discharge to ensure that people are connected to services and supports that meet their needs, reducing the probability of readmission. The process is built on an approach that is centered on people in transition by helping them to define their goals, focus on their strengths, address

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[1] The National Association of State Mental Health Program Directors and the National Academy for State Health Policy.

their needs, and bolster their capabilities. Housing, services, and supports can change over time as a person's needs, capabilities, and preferences evolve.

This report:

- Provides data regarding the characteristics of people who experience long-term or repeated inpatient stays in state hospitals;
- Describes various barriers to transitioning people from state hospitals;
- Describes best or promising practices[2] used in Texas and other states which can serve as strategies to effect successful transitions from psychiatric institutional settings;
- Identifies potential funding sources for step-down programs; and
- Describes barriers and potential strategies specific to rural and remote regions of Texas.

[2] Best practices include interventions proven to be effective through research or demonstration. Promising practices include those reported to be effective in Texas or other states.

2. Background

Population Characteristics

Most people (76 percent) who stay in state hospitals for extended periods of time[3] are men under the age of 65.[4] People served by state hospitals are diagnosed with serious mental illnesses (SMI).[5] The majority are diagnosed with psychotic or schizoaffective disorders. Some people also have chronic medical conditions requiring daily support. Others need assistance or training to execute the activities of daily living. Over 33 percent of people with long stays are African American, although African American men under age 65 represent only 12 percent of the Texas population. Conversely, Hispanic men appear to be underrepresented (21 percent), compared to the general population (39 percent).[6] Approximately 62 percent of people with long-term stays in state hospitals live in urban areas. The rest are distributed among rural or mixed urban-rural regions.[7]

Most people (74 percent) who stay in state hospitals for extended periods of time were initially admitted on a forensic commitment. Almost all forensic commitments involve people determined incompetent to stand trial (IST) for a criminal offense at the time they were committed (58 percent) [8] or those (37 percent) determined not guilty by reason of insanity (NGRI).[9] [10]

Analysis of data[11] demonstrates that the majority of long-term state hospital residents (59 percent) are discharged within three years. Regardless of whether the original reason for commitment was civil, forensic, or voluntary, approximately 30 percent are likely to remain in a state hospital for over four years. The number of people who are frequently re-admitted to a state hospital has decreased

[3] Over one calendar year.
[4] The median age is 44, the most common age is 36 and the mean age is 45.
[5] An illness, disease, or condition (other than a sole diagnosis of epilepsy, dementia, substance use disorder, or intellectual or developmental disability) that substantially impairs thought, perception of reality, emotional process, development, or judgment; or grossly impairs a person's behavior as demonstrated by recent disturbed behavior.
[6] Population size and demographic information are based on 2019 data from the US Census.
[7] For this report, rural regions are defined as regions in which all counties within the designated service area do not exceed 250,000 residents. Mixed urban-rural regions are defined as regions in which most counties within the service area are rural, but at least one county's population exceeds 250,000.
[8] The person is unable to consult with a lawyer or understand the proceedings against them.
[9] The person did not know that their conduct was wrong at the time of the offense.
[10] An additional five percent of admissions were of an undetermined type.
[11] State hospital system records for people admitted from state fiscal year 2017 to 2021.

significantly over the last four years. Several factors may contribute to this trend. Increasing numbers of people with forensic involvement may stay in facilities or on forensic waiting lists for longer periods of time, resulting in fewer readmissions to state facilities. People on civil commitments may also increasingly be referred to private psychiatric beds (PPBs) purchased by LMHAs or LBHAs.

A recent analysis of people with state hospital stays beginning in fiscal year 2020 indicated that 29 percent of people who resided in state hospitals for over one calendar year were enrolled in Medicaid.[12] HHSC is currently in the process of analyzing Medicaid services used by this population.

Please see Appendix B, Characteristics of People in State Hospitals for an Extended Period, for a population data analysis.

[12] Approximately 29 percent of the sample had Medicaid IDs and matching enrollment during the six months prior through 16 months after the first admission date.

3. Barriers

A variety of barriers can prevent people from transitioning from state hospitals and rejoining their communities. These barriers are heightened for people who are returning to rural and remote communities.[13] Common barriers identified through the data sources used for this report, include:

- A lack of transition support that actively engages and assists a person before, during, and after they transition from the hospital into their community;
- Difficulty in obtaining Medicaid coverage and federal disability-related financial benefits;
- Lack of access to medical, behavioral health, long-term care, substance use disorder, peer, and crisis services;
- Physical, behavioral health, or cognitive conditions which make the routine activities of daily living, such as managing a household or regularly taking medications, challenging;
- Untreated substance use disorders (SUDs) that are in remission in the hospital, where access to substances is restricted;
- Lack of access to safe, affordable housing and housing supports; and
- Barriers related to a person's involvement with the justice system.

Additionally, people with SMI face societal concerns and misconceptions regarding their potential to live in the community. This can make it more difficult to leave a state hospital, access housing, and obtain services in the community.[14]

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[13] Ezekiel, N., Malik, C., Neylon, K., Gordon, S., Lutterman, T., & Sims, B. (2021). Improving Behavioral Health Services for Individuals with SMI in Rural and Remote Communities. Washington, D.C., American Psychiatric Association for the Substance Abuse and Mental Health Services Administration.

[14] *The Way Forward: Federal Action for a System That Works for All People Living with SMI and SED and Their Families and Caregivers*. (2017, December). Substance Use and Mental Health Services Administration. https://store.samhsa.gov/product/The-Way-Forward-Federal-Action-for-a-System-That-Works-for-All-People-Living-With-SMI-and-SED-and-Their-Families-and-Caregivers-Executive-Summary/PEP17-ISMICC-RTC-ES

Transition Support

People discharging from state hospitals have complex needs and challenges that require supportive services, which start while the person is in the hospital and continue during and after the person transitions back into their community.

People who discharge from a state hospital into the community can face abrupt changes in services, providers, and places to live. They may be challenged by less structured environments and lack of a familiar routine. Some people may have cognitive issues, residual psychotic symptoms, and/or lack insight into their illness, and thus require more ongoing support than is normally available in the community.

Social work and medical staff at each state hospital assist people with connecting to resources in their community as part of their responsibilities, however there are only three full-time positions dedicated to transition in the state facility system. Additionally, the level of transition coordination between state hospitals and community providers, such as LMHAs or LBHAs, varies across the state due to challenges, such as staffing and resource issues. Coordination is essential to assist people in locating housing, qualifying for benefits, continuing treatment, and becoming engaged in their communities. People who live in state hospitals for extended periods of time may also lose connection with family, friends, and significant others who would normally provide informal support. Helping people establish or re-establish these connections is an important part of transition assistance.

Benefits

In Texas, Medicaid eligibility for non-elderly adults with SMI is usually linked to eligibility for federal Supplemental Security Income (SSI) disability benefits. Establishing or re-instating federal disability benefits, such as SSI or Social Security Disability Insurance (SSDI), can be a lengthy process which complicates transition. The process can last for months or years, in some cases. For example, SSI eligibility requires a disability determination from the Social Security Administration (SSA). Required documentation[15] may be difficult for a person to obtain, especially if they have not lived in their community for an extended period.

A pre-release agreement exists between the SSA and the state hospital system which allows for the federal disability benefits reinstatement process to begin

[15] Required documentation includes a driver's license, birth certificate and past medical records.

before a person is discharged from the state hospital, however local SSA offices vary in their level of coordination with state hospitals and LMHAs/LBHAs. Consequently, some people may be discharged from state hospitals before cash or healthcare benefits can be reinstated. This creates difficulty in obtaining housing, healthcare, and behavioral health supports

Concerns about losing eligibility for Medicaid can also deter people from engaging in employment or saving money to raise their standard of living. For people with previous work history, SSDI benefits can provide income and qualify a person for Medicare before age 65, although it may also disqualify them for Medicaid if their income exceeds the SSI standards.

Lack of income and healthcare coverage also impedes a person's ability to consistently access non-medical supports, such as food and shelter. These factors, known as *social determinants*, are fundamental to sustaining health in the community.[16]

Access to Services

More than 80 percent of Texas counties are designated as Mental Health Professional Shortage Areas.[17] Shortages in the community behavioral health workforce can result in long waits for service or reduced levels of service. Long-term care providers, such as home health agencies, do not usually receive specific training in working with people who are diagnosed with SMI, making it more difficult to recruit and retain qualified personal care attendants and home health aides to serve this population. Access to medical services can be difficult for similar reasons.

Access is an even greater challenge in rural or remote areas, which have fewer medical and behavioral health providers who regularly serve and understand the needs of people with SMI. Additionally, providers in these areas are located over greater distances.

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[16] Drake, R. E., & Bond, G. R. (2021). Psychiatric Crisis Care and the More is Less Paradox. *Community mental health journal*, *57*(7), 1230–1236. https://doi.org/10.1007/s10597-021-00829-2

[17] Texas Statewide Behavioral Health Coordinating Council. (2019, February). *Texas Statewide Behavioral Health Strategic Plan Update and the Foundation for the IDD Strategic Plan*. Texas Health and Human Services. www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/hb1-statewide-behv-hlth-idd-plan-feb-2019.pdf

Daily Living Skills

People with SMI can have issues with memory, attention, and executive functioning. A person can become easily distracted or have difficulty initiating activities. Long-term stays in state hospitals, in which routines are very structured and decisions are largely made with the support of medical and social work staff, can impact a person's ability to act independently in the community and to establish their sense of purpose, daily living skills, and problem-solving abilities. Challenges with daily living skills, such as maintaining one's appearance, home, finances or managing medications, can prevent people from successfully transitioning to the community.

People with a combination of chronic physical, behavioral health, and cognitive conditions (such as dementia or traumatic brain injuries), may have complicated medication regimes or treatment plans. Chronic health conditions, such as diabetes and renal disease, can require daily monitoring and intervention, which may not be readily available in the local community.

In addition, SMI can significantly impact a person's self-awareness which can compromise their ability to recognize the severity of their condition and the importance of treatment. Injectable antipsychotics, which are easier to use because they do not require daily administration, are significantly more expensive than oral medications and thus may not be available to some people who would benefit from them in the community.

Substance Use Disorders (SUDs)

SUDs are a common cause of re-institutionalization. People with SUDs do not have access to substances while in the hospital, but without SUD diagnosis and treatment, they have a significant risk of relapse after discharge. SUDs are treated in all state hospitals using an integrated approach to address psychiatric and substance use issues; however, state hospital staff report barriers, including insufficient state hospital staff to meet the inpatient demand for SUD services and insufficient or inconsistent access to treatment after discharge. SUD services can be especially challenging to access for people who do not have healthcare coverage.

Housing and Residential Supports

Texas lacks a range of housing and housing supports for people with SMI. Finding suitable, affordable community housing is a significant challenge. Housing resources can be complex and time consuming to navigate.

Texas has over 400 local Public Housing Authorities (PHAs) who can set their own tenant selection criteria, though HUD has articulated general guidelines for PHAs to follow.[18] Additionally, some landlords may be reluctant to house people leaving state hospitals due to societal misperceptions and concerns regarding mental illness.

State facility staff may be unaware of how to access community-based alternatives to institutions and consequently seek nursing facility placement for people discharging with medical comorbidities. Nursing facilities, which are not typically designed to support people with mental illness, often decline to admit people with a history of long-term commitment. This is particularly true for people with a history of aggression or those with a previous forensic commitment, regardless of their current level of risk. People leaving state hospitals, who are usually under age 65, may not prefer living in nursing facilities.

People leaving state hospitals after long or repeated stays require varying levels of residential services and supports integrated with housing. Levels of support could range from HCBS for people living independently in homes and apartments to group homes and other congregate living arrangements staffed to provide services 24 hours a day. Texas does not currently have statutes, rules, or licensing standards defining community-based group settings specifically for people diagnosed with mental illness.[19]

Rural and low-income urban areas may lack transportation or amenities, such as grocery stores, pharmacies or medical services near residences available to people with SMI, making it difficult for them to keep medical appointments, access medications, build social supports, or maintain good nutrition. People may have to relocate to areas distant from friends and family to obtain medical, behavioral health, and other services.

People in recovery from mental illness can sometimes experience psychiatric crises, which result in readmission to inpatient hospitals. Community-based crisis programs, which provide extended observation, respite, residential, and/or stabilization services, can be effective in addressing the crisis and averting readmission but are not consistently available throughout Texas.

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[18] *Public Housing Occupancy Guidebook - Waiting List and Tenant Selection*. (n.d.). US Department of Housing and Urban Development. https://www.hud.gov/sites/dfiles/PIH/documents/PHOG_Waiting_List_Chapter.pdf

[19] *Housing Choice Plan. (2022, May). Health and Human Services Commission. https://www.hhs.texas.gov/sites/default/files/documents/housing-choice-plan-report.pdf*

Rural and Remote Areas

Barriers are heightened for people returning to rural and/or remote areas. These include:

- Distance from other people, contributing to social isolation;
- Difficulties in finding and keeping connection with behavioral health, long-term care, and physical medicine providers;
- Lack of employment and educational opportunities;
- Distance to needed services and fewer transportation options;
- Lack of available, accessible, and/or affordable housing;

Reduced likelihood of people seeking mental health services due to limited anonymity in small communities; and

- Limited access to broadband and telephone service, which restricts potential use of telemedicine/telehealth services.

These barriers can contribute to repeated stays in state hospitals or in private hospital beds purchased by LMHAs and LBHAs. People from rural and mixed urban-rural areas represent over 38 percent of the long-term state hospital population and over 50 percent of frequent stays in purchased PPBs[20] (See Appendix B, Characteristics of People in State Hospitals for an Extended Period).

Barriers Related to Criminal Justice Involvement

People who are forensically committed by criminal courts experience additional obstacles in discharging and successfully returning to the community.

People found IST who are likely to regain competency in the foreseeable future enter hospitals on forensic commitment with a restoration period defined in statute.[21] For people who are not restored during the initial commitment and meet civil commitment criteria, courts may order a subsequent forensic commitment[22] that extends their commitment beyond the restoration period in the initial forensic

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[20] Rural regions are defined as regions in which all counties within the designated service area do not exceed 250,000 residents. Mixed urban-rural regions are defined as regions in which most counties within the service area are rural, but at least one county's population exceeds 250,000. Population size is based on 2019 Census Data.
[21] Texas Code of Criminal Procedure, Article 46B.073
[22] Texas Code of Criminal Procedure, Article 46B.102

commitment. Under these commitments, the criminal court retains jurisdiction as charges are still pending and must also approve of discharge from the state hospital. People under these commitments may therefore experience longer inpatient stays due to judicial concerns regarding public safety or discharge plans.

A similar barrier to discharge exists for people found NGRI. People found NGRI are acquitted of the charged offense.[23] However, if the charged offense involved dangerous conduct, the criminal court oversees commitment for evaluation of mental health proceedings and retains authority to order the commitment of the person for inpatient mental health services for the maximum term provided by the law for the charged offense. Although the courts have the authority to order outpatient services for people found NGRI on forensic commitment, they may be reluctant to provide such orders due to concern for public safety. The court must also approve discharges from an inpatient facility. On the clinical side, the treatment team may be reluctant to support discharge for certain forensic patients due to limited step-down placement options in the community. For some people, the seriousness of their charge(s) precludes housing placements.

Additionally, limited access to or availability of evidence-based, community-based mental health services and supported housing for justice-involved people can influence a clinician's or judge's decision pertaining to the discharge of long-term residents of the state hospital system. The treating physician must provide a continuity of care plan prior to discharging someone from the state hospital.[24] If appropriate and timely services are not available in the community, the physician may decline to discharge the person back to the community.

Barriers to discharge experienced by people with criminal justice involvement also relate to the stigma associated with justice involvement, limited availability of safe and stable community-based services and supports, lack of housing which serves justice-involved people. There may also be insufficient collaboration between mental health treatment providers and justice professionals, such as attorneys and judges, to guide effective discharge planning.

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[23] Texas Code of Criminal Procedure Article 46C.155,
[24] Health and Safety Code, Chapter 574, Subchapter F

4. Best Practices

This section includes best or promising practices reported in Texas and other states, which inform key strategies for successfully transitioning people from psychiatric and other institutional settings. Transition efforts reviewed include the Texas State Supported Living Centers (SSLC) transition process, the Texas State Hospital Transition Pilot program, general state hospital transition process, the Texas Money Follows the Person (MFP) Behavioral Health Pilot, the HCBS- Adult Mental Health (AMH) program, and transition efforts in New York State, Ohio, New Jersey, Georgia, Tennessee, Maryland, Louisiana, New Hampshire, and other states.

Further detail on other states' transition programs and practices can be found in Appendix C, Transition Programs in Other States, and Appendix D, State Mental Health Authority Survey.

Transition Support

Transition programs, which help people step-down from state hospitals to the community, require support. Dedicated transition teams are a key element of successful institutional transition programs. Transition teams engage a person up to six months prior to the person's anticipated discharge and continue to support a person in the community for one year or more after discharge. Transition teams help a person build the skills needed to live more independently in the community; establish therapeutic relationships that continue into the community; provide SUD assistance and treatment, when needed; and facilitate the transfer of care to community mental health and SUD programs. In addition, providing a clear point of accountability with defined system-level evaluation and performance measures ensures transition efforts happen consistently across the state.[25] Systematic data collection and reporting supports performance measurement.

Transition teams identify housing options, assist with benefits enrollment or re-instatement, connect people to needed services, and help people realize goals, such as gaining employment. Teams usually include, or regularly consult with, specialists in peer services, housing, benefits, employment, and SUD treatment. They are

[25] New Jersey, for example, employs a director at the state office level who performs transition efforts and performance duties.

adequately resourced to support people with complex needs or criminal justice involvement (e.g., small caseloads with access to medical or nursing consultation).

Transition teams should include both state hospital staff and a locally based component that focuses on specific regions/catchment areas of the state. This focus allows the team to know and coordinate effectively with local resources.

Texas is a large state with inpatient capacity spread across vast geographic regions. Consequently, people may be committed to hospitals distant from their home communities. Virtual technology (video and telephonic) is necessary to effectively coordinate state and local transition team communications and introduce the person transitioning to community resources. For example, virtual reality technology, as piloted in HHSC's "Take Me There"[26] project for people with intellectual and developmental disabilities (IDD), introduces people in transition from an SSLC to potential housing options, enables them to meet residential staff and connect with future roommates prior to discharge.

Transition teams may be managed by the state, with local mental health system involvement, or managed locally, with state oversight and assistance. Variations of teams have been used in successful programs including the Texas SSLC transition process, and states including New York, New Jersey, Georgia, and Tennessee.

The Texas SSLC transition process[27] locates community providers in a person's preferred geographic location, schedules visits and tours of a person's potential housing options and providers, meets with a person's interdisciplinary team to identify barriers, and assists with moving day activities. The team is managed by the state in close coordination with local intellectual and developmental disability authorities. Further detail on the Texas SSLC transition process can be found in Appendix E.

The Texas State Hospital Transition Pilot Program is designed to integrate and test best practices to step-down/transition people with complex psychiatric and/or medical needs from inpatient state hospital settings to more appropriate community-based settings. The Pilot includes a transition team, pre and post discharge services and short term (less than one year) transitional housing. The LMHA/LBHA conducts a needs assessment prior to discharge to identify pre-

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[26] *Take Me There Virtual Reality Tours.* (n.d.) Texas Health and Human Services. www.hhs.texas.gov/services/disability/intellectual-or-developmental-disabilities-idd-long-term-care/state-supported-living-centers-sslcs/take-me-there-virtual-reality-tours
[27] Data from fiscal year 2011 through 2021 shows a 5.8 return rate within 365 days of community placement.

transition supports required to help bolster a person's potential for success in the community.

Through collaboration between the LMHA/LBHA and state hospital clinicians, the person receives pre-transition supports, such as training and assistance with activities of daily living, self-management of medication regimes for physical health conditions such as diabetes, and plans for connections in the community, such as potential employment or volunteering opportunities. This small pilot has achieved promising results in transitioning people to the community to date. Clarifying specific criteria for accepting people into the pilot would further improve coordination between state hospitals and community providers. Independent evaluation of pilot outcomes could provide useful data for future policy directions. The pilot is currently funded through federal grants, including the Mental Health Block Grant (MHBG), MFP Demonstration, the American Rescue Plan Act (ARPA), and state general revenue funds. If shown to be a successful model, sustainable funding sources will need to be identified to sustain and expand the program to more sites. More information on this pilot can be found in Appendix F.

The Texas HCBS-AMH program includes recovery management services for those eligible.[28] The recovery manager assists the person before, during and after transition, participating in predischarge planning; helping the person define their goals, needs and preferences; introducing the person to the community; coordinating with the person and state hospital social work team to start the process of obtaining Medicaid; and assisting people in accessing HCBS-AMH and community resources. State facility staff report that recovery management is effective in facilitating transition, especially when the recovery manager is highly engaged with facility staff in predischarge meetings. More information on AMH can be found in Appendix C.

Person-centered planning (PCP) is the engagement strategy of choice to support people throughout the transition process. Person-centered planning is an individualized process which helps a person to articulate goals from their own perspective, which motivates people to actively participate in achieving those goals. Evidence-based engagement strategies, such as motivational interviewing, help ensure the person's perspective is paramount. HHSC encourages person-centered practices and is working with the Texas Institute for Excellence in Mental Health at UT Austin to assess and refine support for PCP in the State's mental health system.

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[28] Texas Health and Human Services Commission. (2022, July). *Home and Community-Based Services - Adult Mental Health Provider Manual*. https://www.hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/hcbs-amh/hcbs-amh-provider-manual.pdf

Tennessee's Move[29] initiative engages people residing in subacute facilities in Wellness Recovery Action-Planning, a peer-led process, before they transition. The person-centered plan is initiated prior to discharge, reviewed at discharge, and is updated periodically thereafter. It evolves with the person's interests and needs.

The person-centered approach informs program development across many states, including New York, Illinois, and Texas. Illinois includes personalized benefits counseling, rapid job search and integration of mental health services in its program.

Employment is a goal for many people in transition. States, including Texas, generally endorse evidence-based, person-centered models for employment services. Individual Placement and Support (IPS) is an evidenced-based practice to support individuals with diagnosis of SMI in obtaining and retaining competitive employment. It includes personalized benefits counseling, rapid job search, and integration of mental health services.

HHSC has successfully piloted mental health self-direction, an engagement strategy which provides people with more choice and control over how to implement their person-centered recovery plan in the community. Randomized trials in Texas demonstrated that people who self-direct mental health services with the assistance of a trained advisor were more engaged in their recovery and had improved recovery outcomes at no greater cost than traditional care.[30] [31] HHSC is exploring how mental health self-directed services might potentially be offered in the state's Medicaid program in the future.

Some people who have lived in state hospitals for an extended period may have significant concerns about leaving the hospital campus. Short-term campus-based programs are sometimes used to help people transition from an acute care setting and prepare them to return to their community. These programs typically provide people with services and a familiar place to live for several months while they practice community living skills, apply for benefits, connect with community

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[29] *Tennessee Move Initiative*. (n.d.). Tennessee Voices. tnvoices.org/programs/tennessee-move-initiative/

[30] Cook, J. A., Shore, S., Burke-Miller, J. K., Jonikas, J. A., Hamilton, M., Ruckdeschel, B., Norris, W., Markowitz, A. F., Ferrara, M., & Bhaumik, D. (2019). Mental Health Self-Directed Care Financing: Efficacy in Improving Outcomes and Controlling Costs for Adults with Serious Mental Illness. *Psychiatric Services*, *70*(3), 191–201. https://doi.org/10.1176/appi.ps.201800337

[31] Bohman, T., Lodge, A., Peterson, L., & Stevens Manser, S. (2020). My Voice My Choice: Self-Directed Care Final Study Report. Texas Institute for Excellence in Mental Health, University of Texas at Austin Steve Hicks School of Social Work.

resources, and obtain housing. State hospital services and staff are available to support the person, if needed. This option may also be particularly beneficial for people who are criminal justice involved as it allows people's progress to be directly observed. The ability to directly observe progress may reassure physicians and judges that a person admitted through a forensic commitment is ready to live in the community. Maryland's Segue[32] program is an example of incorporating this practice. Additionally, Texas HHSC is developing a plan to establish a step-down pilot program at SSLCs for persons leaving state hospitals.[33]

Short-term residential programs function best when community housing choices are available. The State of New York's inpatient psychiatric centers were originally intended to provide short-term transitional housing from acute psychiatric care. These centers became de-facto long-term institutions because the state had not developed a continuum of community supported housing options. The state subsequently developed these options and worked successfully to move people from long-term residence in step-down facilities to the community.[34]

Comprehensive site-based community programs for people with SMI who are experiencing homelessness, such as the Harris Center's Respite, Rehab, and Re-Entry[35] center and San Antonio's Haven for Hope Transformational Campus,[36] both in Texas, also demonstrate promising practices that might be adapted to help people transition from state hospitals into the community. Such programs provide an array of supports and connection to community resources in a single location. Examples of supports might include forensic diversion and transition services, transitional and supportive housing, benefits counseling, behavioral health services, health services and financial counseling.

Another strategy to ease transition is allowing people to try community living without being discharged from the hospital. Tennessee allows people to try out

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[32] *Segue Residential Transition Program*. (2022). Sheppard Pratt. www.sheppardpratt.org/care-finder/crisis-residential-program/segue-residential-transition-program/

[33] As required by the 2022-23 General Appropriations Act, S.B. 1, 87th Legislature, Regular Session, 2021 (Article II, HHSC, Rider 100)

[34] Tashjian, M. (2018) *The NYS OMH Partnership Model: Collaborating to establish a continuum of supports and services. National Academy for State Health Policy Annual Conference*
Interview with NY Office of Mental Health (2020)

[35] *The Respite, Rehabilitation, and Re-Entry Center*. (n.d.). The Harris Center for Mental Health and IDD. https://www.theharriscenter.org/Services/Our-Services/The-Respite-Rehabilitation-and-Re-Entry-Center

[36] *Haven for Hope*. (n.d.). Haven for Hope. www.havenforhope.org/

community living while on furlough from state facilities, a strategy which Texas is piloting through its HCBS-AMH program.

Obtaining Benefits

In successful state transition programs, benefits specialists coordinate with SSA and other resources to ensure that federal disability benefits and Medicaid are obtained and retained.

Specialized staff work with SSA, state Medicaid programs, insurance exchanges and other resources to ensure timely receipt of disability benefits and health coverage. The Substance Abuse and Mental Health Services Administration's (SAMHSA's) SSI/SSDI Outreach, Access, and Recovery (SOAR)[37] program provides technical assistance and training for case managers in effectively accessing federal disability benefits for people with behavioral health conditions. Some states, such as Tennessee, offer bridge funding for people who are transitioning into the community that can be used to pay for medication and other services.[38] Bridge funding can help people to live in the community, instead of a state hospital, while they wait for their benefits to start or re-start.[39] Transition teams may include or have access to staff certified by SSA as Community Work Incentives Coordinators (CWICs) who provide counseling to people wanting to work to help them retain benefits, such as Medicaid.[40]

The federal Achieving a Better Life Experience (ABLE) Act of 2014 enables states to create programs which allow people with mental or physical disabilities present before age 26 to accumulate savings that can be used to pay for qualified disability-related expenses without losing their Social Security (SSI, SSDI) or Medicaid benefits. The Texas ABLE program allows people to save up to $16,000 per year and maintain up to $100,000 in their account without losing their benefits.[41]

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[37] Substance Abuse and Mental Health Services Administration. (n.d.). *What is SOAR? | SOAR Works!* Substance Abuse and Mental Health Administration. soarworks.samhsa.gov/content/what-soar

[38] *Targeted Transitional Support*. (n.d.). Tennessee Department of Mental Health and Substance Abuse Services. https://www.tn.gov/behavioral-health/housing/ctts-itts.html

[39] HHSC does not offer bridge funding but state hospitals do provide a limited supply (typically 7-14 days) of prescription medications to help people transition to community mental health services.

[40] *The Work Site - Work Incentives Planning and Assistance*. (n.d). Social Security Administration. www.ssa.gov/work/WIPA.html

[41] Texas ABLE is administered by the Texas Prepaid Higher Education Coordinating Board with assistance from the Texas Comptroller of Public Accounts. For more information on the Texas ABLE program, refer to https://www.texasable.org/.

Accessing Services

Health and Long-Term Care Services

New York includes registered nurse consultation on its transition teams and has developed partnerships with home health agencies throughout the state to provide community-based medication management, personal care, and chronic care.

Telehealth can also help people, access medical, SUD, and behavioral health services, especially those in rural areas. Virtual or in-person psychiatric, nursing, and medical consultation before and after discharge can help ensure continuity of care. Virtual technology has been used by Texas public behavioral health providers in the past on a limited basis. Use of virtual technology to provide services expanded significantly in the HHSC's behavioral health and Medicaid systems during the public health emergency, which affords health and behavioral health providers greater flexibility to use virtual technology. HHSC is currently evaluating services to determine whether virtual delivery methods are cost-effective and clinically appropriate. Certain Medicaid and CHIP services may be delivered using telemedicine, telehealth, and audio-only methods on an ongoing basis. This includes services that have been made available through telemedicine, telehealth, and audio-only methods during the COVID-19 public health emergency (PHE) as well as other services.[42]

Technical assistance and training in supporting community transitions can be provided through university partnerships. University of Texas Health San Antonio's (UTHSA's) International Center of Excellence for Evidence Based Practices (COE) offers in-person and virtual training and technical assistance including MCOs, behavioral health providers and long-term service providers on how to support people with SMI to transition into the community from institutions, such as nursing facilities. The COE's training and technical assistance activities are currently funded through HHSC under the federal MFP Demonstration.

SUD Services

Assessing people for SUD before discharge, starting treatment in the hospital and continuing treatment in the community is a best practice. The Texas MFP – Behavioral Health Pilot (BHP), which operated from 2008 through 2017, included

[42] https://www.hhs.texas.gov/services/health/medicaid-chip/provider-information/medicaid-chip-teleservices

transition teams that provided SUD assessment in the nursing facility, initiated treatment up to six months before discharge and continued treatment for a year in the community before warm handoff to community programs. Although only two percent of BHP participants were identified with SUD by facilities,[43] 30 percent of BHP participants were assessed and treated for SUD through the pilot. People often had multiple SUD diagnoses and over 80 percent assessed also used tobacco. Services included counseling, peer support, and connection to community groups. Treatment included adaptive strategies to help people with cognitive issues curb impulsive behavior and reduce use of substances.[44] Further information on the MFP BH pilot can be found in Appendix G, MFP Behavioral Health Pilot.

Home and Community-based Services (HCBS)

Programs developed through Medicaid HCBS state plan amendments authorized under Section 1915(i) of the Social Security Act can provide people with SMI access to services not typically available to the community. Texas' HCBS-AMH program includes a broad array of services for adults with SMI in addition to behavioral health services. These include recovery management, adaptive aids, assisted living, host home companion care, supervised living, supported home living, employment services, home delivered meals, minor home modifications, transition assistance, flexible funds, counseling, psychosocial rehabilitation, nursing, peer support, respite services, SUD services, and transportation. Since 2016, the program has served 624 people in Texas.

State hospital staff report that, where available, HCBS-AMH has been effective in transitioning and supporting people with long-term hospital stays to live in their communities. Eighty-three percent of people with long-term psychiatric hospital experience enrolled in HCBS-AMH did not have a subsequent hospital admission after enrolling in the program. People enrolled in HCBS-AMH also report high levels of satisfaction. [45] HCBS-AMH also has some limitations, which could be addressed to make it more accessible to people in transition.

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[43] Previous substance use may not be known to facility staff and people have less access to substances while in nursing facilities. As a result, SUDs may be less often observed and documented by facilities.
[44] Bohman, T., Bradley, J., & Wallisch, L. (2016). Money Follows the Person- Behavioral Health Pilot, Year 4 Evaluation: Final Report. The Addiction Research Institute of the Center for Social Work Research, University of Texas at Austin.
[45] IDD-BHS Office of Decision Support

Further information on HCBS-AMH and potential changes that could be made to the program can be found in Appendix C.

Peer Services

Peer support services are a primary strategy for transition efforts in states such as Georgia and New York. Peer support provides the invaluable perspective of people in recovery who have lived experience of SMI and specialized training. Peer specialists promote recovery and resilience by offering emotional support, sharing knowledge, teaching skills, providing practical assistance, and connecting people with resources, opportunities, and communities of support.

Some states encourage involvement in community-based peer organizations, such as mental health clubhouses and recovery community organizations, to facilitate community integration. In the Peer Bridger model, used in states like New York, peer specialists connect with people prior to discharge and continue to support them in their community. The Texas HCBS-AMH program provides peer services, which can be used to help participants integrate into their communities.

Recovery Support Services (RSS) is an evidence-based practice that provides support from peer specialists for alcohol or drug problems, including co-occurring mental health disorders. There are 23 RSS sites across Texas that could be leveraged to do more extensive in-reach and collaboration with state hospitals and their peer support staff for pre-discharge planning. Additionally, online resources such as PeerForce Texas[46] provide support for peer specialists.

Crisis Services

People who have transitioned to the community may occasionally need short-term crisis services. HHSC funds community-based and institutional crisis services across Texas. Crisis services are available 24 hours/7 days a week and include prompt face-to-face crisis assessment, crisis intervention services, crisis follow-up and relapse prevention services.[47]

Crisis residential, respite, or stabilization services can help divert people from unnecessary hospitalizations or involvement with the criminal justice system.

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[46] *PeerForce – Supporting the Peer Workforce*. (n.d.). PeerForce. peerforce.org
[47] *HHSC Crisis Services Guide*. (2020, December). Texas Health and Human Services Commission. https://www.hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/improving-services-texans/hhsc-crisis-services-guide.pdf

Additionally, peer-run crisis respite models, such as the Texas P.E.E.R.S[48] for Hope House, can be a powerful tool in supporting people who do not wish to engage with traditional provider-run services.

Managing Daily Activities

Daily living skills are required to perform activities such as managing one's household, hygiene, finances, appointments, and medications. Improving these skills is a core strategy for successful transition. The Texas MFP-BHP successfully used Cognitive Adaptation Training (CAT), an evidence-based rehabilitative practice, to help people with a combination of SMI, SUD, and significant physical comorbidities transition from nursing facilities to the community.[49] CAT enabled people to achieve sustained improvements in a range of daily living activities and in medication self-management. HHSC is working with UT Health San Antonio to expand and sustain CAT and other successful MFP techniques in the state's Medicaid system. CAT was also used in a three-year MHBG funded pilot project which transitioned people from San Antonio State Hospital (SASH) to the community. Additional information on the Money Follows the Person-Behavioral Health Pilot can be found in Appendix G.

Some people require more assistance in managing some or all of their daily affairs, such as making decisions about their homes, finances, and/or medications. Potential options for helping people make decisions include supported decision-making agreements, money management programs, representative payee relationships, power of attorney, or guardianship. The option used depends on the person's needs and capabilities.[50] Supported decision-making agreements can provide an informal, less restrictive alternative to guardianship for some people. Texas was the first state to pass a law establishing supported decision-making as an alternative to guardianship.[51] [52]

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[48] Person-centered, Engaging, Empowering, Recovery-oriented Support

[49] Bohman, T., Bradley, J., & Wallisch, L. (2016). Money Follows the Person- Behavioral Health Pilot, Year 4 Evaluation: Final Report. The Addiction Research Institute of the Center for Social Work Research, University of Texas at Austin.

[50] A Texas Guide to Adult Guardianship (n.d), HHSC. https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/legal-information/guardianship/pub395-guardianship.pdf

[51] *Guardianship. (n.d.).* Office of the Texas Governor. https://gov.texas.gov/organization/disabilities/guardianship

[52] Supported Decision-making (n.d.), Disability Rights of Texas. https://www.disabilityrightstx.org/en/category/supported-decision-making/

Housing

States, including Texas, generally encourage permanent supportive housing—which pairs housing with case management and supportive services—and may incorporate Housing First principles in their service system. The Housing First approach provides housing and housing support services to a person without preconditions, such as sobriety, treatment, or service participation requirements.[53] Housing First addresses many housing-related barriers faced by people discharging from state hospitals, such as removing housing pre-conditions, poor credit history and prior justice involvement. This model is specific to scattered site[54] and project-based apartments and rental properties.

Some people need varying levels of additional residential supports on a short or long-term basis, which may be provided in small group homes in the community. States such as Ohio and Georgia formally define and regulate structured housing options, such as group homes, to ensure consistency and quality. Ohio licenses different categories of group homes, providing different levels of service and allows people to move with their subsidy between each category of home, based on their changing needs and preferences. Homes are licensed by the state and periodically inspected by surveyors. Surveyors are also responsible for providing technical assistance and coordinating with local mental health boards. See Appendix H for more information on Ohio's group home categories.

Several states directly invest in community housing. New Jersey[55] and New York[56] reinvest state funds formerly used to fund more restrictive settings into community-based housing options. Pennsylvania invests in residential options

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[53] United States Department of Housing and Urban Development. (2014, July). *Housing First in Permanent Supportive Housing*. https://www.hudexchange.info/resource/3892/housing-first-in-permanent-supportive-housing-brief/
[54] Rental housing developments or projects that span multiple properties or units
[55] Division of Mental Health and Addiction Services. (2016, July). *Medically Enhanced Supportive Housing and Community Support Services for Individuals Discharged from State Psychiatric Hospitals Request for Proposals*. State of New Jersey Department of Human Services.
https://nj.gov/humanservices/providers/grants/rfprfi/RFPfiles/Medically%20Enhanced%20Supportive%20Housing%20And%20Community%20Support%20Services%20For%20Individuals%20Discharged%20From%20State%20Psychiatric%20Hospitals%20RFP.pdf
[56] *Office of Mental Health Transformation Plan*. (2022). New York State Office of Mental Health. https://omh.ny.gov/omhweb/transformation/

ranging from conventional single-family residences and apartments to small group homes with more intensive services and supports available onsite.[57]

People moving into houses or apartments from state hospitals may require assistance with transition costs, including utility deposits and household goods. States provide transition assistance through Medicaid HCBS programs or through state/local funds for those not Medicaid eligible. For example, the Texas HCBS-AMH program provides transition assistance. Additionally, the Supported Housing Rental Assistance offered at some LMHAs and LBHAs provides utility and security deposits, temporary rent subsidies and funding to pay for move-in costs for people with a mental illness who are homeless or at risk of becoming homeless.[58]

Nursing facilities are not a primary strategy for housing people with SMI because they are not specifically designed to support mental health recovery, may not meet Americans with Disabilities Act requirements to provide choice [59] and would not be eligible for federal Medicaid funds, if the majority of their residents were institutionalized due to mental illness.

Additional training and technical assistance for nursing facilities is important to support mental health recovery when people with high medical needs chose to reside in them. New York provides technical assistance to skilled nursing facilities who serve medically fragile people with SMI through its teleECHO project. Federal HHS is also establishing a national center of excellence, which will work to strengthen behavioral health care in long-term care facilities.

Addressing Justice Involvement

Strategies to address discharge barriers experienced by people forensically or civilly committed to the state hospital system include:

- Enhanced stakeholder education initiatives; and

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[57] Department of Human Services. (n.d.). *Supportive Housing*. Pennsylvania Department of Human Services. https://www.dhs.pa.gov/Services/Mental-Health-In-PA/Pages/Supportive-Housing.aspx

[58] *Programs for People who are Homeless or at Risk of Becoming Homeless | Texas Health and Human Services*. (2022). Texas Health and Human Services Commission. https://www.hhs.texas.gov/services/mental-health-substance-use/mental-health-crisis-services/programs-people-who-are-homeless-or-risk-becoming-homeless#:%7E:text=Supported%20Housing%20Rental%20Assistance%20Program,payments%20and%20move%2Din%20costs.

[59] *Olmstead v. LC* (AKA The Olmstead Decision) is a 1999 United States Supreme Court decision based on the Americans with Disabilities Act. The Supreme Court held that people with disabilities have a qualified right to receive state-funded supports and services in the community rather than institutions.

- Increased and diversified funding for evidence-based interventions for justice-involved people in community settings.

Stakeholder education initiatives provide the state opportunities to share resources with judges, attorneys, clinicians, family members, and justice-involved people to improve awareness and understanding of available resources and current best practices in the treatment of justice-involved people with complex medical and psychiatric needs.

Recently, HHSC collaborated with the Texas Judicial Commission on Mental Health to create the *Eliminate the Wait* Toolkit[60] designed to provide courts, police, jailers, and mental health providers strategies to divert people with behavioral health concerns from the justice system. A similar toolkit for stakeholders involved in the care of justice-involved people on forensic commitments may improve the transition from the hospital to the community.

Initiatives that strengthen stakeholder relationships provide additional value by promoting active and ongoing problem-solving at the community level. HHSC offers technical assistance and strategic planning support to counties throughout the state through Sequential Intercept Model (SIM) Mapping Workshops and learning collaboratives. SIM Mapping Workshops bring together local justice and behavioral health system stakeholders to document how people with mental illness and substance use disorders encounter and move through the justice system and design action plans to promote diversion, support reentry, and address gaps in services.

Increased investment in evidence-based practices designed to meet the unique needs of justice-involved people can help to minimize the perceived risk of harm to self or others after a forensic commitment.

Rural and Remote Areas

States such as Ohio and New Hampshire have developed successful transition programs in rural areas. New Hampshire has piloted four Recovery Oriented Step-Up/Step-Down programs that are entirely peer-operated and designed for up to 90-day stays.[61]

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[60] Texas Judicial Commission on Mental Health & Texas Health and Human Services Commission. (2021, October). *Eliminate the Wait - The Texas Toolkit for Rightsizing Competency Restoration Services*. Texas Health and Human Services Commission. https://www.hhs.texas.gov/sites/default/files/documents/eliminate-the-wait-toolkit.pdf

[61] https://www.nhpr.org/nh-news/2021-09-07/new-peer-run-mental-health-program-aims-to-reduce-vicious-cycle-of-recurring-hospitalizations

Increasingly, states leverage telemedicine and telehealth services. Vermont's Pathways Programs uses a Housing First model that provides scattered site housing with telemedicine and telehealth support.[62] LMHAs and LBHAs in rural Texas have benefited from pandemic-related flexibilities, which allow audio-visual and audio-only service delivery. House Bill 4 (87th Legislature, Regular Session, 2021) requires that HHSC permanently allow Medicaid reimbursement for telemedicine, telehealth, and audio-only service delivery methods if they are clinically appropriate and cost-effective. HHSC is also exploring similar flexibility for general revenue funded behavioral health services.

UTHSA's Behavioral Wellness Clinic (Be Well Texas) offers on-demand telemedicine services, including medication management, counseling, medication assisted treatment, peer support, and case management for people with SUD and SMI.[63] Services are available to anyone in Texas, regardless of their ability to pay. The Be Well Texas clinic primarily serves people with co-occurring SMI and SUD but could serve as a model for assisting people in transition from state facilities.

Another complementary approach is to build the capacity of primary care providers to support people with SMI. Through its Project Extension for Community Healthcare Outcomes, the Texas A&M Health Science Center is developing tele-mentoring communities of subject matter experts to reach primary care providers. One of the project's goals is to strengthen the capacity of rural mental health and SUD providers.[64] Models such as Certified Community Behavioral Health Clinics (CCBHCs) and co-located mental health and community health clinics can help make primary care resources more accessible in rural areas. Texas Medicaid recently implemented a policy to reimburse services within the Collaborative Care Model, which integrates treatment for mental health and substance use into primary care settings.

Community partnerships in Texas, such as Bastrop County Cares, leverage collective knowledge and resources across public, private, faith-based, non-profit organizations and community members, including people with lived experience. These partnerships can identify formal and informal supports for people in rural and remote communities.

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[62] Pathways Vermont (n.d.) accessed at: https://www.pathwaysvermont.org/
[63] New Hampshire Department of Health and Human Services. (n.d.). *Peer Support Agencies*. www.dhhs.nh.gov/dcbcs/bbh/peer.htm
[64] Project Echo: Extension for Community Health Outcomes, TAMU (ND) accessed at: https://health.tamu.edu/echo/index.html#:~:text=Texas%20A%26M%20Health%20utilizes%20the,rural%2C%20military%20and%20underserved%20populations.

Some rural LMHAs in Texas cultivate relationships with local landlords to identify affordable housing for people with SMI. Anderson Cherokee Community Enrichment Services (ACCESS) has a small team including clinicians, case managers, and a benefits coordinator who maintain strong relationships with landlords in their community. When housing issues arise for people receiving services, the ACCESS team partners with landlords to resolve them.

Developing a strong peer support network can help alleviate the feeling of isolation and stigma a person with SMI may experience, especially in small or rural communities where anonymity is decreased. Peer based virtual support groups are offered by Texas-based Recovery Community Organizations and Consumer Operated Service Providers. Virtual support groups and peer training are also offered by organizations such as the National Alliance on Mental Illness.

Evaluation and Oversight

Successful transition efforts include a clear point of accountability with well-defined measures supported by a data system that tracks and reports performance data. New Jersey employs a director for transitions at the state office level whose performance is assessed regularly. HHSC collects, analyzes and reports data on community and facility services but does not currently have a transition performance reporting and management system.

5. Potential Funding Sources

States primarily rely on federal and state funding sources to finance transition of people from long-term state hospital stays into the community. Financing strategies to enable people to transition from a state hospital must address the following elements:

- Transition, including transition teams and related services;
- Housing;
- Services in the community - including medical, behavioral health, prescription drug, rehabilitative, long-term care, peer, crisis and other services, as needed;
- Hospital services, when needed; and
- Program administration.

State funding is sometimes needed to bridge the gap until federal disability benefits and Medicaid eligibility are established, since the SSA eligibility process can be lengthy. The HCBS-AMH program uses general revenue funding to enable people to obtain services while awaiting benefits.

Application for benefits or reinstatement of benefits can begin well before a person leaves the institution to minimize or eliminate gaps in coverage. SSA operating procedures include an expedited reinstatement process that can be used to reinitiate benefits for some people.

Transition

Pre-transition services are not currently covered by Medicaid because federal Medicaid statutes exclude Medicaid coverage of services for people under age 65 while they are in in an institution for mental disease. According to the Centers for Medicare & Medicaid Services (CMS), pre-transition services could potentially be considered as a limited (30 day) benefit under the relatively new research and demonstration waiver opportunity for people with SMI. Additionally, Texas recently obtained approval from CMS under the federal MFP Demonstration grant to test pre-transition services in a pilot designed to help adults who qualify for a nursing facility level of care move from state hospitals to the community using Medicaid managed care HCBS, instead of seeking nursing facility placement.

State general revenue currently remains the primary source of funding for pre-transition services. Some states, such as Tennessee, provide state-funded payments to MCOs while the person is hospitalized to ensure continued access to services and more seamless community transition.

Transition teams could potentially be funded through a combination of general revenue, local funds, and Medicaid administrative and/or service funding.

Housing

States with well-established transition programs invest in residential options. States may employ federal, state, and local resources to defray rental or leasing costs. People moving into community housing from a state hospital may require assistance with transition costs, including utility deposits and household goods which states can fund through Medicaid HCBS state plan amendments, as in HCBS-AMH. State or local funds can be used for people who are not eligible for Medicaid.

Single family residences, such as homes and apartments, may qualify for federal assistance. HHSC has a long-standing partnership with the Texas Department of Housing and Community Affairs (TDHCA) to leverage federal HUD benefits and is working with the Texas State Affordable Housing Corporation to expand housing options for people with SMI. Some local public housing authorities in Texas give priority to people with SMI.

States and local communities sometimes use a process, called "bridging," which allows a person to be housed immediately using non-federal or short-term funding sources while they wait for a federal housing subsidy, which may take months to be approved. In Texas, both Supportive Housing Rental Assistance (state funded) and Tenant-Based Rental Assistance (federally funded, short-term assistance through TDHCA) have been used by LMHAs/LBHAs and other housing providers to bridge people into permanent federally subsidized housing. Tenancy supports to assist people in obtaining and maintaining housing could potentially be funded through an amendment to the Texas 1115 Medicaid Transformation Waiver, as they are in some other states. Tenancy supports enable activities, such as advocacy and dispute resolution, that are not possible through existing state plan options, which are limited to direct interaction with the person receiving services.

Louisiana's permanent supported housing program prioritizes people exiting institutions and those at risk by virtue of previous institutional stays for housing vouchers. They are awarded "preference points" which raise their position on the waiting list. A complex care code is used in Louisiana to provide higher Medicaid

reimbursement to Community Psychiatric Support teams and mental health rehabilitation providers who are trained and certified by the state to provide tenancy supports.[65] Efforts to stimulate development of more affordable, accessible, and safe housing also include private sector initiatives. Amerigroup and United Healthcare, MCOs which serve Medicare and Medicaid clients, are investing in affordable housing in Texas under the federal Low Income Tax Credit program.[66] Amerigroup is currently investing over $85 million to develop affordable housing in Texas.[67]

Small group homes and other residential settings[68], which integrate services and supports with housing, are not financed by HUD. Although Medicaid does not pay for room and board, Medicaid can fund services and supports through Medicaid HCBS and other state plan benefits. Small group homes serving four to six people are available to people with IDD in Texas. The person pays rent derived from their federal benefits check or other income. For people who are not Medicaid eligible, service costs would be financed primarily through general revenue or local funds. In states such as Ohio, group home rents are funded with SSI/SSDI payments from residents combined with Residential State Supplements (RSS) administered through county-based boards using property tax levies and local taxes. To qualify for these supplements, group homes must be licensed by the state.[69]

The State of Texas Access Reform Plus Long-Term Care (STAR+PLUS) HCBS program includes adult foster care under its residential service array for people who meet a nursing facility level of care. HHSC could potentially explore pilot testing Adult Foster Care as an option for people with SMI and, if successful, incorporating under an HCBS state plan or 1115 waiver amendment.

Further detail on Texas housing resources can be found in Appendix I.

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[65] Wagner, R. (2017, June). *Louisiana Permanent Supportive Housing* [Presentation]. The National Academy for State Health Policy, Portland, Oregon.
[66] Scally, C., Waxman, E., & Gourevitch, R. (2017). *A National Insurer Goes Local: Emerging Strategies for Integrating Health and Housing*. Urban Institute. www.urban.org/sites/default/files/publication/91966/2001419_uhc_case_study_3.pdf
[67] *Amerigroup Brings More than $85 Million to Texas for Affordable Housing*. (2022, May 28). Business Wire. www.businesswire.com/news/home/20220328005146/en/Amerigroup-Brings-More-Than-85-Million-to-Texas-for-Affordable-Housing
[68] Settings generally serve less than 16 people
[69] Ohio Administrative Code Chapter 5122-36-04

Services

Medicare and Medicaid

Medicare and Medicaid represent significant sources of medical, prescription drug, and behavioral health coverage. Medicare is the primary source of medical and drug coverage for dual (Medicare/Medicaid) eligible people and SSDI recipients who exceed the financial criteria for Medicaid eligibility. Medicare Part A covers limited inpatient psychiatric care.[70] Medicare Part B covers limited outpatient mental health and SUD services, excluding some provider types. Medicare Part D covers prescription drugs, including oral and injectable antipsychotics. Medicare Advantage managed care plans, authorized under Part C, may offer additional services to members with chronic health conditions.[71]

Medicaid covers Medicare deductible and co-insurance costs for Medicaid-covered services provided to people who are dually eligible. Medicaid also provides access to services, such as personal care and rehabilitation, which address functional limitations, and other non-medical home and community-based supports, such as peer support and transportation to medical and behavioral health appointments.[72] Medicaid covers inpatient psychiatric hospital services for children and people over age 65. Additionally, people between 21 and 65 who are enrolled in Medicaid managed care are eligible for very limited coverage of psychiatric hospital services. Additionally, Medicaid will not reimburse other providers for services while people are in a psychiatric hospital. A research and demonstration waiver for people with SMI could provide some additional flexibility to fund psychiatric hospital services while requiring that the state ensure a continuum of community-based supports to avert institutionalization.[73]

In Texas, physical health, mental health, and SUD services for people who are Medicaid-eligible are primarily provided through capitated managed care plans. Medicaid funds a wide range of medical, mental health, SUD, prescription drug,

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[70] Lifetime limit of 190 days

[71] *Medicare and You*. (2022). Centers for Medicare and Medicaid Services. https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf

[72] *Dually Eligible Beneficiaries :* (n.d.). Medicaid and CHIP Payment and Access Commission. https://www.macpac.gov/topics/dually-eligible-beneficiaries/

[73] *Payment for services in institutions for mental diseases (IMDs)* (2019, July 30). Medicaid and CHIP Payment and Access Commission. https://www.macpac.gov/subtopic/payment-for-services-in-institutions-for-mental-diseases-imds/

rehabilitative and community services through the state plan and various waiver programs. [74] Drug coverage includes both oral and injectable antipsychotics.[75]

The Texas Medicaid state plan covers mental health rehabilitation, which can be used to provide evidence-based practices, such as CAT. Texas could also explore potentially funding the modest supplies[76] used to support CAT as a Medicaid managed care service, quality improvement activity or administrative activity in the future.

Some Medicaid waiver programs, such as STAR+PLUS HCBS, include expanded eligibility which enables people to qualify for Medicaid at up to 300 percent of the SSI income standard, if they meet level of care criteria for Medicaid-funded settings such as nursing facilities and other program requirements. These waiver programs also offer an expanded array of community support services such as home modifications, adaptive aids, meals and non-medical transportation. [77]

The STAR+PLUS HCBS program is available without a waiting list for current Medicaid-funded nursing facility residents rejoining the community who meet program requirements, including financial and nursing facility level of care criteria. Financial criteria for Medicaid eligibility in nursing facilities is 300 percent of the SSI standard. Texas could consider extending the same policy to people leaving state hospitals. This would potentially enable more people leaving state hospitals to access STAR+PLUS HCBS services upon discharge.

Medicaid HCBS state plan amendments[78] enable states to finance specialized HCBS services for people with SMI. States can also apply income and resource exclusions to people who qualify for HCBS state plan services, enabling these people to obtain Medicaid coverage at income levels above the SSI standard.[79] The state cannot limit HCBS state plan services to a defined number of people or restrict it to specific

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[74] *Texas Medicaid and CHIP Reference Guide* (Thirteenth Edition). (2020). Texas Health and Human Services Commission.
https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/medicaid-chip-perspective-13th-edition/13th-edition-complete.pdf
[75] *Formulary*. (2022). Vendor Drug Program. https://www.txvendordrug.com/formulary
[76] CAT supplies may include items such as clocks, calendars, pill keepers, signs, closet organizers, and other similar devices used to help people manage everyday activities.
[77] *Texas Medicaid and CHIP Reference Guide* (Thirteenth Edition). (2020). Texas Health and Human Services Commission.
https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/medicaid-chip-perspective-13th-edition/13th-edition-complete.pdf

[78] HCBS State Plan Amendments are authorized under Section 1915(i) of the Social Security Act
[79] The 2021 SSI standard for individuals is 74% of federal poverty level.

geographic areas. The state can use needs-based criteria to target HCBS state plan services to subsets of people, such those who have extended or repeated psychiatric hospital stays. People do not need to meet a nursing facility or other institutional level of care to qualify for state plan HCBS services.[80]

With some modifications, the Texas HCBS-AMH state plan program could become a key strategy for financing services for people transitioning. HCBS-AMH is significantly less costly than state hospital care. Serving a Medicaid-eligible person for one year through HCBS-AMH, including transition team costs, is approximately 25 percent of the annual state cost for serving a person in a state hospital. Serving an uninsured person in HCBS-AMH is approximately 40 percent of the annual state cost of state hospital care.[81] HCBS-AMH has some significant limitations, though, such as restrictive eligibility criteria and limited availability, especially in rural areas.[82]

More information on AMH can be found in Appendix C, Tables 1 and 2.

Medicaid Managed Care

Capitated Medicaid managed care programs provide additional flexibility in what services Medicaid can finance, how services are financed and who can receive them. For example, MCOs can offer additional supports to members, which are known as value-added services. They can also provide services not typically covered by Medicaid in-lieu-of regular Medicaid services. Texas is in the process of adding more behavioral health services, which MCOs can choose to offer to members in-lieu-of inpatient care, when clinically indicated. These services include partial hospitalization, intensive outpatient services, and coordinated specialty care.

MCOs are also required, in Texas and other states, to increase their use of value-based purchasing strategies over time. Value-based purchasing can involve alternate payment methodologies such as per diem, bundled rates, case rates and financial incentives or disincentives. Such methodologies are designed to enable or

[80] *Home & Community Based Services 1915(i)*. (n.d.). Medicaid. https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915i/index.html
[81] Per person per year costs for Medicaid clients include: {expenditures for HCBS-AMH services plus Medicaid managed care premiums for non-dual Medicaid clients plus transition team cost minus the federal Medicaid share of costs} plus state costs for flexible benefits. Per person per year costs for indigent clients include: {expenditures for HCBS-AMH services plus transition team cost} Data sources: HHSC Budget, Forecasting and Rate Analysis, HHSC Health and Specialty Care, and US Department of Health and Human Services.
[82] 1,095 days of inpatient care within the five years preceding enrollment.

encourage desired outcomes, such as improving health to avoid unnecessary hospitalization, unlike traditional fee for service payment, which incentivizes greater volume of services. Aligning goals for helping people step down from state hospitals with managed care value-based payment to providers is a strategy that could be explored as value-based payment continues to expand.

Capitated Medicaid programs pay per member per month rates to MCOs, which accept the financial risk for serving their members. Capitation can stimulate a different way of thinking about budgeting than traditional fee-for-service. When Texas implemented STAR+PLUS, a managed care system for older adults and adults with disabilities, HCBS services for people who met a nursing facility level of care were included in capitated rates. This allowed Texas to eliminate the HCBS waiting list for STAR+PLUS members with SSI-related Medicaid.

HHSC is currently developing the STAR+PLUS Pilot Program (SP3) to test a managed care delivery model for long-term services and supports (LTSS) for people with IDD, traumatic brain injury (TBI) that occurred after age 21, and people with similar functional needs as a person with IDD. SP3 will operate for 24 months in one managed care service area selected by HHSC with up to two STAR+PLUS Medicaid MCOs. The SP3 pilot will provide LTSS to STAR+PLUS members who meet SP3 eligibility criteria including new LTSS not currently available in other Medicaid waiver programs such as remote monitoring, housing supports, and enhanced medical and behavioral health services.

HCBS services for people with SMI could potentially be piloted under capitation in the future, enabling the state to include managed care members with SMI who need, but do not currently qualify for managed care HCBS, and to better integrate health coverage with HCBS services.

Medicaid managed care plans in Texas are also encouraged to include CCBHCs in their networks. CCBHCs provide an array of mental health and SUD services. They also integrate physical health screening into the service array. The Texas 1115 Medicaid Transformation waiver enables CCBHCs to receive additional directed payments through managed care plans.

Better coordination of Medicare and Medicaid can improve access and continuity of services for people who are dually eligible. Such coordination is occurring in states through Medicaid contractual requirements and pilot programs which seek to better align the two programs.

Indigent Healthcare

An estimated 60 percent of adults currently receiving services from the State's mental health system are not covered by Medicaid. Most of these people are uninsured[83] and considered medically indigent.

The Affordable Care Act (ACA) subsidizes health coverage at zero to reduced cost for people with incomes between 100 percent and 400 percent of federal poverty level. Coverage includes behavioral health services.

The County Indigent Health Care Program helps very low-income Texans (below 21 percent of the federal poverty limit), who do not qualify for other public health care programs, to access health care services and obtain up to three prescription drugs per month. Safety net providers, such as Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), and CCBHCs provide screening and treatment for medical and/or behavioral health conditions. FQHCs and RHCs can access low-cost prescription drugs, including long-acting injectable antipsychotics, through the federal 340b Drug Pricing Program. Providers must establish reasonable rates or charges and assure that no person will be denied services due to inability to pay.[84]

Large metropolitan areas with public hospital districts, such as Houston, Dallas, Austin, and San Antonio, may provide discounted access to healthcare services through programs funded by local appropriations and can also access 340b drug pricing.

The Public Health Provider–Charity Care Program, authorized under the Texas 1115 Medicaid Transformation waiver, is designed to allow qualified providers, including Community Mental Health Clinics (CMHCs), Community Centers, LMHAs or LBHAs, local health departments and public health districts to receive reimbursement for the cost of delivering healthcare services. This includes behavioral health services, immunizations, and other preventative services when those costs are not reimbursed by another source.

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[83] 20202020 SAMHSA Uniform Reporting (URS) Output Tables
2020 SAMSHA Uniform Reporting System (URS) Output Tables
[84] *Chapter 16: Billing and Collections*. (2018, January). Bureau of Primary Health Care. https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-16.html

Federal Block grants such as the Community MHBG [85] and Substance Abuse Prevention and Treatment Block Grant (SABG)[86] can also fund indigent behavioral health services for their target populations.

Texas Drug Card, the state's prescription assistance program, provides any uninsured Texan with significant medication discounts (up to 75 percent savings). There are no enrollment fees, qualifications, or waiting periods.

Program Administration

Administrative activities, such as evaluation and oversight of additional or enhanced behavioral health services/programs could be funded with additional general revenue. A 50 percent federal match could potentially apply to activities which relate to Medicaid.

[85] *Community Mental Health Services Block Grant*. (2020). Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/grants/block-grants/mhbg
[86] *Substance Abuse Prevention and Treatment Block Grant*. (2022, April). Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/grants/block-grants/sabg

6. Strategies

Potential strategies for transitioning people with long or repeated state hospital stays into the community are outlined below. These strategies relate to five key elements of successful transition programs:

1. Develop and implement a well-defined transition process and team.
2. Develop and implement a continuum of housing options.
3. Provide evidence-based and evidence-informed services and supports before and after discharge.
4. Maximize federal and other financial participation.
5. Monitor and evaluate the transition program to assess its performance and to improve performance.

Table 1 below provides further detail on strategies for transition. Some identified strategies, such as expanding training; reviewing policies; leveraging existing resources in Medicaid and indigent health; and negotiating priority with local housing authorities may have minimal fiscal impact while others could have a moderate to significant fiscal impact. The costs for implementing a robust transition system would be offset by improved individual outcomes, resulting in increased state bed capacity.[87]

Strategies to Support Transition

1. Develop and implement a well-defined transition process and team.

Element	Strategies
Policy and Oversight	• Establish a state-level staff position that would oversee transition efforts and performance across Texas. • Review and revise HHSC rules, policies, procedures, and guidance to state hospital staff, MCOs, LMHAs/LBHAs and other contractors to further clarify roles, responsibilities, and requirements of the transition process.

[87] For example, the HCBS-AMH program is significantly less costly to the state than serving the same people in long term state hospital commitment. Expansion of AMH to serve more people would require additional state match but would also free beds in state hospitals to serve more people. Expanding state facility step-down pilot services that prove successful could significantly reduce state hospital readmissions.

Element	Strategies
Transition Team	• Fund transition teams wholly dedicated to the transition process which would operate across the state. Dedicated transition teams would provide pre-transition services to people in a state hospital for up to six months before discharge and up to one year after community placement (or longer, if needed). Teams would include expertise in benefits, peer support, housing, employment, SUD, evidence-based rehabilitative services, such as CAT, and local community mental health, physical medicine, and HCBS systems.
Transition Planning	• Use person-centered planning, incorporating evidence-based motivational approaches to engagement, with people transitioning out of a state hospital. • Improve consideration of and connection to medical resources in the state hospital discharge assessment process, including resources for people who are medically indigent. • Leverage community partnerships to identify formal and informal supports for people in rural and remote areas.
Access to Services	• Explore the use of telemedicine/telehealth to extend the reach of transition teams, behavioral health, physical medicine, and peer support services. • Assess people for SUD before discharge, starting treatment in the hospital and continuing treatment into the community. • Use community-based peers to initiate support at least one month prior to discharge from the hospital.
Bridge Funding	• Explore state funding to bridge the gap until federal disability benefits and Medicaid eligibility are established. • Begin the process of applying for benefits or reinstating benefits before a person leaves the institution to minimize or eliminate gaps in coverage.

2. Develop and implement a continuum of housing options.

Element	Strategies
Policy and Oversight	• Institute standards and licensing categories for community-based mental health residential settings, which include varied levels of support ranging from homes with access to community-based services to those staffed to provide 24/7 services and supervision. • Negotiate priority status for people transitioning from state hospitals to HUD programs with local housing authorities.
Infrastructure	• Provide start-up funding or other incentives to stimulate development of supported housing, especially in rural or remote areas.

3. Provide evidence-based and evidence-informed services and supports before and after discharge.

Element	Strategies
Evidence-Based Supports	• Consider including the supported employment model IPS as a standard transition service. IPS includes personalized benefits counseling, rapid job search, and integration of mental health services. • Increase investments in training and technical assistance to facilitate use of evidence-based practices.
Training	• Continue to provide and expand training and technical assistance for state hospital staff, behavioral health, physical medicine, long-term care providers, LMHAs/LBHAs, and the justice system in transition best practices, such as CAT, with additional focus on forensic services and treatment, such as FACT. • Leverage existing HHSC contracted provider training resources, such as the International Center of Excellence for Evidence-Based Practices at UT Health San Antonio to train state hospital staff, providers, and other community partners in CAT and other transition-related evidence-based practices.

4. Maximize federal and other financial participation.

Element	Strategies
Medicaid Options	• Develop a process to retroactively claim federal Medicaid share for individuals eligible for the HCBS-AMH program. • Explore mechanisms to fund evidence-based services and supports through Medicaid. • Explore mechanisms to fund components of transition teams as a Medicaid administrative cost. • Continue to explore new ways to potentially obtain Medicaid coverage for services to prepare people for transition from state hospital services, such as the Medicaid 1115 SMI/SED Waiver opportunity. • Explore how existing Texas Medicaid state plan and waiver services could be used to support people who have transitioned to the community. • Expand and refine the HCBS-AMH program by broadening eligibility criteria; reviewing and modifying the service array and rate structure; developing a process to retroactively claim federal Medicaid share; and improving service coordination with STAR+PLUS MCOs and community behavioral health systems. See Appendix C, Table 2 for additional information.
Other Opportunities	• Leverage FQHCs with integrated behavioral health services and medical homes. • Leverage CCBHCs capabilities to provide integrated behavioral health services in the community • Leverage local hospital district indigent care health systems, where available, to provide medical coverage to people who are uninsured.

5. Monitor and evaluate the transition program to assess its performance and improve performance.

Element	Strategies
Evaluation	• Evaluate, and if successful, expand elements of Texas pilot programs which offer community or campus-based short-term residences, step-down, furlough options, or other services to help people transition.
Data Collection	• Improve data collection, integration and reporting on the state hospital transition candidate population. Standardize response categories on reports used by state hospitals and collect additional fields on demographics, comorbidities, needs and strengths. • Develop additional measures of performance and regularly collect and report evaluative data on the transition system.
Policy Refinement	• Continue to review and revise HHSC rules, policies, procedures and guidance to staff, MCOs, LMHAs/LBHAs and other contractors to support transitions from state hospitals

7. Conclusion

Effective programs for transitioning people with long or repeated state hospital stays require significant investment of time, staff and financial resources. Elements of successful programs currently exist in Texas, but improvements can be made to create a more effective transition system.

Potential strategies for improving the Texas state hospital transition process that may be explored include:

- Establishing a state-level staff position that would oversee transition efforts and performance across Texas;
- Funding teams wholly dedicated to the transition process which would operate across the state. These teams would include expertise in benefits, peer support, housing, employment, SUD, evidence-based rehabilitative services, such as CAT, and local community mental health, physical medicine and HCBS systems. The teams would receive ongoing training and technical assistance on person-centered recovery planning and motivational engagement and evidence-based service modalities such as FACT. They would work with people before, during, and after transition;
- Evaluating and, if successful, expanding elements of Texas pilot programs which offer community or campus-based short-term residences, furlough options, or other services to help people transition.
- Improving access to services including:
  - Expanding and refining the HCBS-AMH program by broadening eligibility criteria; reviewing and modifying service array and rate structure; developing a process to retroactively claim federal Medicaid share; and improving service coordination with STAR+PLUS MCOs and community behavioral health systems (See Appendix C, Table 2);
  - Exploring ways to potentially obtain Medicaid coverage for services to prepare people for transition from the state hospital (pre-transition services), such as the Medicaid 1115 SMI waiver opportunity;
  - Exploring how other existing Texas Medicaid state plan and waiver services could be used to support people who have transitioned to the community; and
  - Exploring use of telemedicine/telehealth to extend the reach of transition teams, behavioral health, physical medicine and peer support services.

- Improving access to a range of suitable housing by:
  - Instituting standards and licensing categories of community-based mental health residential settings which include varied levels of support ranging from homes with access to community-based services to those staffed to provide 24/7 services and supervision;
  - Negotiating priority status for people transitioning from state hospitals to HUD programs with housing authorities;
  - Providing start-up funding or other incentives to stimulate development of supported housing, especially in rural/remote areas; and
  - Continuing and expanding training and technical assistance for state hospital staff, behavioral health, physical medicine, and long-term care providers, LMHAs/LBHAs, and the justice system (law enforcement, judges, attorneys) in transition best practices, with additional focus on forensic services and treatment, such as FACT.
- Continuing to review and revise HHSC rules, policies, procedures, and guidance to staff, MCOs, LMHAs/LBHAs and other contractors to support transitions from state hospitals;
- Improving data collection and reporting on the state hospital transition candidate population. Standardize response categories on reports used by state hospitals and collect additional fields on demographics, comorbidities, needs, and strengths; and
- Developing additional measures of performance and regularly collecting and reporting evaluative data on the transition system.

List of Acronyms

Acronym	Full Name
ACA	Affordable Care Act
ARPA	American Rescue Plan Act
BHP	Behavioral Health Pilot
CAT	Cognitive Adaptation Training
CCBHC	Certified Community Behavioral Health Center
CMS	Centers for Medicare & Medicaid Services
COE	Center of Excellence
CPS	Certified Peer Specialist
CTI	Critical Time Intervention
DSA	Designated Service Area
FACT	Forensic Assertive Community Treatment
HCBS	Home and Community-Based Services
HCBS-AMH	Home and Community-Based Services – Adult Mental Health
HHSC	Health and Human Services Commission
HUD	Housing and Urban Development
IDD	Intellectual and Developmental Disabilities
IMD	Institution for Mental Disease
IST	Incompetent to Stand Trial
LBHA	Local Behavioral Health Authority
LMHA	Local Mental Health Authority
MCO	Managed Care Organization
MHBG	Mental Health Block Grant
MFP	Money Follows the Person
MIT	Mobile Integration Team
NGRI	Not Guilty by Reason of Insanity
PPB	Purchased Psychiatric Beds
RSS	Recovery Support Services
RHC	Rural Health Center
SAMSHA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill
SIM	Sequential Intercept Model
SMI	Serious Mental Illness
SOAR	SSI/SSDI, Outreach, Access, and Recovery
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SSLC	State Supported Living Center
STAR+PLUS	State of Texas Access Reform Plus (Long Term Care)
SUD	Substance Use Disorders
TDHCA	Texas Department of Housing and Community Affairs
TMI	Tennessee Move Initiative
UTHSA	University of Texas Health San Antonio

Appendix A. Definitions

Activities of Daily Living – Routine daily activities, such as 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, participating in the community, and other activities.

Civil – In a state hospital, an admission of a person not related to a criminal charge.

Cognitive Adaptation Training (CAT) – A rehabilitative service designed to help people establish daily routines, organize their environment, and build social skills.

Fiscal Year (FY) – For Texas, this represents September 1 through August 31, with the second calendar year identified with the fiscal year. For example, September 1, 2019, through August 31, 2020, is fiscal year 2020.

Forensic – In a state hospital, an admission of a person related to a criminal charge.

Incompetent to stand trial (IST), Code of Criminal Procedure, Chapter 46B - The person does not have sufficient present ability to consult with their lawyer with a reasonable degree of rational understanding or a rational as well as factual understanding of the proceedings against them.

Not Guilty by Reason of Insanity (NGRI), Code of Criminal Procedure Chapter 46C: The person is acquitted of a criminal offense by reason of insanity. Under Texas Penal Code, Section 8.01 (Insanity), it is an affirmative defense to prosecution that, at the time of the conduct charged, the person, because of "severe mental disease or defect", did not know that their conduct was wrong.

Purchased Psychiatric Beds (PPBs) – Beds in private psychiatric hospitals used via contract by LMHA or LBHAs to provide acute inpatient care when state hospital beds are not available.

Recovery – SAMHSA defines recovery as process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential.

Rural – For the purposes of this report, a Texas county with a population of 250,000 or less.

Serious Mental Illness (SMI) - An illness, disease, or condition (other than a sole diagnosis of epilepsy, dementia, substance use disorder, or intellectual or developmental disability) that substantially impairs thought, perception of reality, emotional process, development, or judgment; or grossly impairs a person's behavior as demonstrated by recent disturbed behavior.

Urban – For the purposes of this report, a Texas county with a population of more than 250,000.

Appendix B. Characteristics of People in State Hospitals for an Extended Period

Data was aggregated by HHSC to identify the characteristics of people who are admitted to a state hospital and stayed for an extended period, defined as over 365 calendar days. The purpose of the review was to determine:

1. What provider, resource or individual factors may impact successful transition of people from a state hospital to community-based care?
2. What provider, resource or individual factors may impact or lead to subsequent admission to a state hospital?
3. Does a correlation exist between the repeated use of purchased psychiatric beds (PPBs) and future state hospital admission?
4. What provider, resource or individual factors may prevent future or repeated admission to a state hospital?

Data was collected across various sources (state hospital system records, LMHA/LBHA records, and Medicaid encounters and enrollment) for people admitted to a state hospital or PPB between state fiscal years 2017 to 2021. Four distinct populations were identified for review and comparison:

1. People who have been admitted to a state hospital for over one calendar year but less than four calendar years;
2. People who have been admitted to a state hospital for over four calendar years;
3. People who frequently accessed PPBs; and
4. People who have been admitted to a state hospital two times within the same state fiscal year.

For the purposes of this review, frequent admission or utilization is defined as two or more admissions within the same state fiscal year. Unless otherwise noted, any person admitted to a state hospital for over one calendar year will be referred to as a long-term state hospital resident.

Limitations

Some people included in this review were admitted to a state hospital a significant amount of time prior to the review period. Current commitment data may not reflect the original reason for commitment. Additionally, during periods of community living, people may relocate or receive services from providers, such as LMHAs or LBHAs, in multiple counties which may impact the results. This may limit conclusions that can be drawn from the data.

Another limitation is that not all people have prior or continuous enrollment in Medicaid, which may limit comparison of prior utilization. This review uses data over a five-year period and variance in enrollment dates and time periods used may impact the results.

Summary of Findings

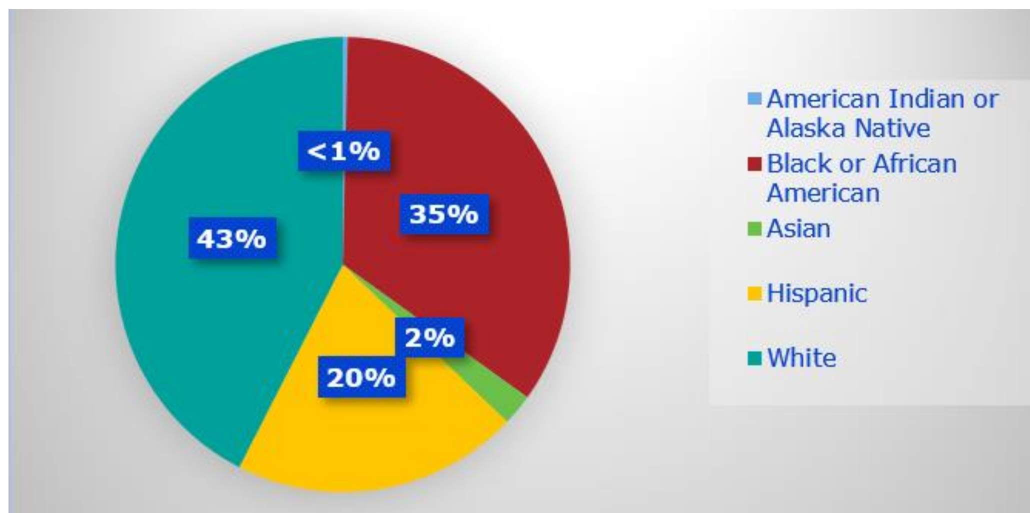
Demographics

Figure 1 on the following page shows most people who reside in a state hospital for an extended period are white males between the ages of 25 to 64 with forensic charges. Males account for 76 percent of long-term state hospital residents.[88]

Figure 1 below shows the racial and ethnic makeup of long-term state hospital residents.

[88] Defined as over one calendar year

Figure 1: Race and Ethnicity of Long-Term State Hospital Residents



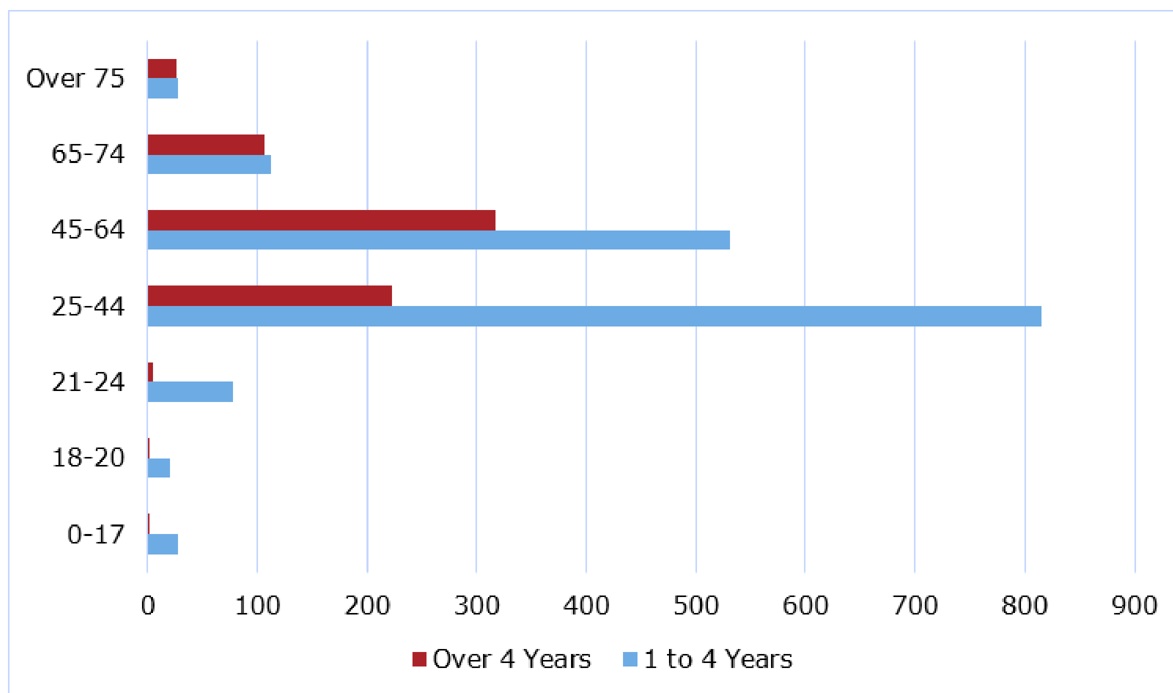
Race and Ethnicity	Percent
American Indian or Alaska Native	<1%
Black or African American	35%
Asian	2%
Hispanic	20%
Caucasian	43%

Long-term state hospital residents admitted for over four years are slightly older than long-term state hospital residents admitted between one to four years. Approximately 88 percent of long-term state hospital residents are under age 65 as shown in Figure 2 below. The predominant diagnoses include psychotic or schizoaffective disorders.[89]

Figure 2 below shows the age distribution of long-term state hospital residents by length of stay. Figure 2 compares long-term state hospital residents with a length of stay between one to four years and long-term state hospital residents with a length of stay over four years.

[89] The most common diagnoses were schizoaffective disorder - bipolar type, schizophrenia, paranoid schizophrenia, and schizoaffective disorder.

Figure 2: Age of Long-Term State Hospital Residents, by Length of Stay



Age Range	Length of Stay 1 to 4 Years	Length of Stay Over 4 Years
0 - 17	28	2
18 - 20	20	1
21 - 24	78	4
25 - 44	815	222
45 - 64	531	318
65 - 74	112	107
Over 75	27	26

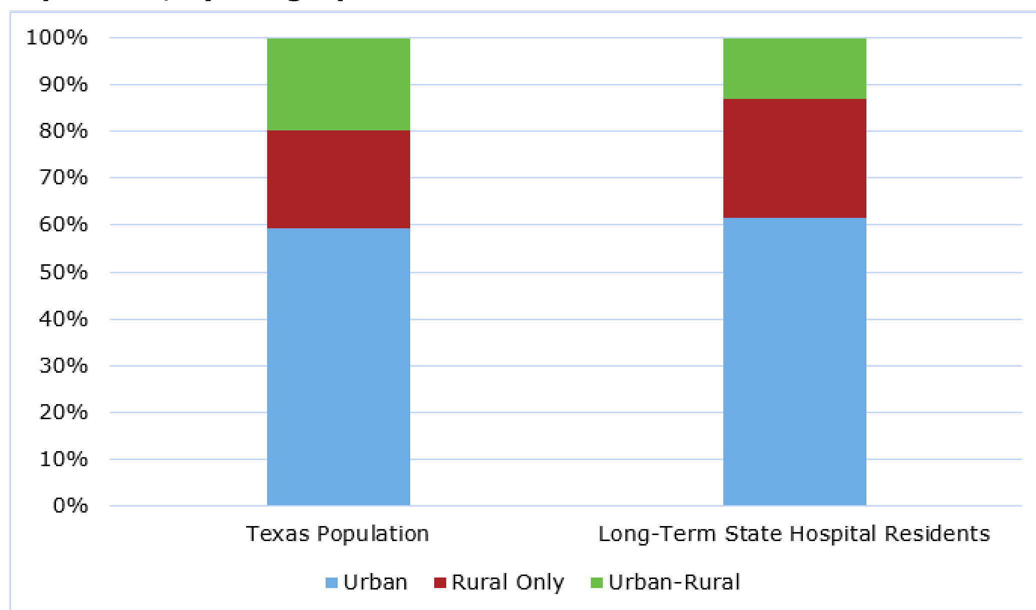
Regional Differences

Figure 3 illustrates most long-term state hospital residents live in urban regions (61.4 percent) served by large LMHA/LBHAs, while 38.5 percent live in rural or mixed urban-rural regions.[90]

[90] Rural regions are defined as regions in which all counties within the designated service area do not exceed 250,000 residents. Mixed urban-rural regions are defined as regions in which most counties within the service area are rural, but at least one county's population exceeds 250,000. Population size is based on 2019 Census Data.

Figure 3 below shows the percentage of Texas residents and long-term state hospital residents who live in rural, urban, or urban-rural geographic regions.

Figure 3: Comparison of Long-Term State Hospital Residents to the Texas Population, by Geographic Area



Geographic Area	Texas Population	Long-Term State Hospital
Urban	59%	61.5%
Rural Only	21%	25.4%
Urban-Rural	20%	13.1%

Each state hospital has at least one long-term state hospital resident. Austin State Hospital and Rusk State Hospital serve the most long-term state hospital residents admitted on a civil commitment at 25.95 and 24.55 percent, respectively. El Paso Psychiatric Center and Rio Grande State Center serve the fewest long-term state hospital residents, accounting for approximately two percent of the state's long-term state hospital residents combined. El Paso Psychiatric Center and Rio Grande State Center—which are the smallest state hospitals—also serve the third and fourth largest number of people frequently admitted to a state hospital,[91] respectively.

Although state hospitals have a designated service area (DSA) for the purpose of ensuring continuity of care between inpatient and community mental health

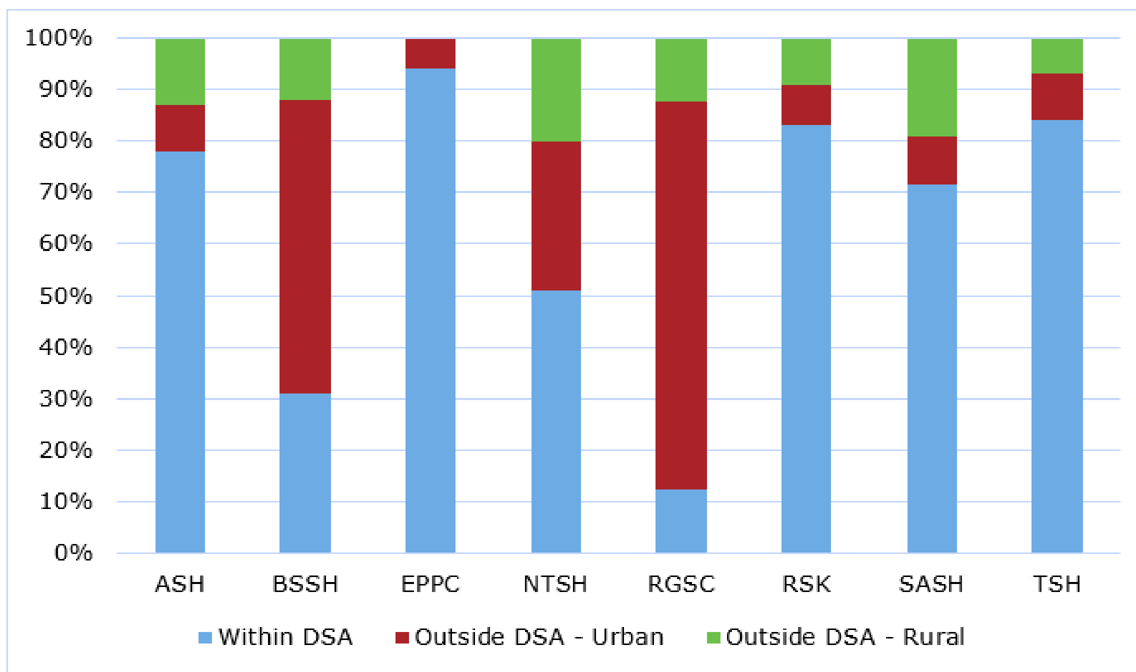
[91] This does not distinguish between civil and criminal commitment type.

services, many long-term state hospital residents do not reside within their designated state hospital service area. This is particularly true for Big Spring State Hospital and Rio Grande State Center which are both located in rural regions and serve the largest percentages of long-term state hospital residents from outside of their DSA. Many rural communities are located an hour or more away from mental health inpatient facilities and people may be transported to the nearest state hospital, even if it is outside of their DSA.

Figure 4 below illustrates the percent of state hospital residents whose county of origin is within the state hospital's DSA, outside of the state hospital's DSA in an urban region, or outside of the state hospital's DSA in a rural region. Figure 4 provides a comparison across all state hospitals – Austin State Hospital, Big Spring State Hospital, El Paso Psychiatric Center, North Texas State Hospital, Rio Grande State Center, Rusk State Hospital and Terrell State Hospital. [92]

[92] Kerrville State Hospital is not included for comparison because Kerrville State Hospital provides statewide adult forensic services and does not have a designated service area.

Figure 4: Percent of the Population Served from Within the Designated Service Area, by State Hospitals[93]



State Hospital	Within DSA	Outside DSA - Urban	Outside DSA - Rural
Austin State Hospital	78%	9%	13%
Big Spring State Hospital	31%	57%	12%
El Paso Psychiatric Center	94%	6%	0%
North Texas State Hospital	51%	29%	20%
Rio Grande State Center	12.5%	75%	12.5%
Rusk State Hospital	83%	8%	9%
San Antonio State Hospital	71.4%	9.3%	19.3%
Terrell State Hospital	84%	9%	7%

Another contributing factor may be related to the increase in the forensic population. An individual admitted to a maximum-security unit at a state hospital who is determined to be not manifestly dangerous requires timely placement and may be transferred to a less-restrictive state hospital that has availability. When

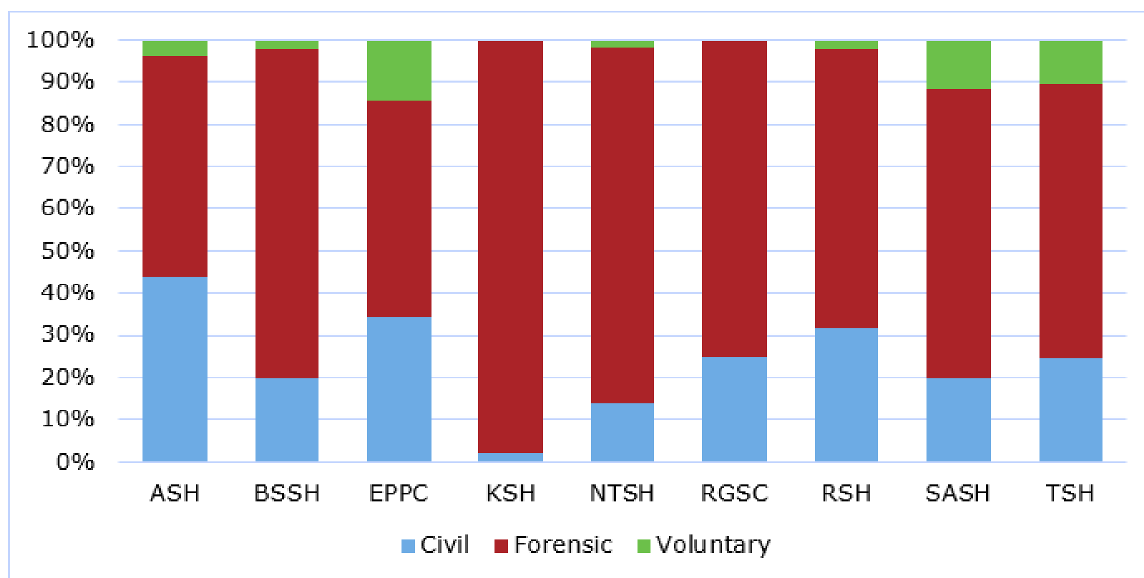
[93] Kerrville State Hospital provides statewide adult forensic services and does not have a designated service area.

the forensic population is excluded, the percent of people served in a state hospital within their DSA increases.

Across all state hospitals, over 50 percent of the population within each hospital is forensic. Most long-term state hospital residents within the forensic population are admitted to North Texas State Hospital (21.05 percent) or Rusk State Hospital (15.26 percent). The Vernon campus at North Texas State Hospital is a maximum-security campus that is almost entirely forensic, and Rusk State Hospital has a dedicated maximum-security unit. An additional 19.93 percent of people within the forensic population are located at Kerrville State Hospital which provides specialized services to people determined NGRI.[94]

Figure 5 below illustrates the percent of state hospital residents who were admitted on a civil, forensic, or voluntary commitment. Figure 4 provides a comparison across all state hospitals – Austin State Hospital, Big Spring State Hospital, El Paso Psychiatric Center, Kerrville State Hospital, North Texas State Hospital, Rio Grande State Center, Rusk State Hospital and Terrell State Hospital.

Figure 5: Population within State Hospital, by Population Type



[94] Many people admitted to Kerrville State Hospital are transferred from the Vernon campus at North Texas State Hospital or Rusk State Hospital after they have been determined to not be manifestly dangerous and require a longer stay in a state hospital.

State Hospital	Civil	Forensic	Voluntary
Austin State Hospital	43.6%	52.7%	3.7%
Big Spring State Hospital	20%	78%	2%
El Paso Psychiatric Center	34.3%	51.4%	14.3%
Kerrville State Hospital	2%	98%	0%
North Texas State Hospital	13.9%	84.2%	1.9%
Rio Grande State Center	25%	75%	0%
Rusk State Hospital	31.5%	66.2%	2.3%
San Antonio State Hospital	19.9%	68.6%	11.5%
Terrell State Hospital	25%	65%	10%

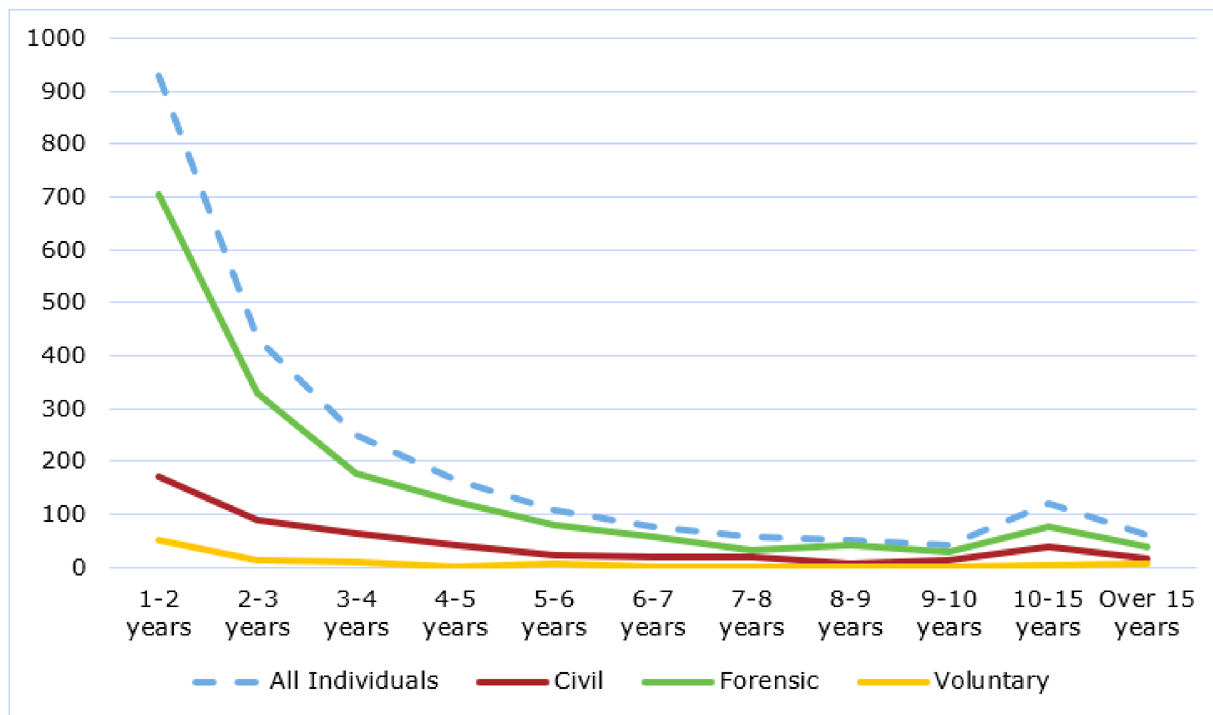
Length of Stay

In Texas, the median length of stay in a state hospital for adults is seven calendar days;[95] for adult residents who remain in a state hospital for less than one calendar year, the median length of stay is 75 days.[96] From state fiscal year 2017 through state fiscal year 2021, 2,291 people were admitted to a state hospital for over one calendar year. This number is heavily skewed by the forensic population, which account for approximately 74 percent of long-term state hospital resident admissions. Most long-term state hospital residents admitted on a forensic commitment (58 percent) were admitted to restore their competency to stand trial and account for approximately 35 percent of all long-term state hospital residents. A smaller number (37 percent) were determined NGRI and ordered commitment by the court.

Figure 6 below shows the length of stay in a state hospital by long-term state hospital residents who were admitted on a civil, forensic or voluntary commitment.

[95] 2020 SAMSHA Uniform Reporting System (URS) Output Tables
[96] 2020 SAMSHA Uniform Reporting System (URS) Output Tables

Figure 6: Length of Stay in a State Hospital, by Initial Commitment Type

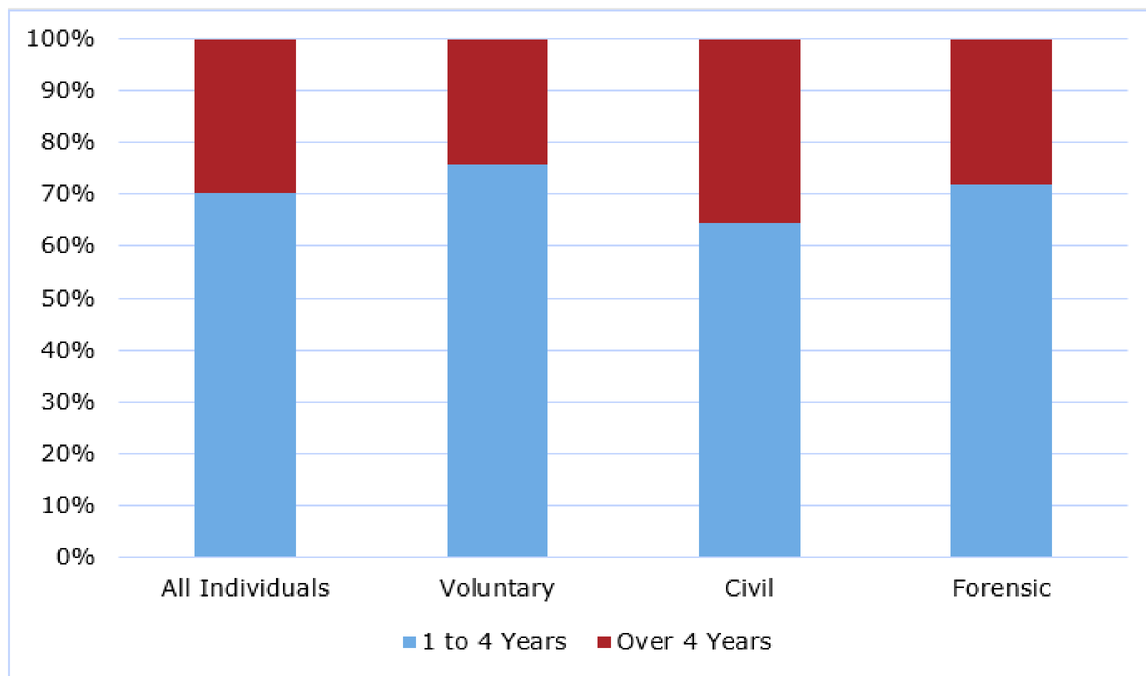


Length of Stay	All Individuals	Civil	Forensic	Voluntary
1-2 years	928	170	706	52
2-3 years	434	90	330	14
3-4 years	249	63	177	9
4-5 years	166	41	123	2
5-6 years	107	22	79	6
6-7 years	77	18	57	2
7-8 years	56	21	33	2
8-9 years	51	7	43	1
9-10 years	43	13	29	1
10-15 years	119	39	76	4
Over 15 years	61	17	38	6

Most long-term state hospital residents are discharged within three years. However, regardless of a person’s initial reason for admission, approximately 30 percent of people from each population (voluntary, forensic, or civil) remained in a state hospital for over four years.

Figure 7 below compares the length of stay for long-term state hospital residents who were admitted on a civil, forensic and voluntary commitment. Figure 7 shows the percentage of each group with a length of stay from one to four years compared to a length of stay over four years.

Figure 7: Long-Term State Hospital Residents Length of Stay, by Initial Commitment Type



Length of Stay	All Individuals	Voluntary	Civil	Forensic
1-4 years	70%	76%	64%	72%
Over 4 years	30%	24%	36%	28%

B-Barriers to Discharge

In keeping with the large forensic population, the most common barriers to discharge are specific to the forensic population—primarily related to competency restoration. Most people in the forensic population are determined to be *Not Yet Competent* or *Not Likely to Restore*. Additionally, for the forensic population, an additional barrier occurs when a person is determined to be *Not Appropriate for a Less Restrictive Setting* or when a judge rejects the person's proposed outpatient plan.

In addition to the forensic-specific barriers to discharge, common barriers to discharge include a lack of benefits, appropriate placement to live within the

community and the need for a guardian or supported decision maker. Despite the young age of this population, long-term state hospital residents are commonly referred to nursing homes for placement; however, a number of long-term state hospital residents refuse placement in nursing homes. Additionally, nursing homes often refuse to accept long-term state hospital residents for admission.

Readmission to a State Hospital

There were 1,628 people admitted to a state hospital two or more times within the same fiscal year during the years reviewed. Long-term state hospital residents accounted for 4.5 percent of this population. Of the long-term state hospital residents who were re-admitted to a state hospital, 80 percent were re-admitted once while 5.4 percent were re-admitted four or more times. Most people who are frequently admitted to a state hospital are re-admitted less than 90 days after their discharge; long-term state hospital residents, however, are slightly more likely to be re-admitted to a state hospital six months after discharge as compared to all people who are frequently admitted to a state hospital. Long-term state hospital residents may not be identified in regular reporting as most state hospital data describes re-admission within 180 days after discharge.

Like long-term state hospital residents, most people who are frequently admitted to a state hospital are white males between the ages of 25 to 64. However, whereas children[97] account for less than 2 percent of long-term state hospital residents, they represent approximately 16.5 percent of people who are frequently admitted to a state hospital within the same fiscal year. This disparity may warrant further analysis of state hospital use for children.

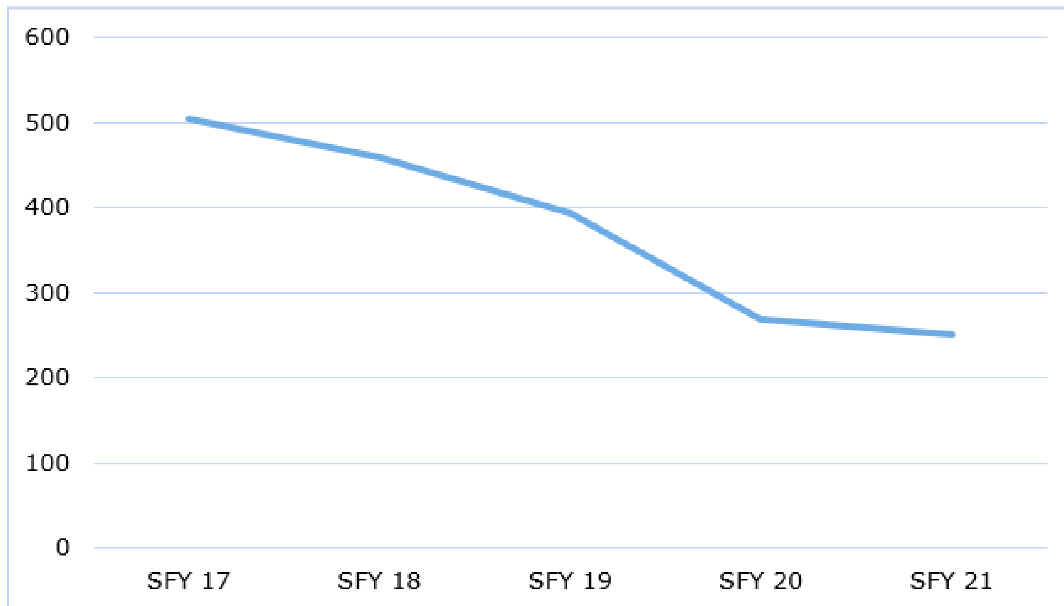
It is also important to note that the number of people who are frequently admitted to a state hospital has significantly decreased over the years; the number of frequent state hospital users re-admitted in fiscal year 2021 was half the number admitted in fiscal year 2017.[98]

Figure 8 shows the number of people who were re-admitted to a state hospital two or more times within the same fiscal year across a five-year time period.

[97] People under the age 18.

[98] In fiscal year 2017, 504 frequent state hospital users were re-admitted to a state hospital and in fiscal year 2021 this number was 251.

Figure 8: Number of People Frequently Readmitted to a State Hospital Within the Same Fiscal Year



State Fiscal Year	Number of Individuals
SFY 17	504
SFY 18	459
SFY 19	394
SFY 20	268
SFY 21	251

Purchased Psychiatric Beds (PPBs)

There were 4,471 people who used a PPB two or more times within the same fiscal year during fiscal years 2017 to 2021. Of the people who frequently used a PPB, 419 people used a PPB two or more times within the same fiscal year, across multiple years. While some people who frequently used PPBs were later admitted to a state hospital, this was only a small percentage of people. Only 3.2 percent of long-term state hospital residents also frequently used a PPB. Similarly, only 2.76 percent of all long-term state hospital residents had previously used a PPB psychiatric bed. However, rural and mixed urban-rural regions collectively accounted for 52 percent of people who frequently used a PPB.

Medical and Mental Health Needs

A 2020 analysis[99] of data on long-term civil and voluntary state hospital patients with identified barriers to discharge indicated that 82 percent had a medical condition described as requiring daily care. Additionally, 40 percent of people had a function care limitation that required personal care. People most needed support with prescription monitoring.[100]

A more recent analysis sampled a small subset of people who used state-funded hospital services during state fiscal year 2020.[101] Less than half of the individuals sampled were enrolled in Medicaid during the six months prior to their first admission. Frequent PPB users appear to have lower rates of Medicaid enrollment (17 percent) as compared to frequent state hospital users (57 percent). Most people who were enrolled in Medicaid were enrolled in the STAR+PLUS program or had fee-for-service enrollment.

An additional analysis within this subset of people which looked at members with non-dual[102] enrollment showed that frequent state hospital users had slightly fewer Medicaid encounters than frequent PPB users, but greater expenditures, particularly in the period after their first admission. Members in the year stay cohort had fewer encounters in the six months prior to their admission than members in other cohorts. This may be because members had prior short stays that are not accounted for by the data.

Additionally, the preliminary data suggests that frequent state hospital users and frequent PPB users may have had significant rates of emergency department encounters after their first hospital admission. However, due to the small sample size of the Medicaid eligible population, it is difficult to interpret the significance of the results. HHSC is in the process of further analyzing Medicaid utilization for these populations to better understand involvement with the healthcare system.

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[99] HHSC Health and Specialty Care System State Facilities data, 2020

[100] Data was reviewed in early 2020 for individuals who had been under civil commitment to a Texas state hospital for at least one year. This review did not include the forensic population. Functional needs and limitations may be underrepresented.

[101] The sample included people who were admitted to a state hospital and lasted at least one year, people who had at least two state hospital stays starting during, and people who had at least two states in a purchased psychiatric bed.

[102] People enrolled in Medicaid, who were not also enrolled in Medicare.

Appendix C. State Transition Programs

Table 1 below provides an overview of several state transition programs for people with SMI.

Table 1. Overview of State Transition Programs for People with SMI.

State and Program Name	Program Description	Outcomes
New York Mobile Integration Team (MIT)[103]	The goal of the MIT program is to prevent long stays in a psychiatric hospital and to support the transition of people with longer inpatient stays into the community. New York has 19 MITs across the state. The program supports efforts to keep people in their community by providing an intensive level of care that is fully community-based and occurs in the person's home environment or another preferred community setting. MIT services are intended to enhance the existing system of care, to fill in service gaps, and to focus on activities needed to prevent psychiatric hospitalization and emergency department use. MITs are comprised of a multidisciplinary team including social workers, community health nurses, registered nurses, licensed nurse practitioners, rehabilitation counselors, and peer specialists, with the availability to consult with psychiatrists.	As of 2016 MIT had helped 1,295 people transition to the community and spend less than a year in the state psychiatric hospital. These were people likely to remain in the hospital in the absence of these services. During 2016, 15 MITs served 4,270 people. Of these: • 10.4% had a psychiatric hospitalization • 8.5% had an ER visit without hospitalization

[103] *Program Mobile Integration Team*. (2022, July 8). NY Connects. https://www.nyconnects.ny.gov/services/mobile-integration-team-omh-pr-901700018019

State and Program Name	Program Description	Outcomes
New York Pathway Home[104]	The Pathway Home program is a collaboration between the New York State Office of Mental Health, Coordinated Behavioral Care, Inc (a non-profit Health Home provider), and a network comprised of hundreds of outpatient programs (clinics, ACT teams), thousands of supportive housing units, and supportive services (e.g., clubhouses, employment services). The focus of the program is to facilitate a seamless transition from hospital to home for people with SMI. Pathway Home utilizes a multidisciplinary team approach, a rapid referral and enrollment process (2 days), engagement while the person is still in the hospital, small and flexible caseloads, and wrap-around funding to address both immediate needs and innovative recovery promoting expenses. The program uses the Critical Time Intervention (CTI) model and is driven by several guiding principles: 1) pre-discharge engagement and discharge planning; 2) Engaging in meaningful activities, and in family and social networks; 3) Accompanying the person home upon discharge, and to initial as well as follow-up behavioral health and medical appointments; 4) Linkage to community providers and natural support systems and 5) Fostering tools that support skill development and self-reliance.	Between April 2016 and June 2017, 474 people participated in the program and of these *(n=453)*: 91% were not readmitted to any hospital within 30-days of re-entering the community 94% were not readmitted to a state psychiatric center while participating in the program 92% had a behavioral health appointment within 30 days of discharge 84% had a medical appointment within 90 days of discharge 75% were enrolled in a Health Home 8% were bridged to more intensive services

[104] *Pathway Home*. (2022). NYC Human Resources Administration. https://www1.nyc.gov/site/hra/help/pathway-home.page

State and Program Name	Program Description	Outcomes
Georgia Community Transition Peer Support (Peer Mentor) Service[105]	The Peer Mentor service supports the integration of people leaving psychiatric inpatient settings back into their communities. The service focuses on people who have lengthy hospital stays (60 plus days) or frequent admissions. The service began in 2005 as a collaboration between the Georgia Department of Behavior Health and Developmental Disabilities and the Georgia Mental Health Consumer Network (a consumer-run non-profit organization). The service is delivered by Certified Peer Specialists (CPS) and provides interventions to promote recovery, wellness, independence, self-advocacy, and the development of natural supports among people transitioning to community-based service settings. The goal of the service is to foster a positive and intentionally mutual relationship between a CPS and person hospitalized to support his/her transition to the community and in regaining control over his/her own life and recovery process.	July 2014 thru June 2015, out of 2,019 people served, 62.8% remained in the community greater than 90 days without re-hospitalization In 2015-2016 and 2016-2017, 86 percent and 80 percent respectively reported that the CPS played a role in improving a person's quality of life.

[105] *Peer Mentoring and Forensic Peer Mentoring*. (2022). Georgia Mental Health Consumer Network. https://www.gmhcn.org/peer-mentoring-forensic-peer-mentor

State and Program Name	Program Description	Outcomes
Tennessee The Move Initiative (TMI)[106]	The TMI is a collaborative effort among the Tennessee Division of Mental Health Services and Division of Hospital Services, to provide intensive and customized care coordination services to people in long-term units within Tennessee's state owned regional mental health institutes. The primary purpose is to successfully transition adults staying longer than 90 days in a psychiatric hospital to the community by providing short-term intensive support services. Community Mental Health Centers develop, implement, and monitor this Initiative's programming. In direct partnership with the state owned regional mental health institutes, the local teams ensure personal, family, and housing provider support while connecting and coordinating with natural and formal supports within the person's home community.	Decreased hospital stays, client satisfaction with living situation, restoration or application for service benefits, decreased psychiatric hospital readmission

[106] *Tennessee Move Initiative*. (n.d.). Tennessee Voices. https://tnvoices.org/programs/tennessee-move-initiative/

State and Program Name	Program Description	Outcomes
Texas HCBS-AMH[107]	HCBS-AMH is funded via a 1915(i) Medicaid State Plan Amendment. The program was authorized by the legislature and approved by CMS in 2015 to enable people with extended tenure in state psychiatric hospitals to be served in the community. The program was subsequently expanded to include people with a history of incarceration or emergency department (ED) use. HCBS-AMH provides a broad array of HCBS services including recovery management, housing Related Services, employment services, adaptive aids, community psychiatric supports and treatment, psychosocial rehabilitative services, home delivered meals, minor home modifications, nursing, peer support, respite care, substance use disorder services, transition assistance, transportation services. It also includes flexible state funding for non-Medicaid supports. Available in 20 LMHA catchment areas as of August 2022. There are two types of providers: Recovery Management Entities (RMEs) and Provider Agencies (PAs). Providers include LMHAs or LBHAs and others who meet state-defined criteria.	624 served since 2016 (most had previous long-term hospitalization) 83% of people with long-term previous hospitalization were not readmitted after enrolling in HCBS-AMH The average number of emergency department visits dropped more than threefold after enrollment from a rate of 0.75 visits per member per month to 0.20 visits per member per month.[108]

[107] *Home & Community-Based Services — Adult Mental Health | Texas Health and Human Services*. (2022). Texas Health and Human Services Commission. https://www.hhs.texas.gov/providers/behavioral-health-services-providers/home-community-based-services-adult-mental-health
[108] IDD-BHS Office of Decision Support

Table 2 below provides some potential options for modifying the HCBS- AMH program.

Table 2. Options to modify the HCBS-AMH program to increase options

Area	Potential Change
Program Eligibility	● Explore amending the HCBS-AMH income and resource exclusion criteria to enable people to qualify for Medicaid/HCBS-AMH at up to 300 percent of the full SSI federal benefit rate. This would align with other existing Texas HCBS programs. People in AMH are currently typically qualified at 100 percent of the SSI federal benefit rate. ● Explore changing the inpatient risk factor to enable people with at least 365 days of continuous or repeated inpatient hospitalization to qualify. Currently 1,095 days of inpatient care within the five years preceding enrollment are required. ● Revise HCBS-AMH eligibility risk factors to enable combinations of risk, such as allowing time spent in jail waiting for a hospital bed to count towards the required hospital bed days. ● Revise the HCBS-AMH clinical eligibility process. Explore adjusting the assessment instrument logic to enable people with somewhat higher support needs to qualify for the program.
Residential Services	● Examine existing rate structure and policies for residential services to identify potential disincentives to providing a continuum of housing options. ● Explore creating a licensure category for supported group home living arrangements.
Enhanced Supports	● Explore implementing an enhanced observation rate for HCBS-AMH participants who require more assistance and supervision than the HCBS-AMH Medicaid reimbursement currently supports.
Service Array	● Review the existing service array and service utilization to determine whether services should be continued, modified or eliminated from the program.

Area	Potential Change
Housing Options	• Improve access to housing opportunities by formalizing coordination with TDHCA and local housing authorities.
Coordination with STAR+PLUS MCOs and community behavioral health systems	• Clarify and formalize HCBS-AMH coordination requirements in Medicaid MCO contracts and guidance. • Explore piloting HCBS-AMH services in the capitated Medicaid managed care system (STAR+PLUS) in the future. • Improve integration of HCBS-AMH service with local service delivery systems and models, such as CCBHCs.
Finance	• Implement a process to retroactively claim federal share on HCBS-AMH service costs for people determined retroactively Medicaid eligible after HCBS-AMH enrollment.

Appendix D. State Mental Health Authority Survey

Below is the summary of state responses to a survey on community hospital transition strategies which HHSC conducted with the assistance of the National Association for State Mental Health Program Directors (NASMHPD). The survey explored transition strategies for people who experienced an extended stay in a state hospital. Nineteen states responded to the survey. Some questions allowed for multiple responses. Some states submitted multiple responses representing different programs. In these cases, percentages may total more than 100.

The states participating in the survey were: Alaska, Arkansas, California, Colorado, Delaware, Florida, Idaho, Iowa, Maryland, Missouri, Montana, Nebraska, Nevada, Tennessee, Texas, Utah, Washington, West Virginia, and Wyoming.

Summary of state responses to a survey on community hospital transition strategies.

1. How do you define a long-term stay in a state hospital?

Summary of Responses	% Of Respondents Using Strategy
3 to 6 months	17%
6 months to 1 year	35%
1 year or longer	48%

2. Which types of setting do people transition to?

Summary of Responses	% Of Respondents Using Strategy
Small Group Homes	87%
Assisted Living Facilities	84%
Single Family Residence	78%
Nursing Home	78%

3. What strategies does your state use to support people to transition from a state hospital?

Summary of Responses	% Of Respondents Using Strategy
Assistance with Applying for or Reestablishing Benefits	96%
Dedicated Transition Staff or Team	83%
Tenancy Supports to Find or Maintain Housing	65%
Rental Assistance Subsidies	61%
Representative Payee or Guardianship Services	61%
Personal Care Services for Assistance with Daily Living	57%
Employment Services	52%
Transition Assistance	48%
Medical/Dental/Nursing Services	39%
Temporary Income Assistance	22%

4. What percentage of this population is uninsured?

Summary of Responses	% Of Respondents Using Strategy
Less than 25% are uninsured	70%
More than 25% are uninsured	30%

5. How do you fund community strategies?

Summary of Responses	% Of Respondents Using Strategy
Medical/Dental/Nursing Services funded by Medicaid State Plan	48%
Medical/Dental/Nursing Services funded by State Funds	52%

Appendix E. Texas SSLC Transition Process

SSLCs use transition specialists to increase the number of successful transitions of people residing in SSLCs to community settings. Transition specialists assist with supporting people to relocate from SSLCs to community settings. Transition specialists also educate people residing in SSLCs, their legally authorized representative, actively involved family members and SSLC staff on available and appropriate community supports and services that can assist people to relocate from SSLCs to community settings.

Program Description

Each person who is considering relocating from an SSLC to the community has an interdisciplinary support team. The team works with the person to develop a support plan that includes the protections, services and supports that are needed by the person to keep them safe and ensure they are living in the most integrated and appropriate setting based on their needs. The interdisciplinary support team identifies the major obstacles to the person's movement to the most integrated setting consistent with their needs and preferences. The personal support team also implements strategies intended to overcome such obstacles.

The transition specialist works with a person who is considering relocating into the community while they are still residing in the SSLC. The transition specialist may work with the person for up to six months or longer prior to the person's transition into the community.

A post-move monitoring staff collaborates with the person's local intellectual and developmental disability authority to provide monitoring and support for a person for up to one year after they have moved into the community.

Staffing

Each transition team is made up of an interdisciplinary team which includes a transition specialist, local intellectual and developmental disability authority staff, and SSLC staff. The transition specialist performs complex consultation and identifies resources in SSLC service areas.

Funding

Transition specialist positions are currently funded through the federal MFP Demonstration grant.

Outcomes

From state fiscal year 2011 through state fiscal year 2021, the SSLC transition program demonstrated a low readmission rate of 3.9 percent within 180 days of the person's relocation into the community and 5.8 percent within 365 days of the person's relocation into the community. Over 2,000 people have transitioned into the community under the program since fiscal year 2009.

Appendix F. Texas State Hospital Transition Pilot Program

The Texas State Hospital Transition Pilot program was created in response to the 2020 Texas *Health and Human Services Business Plan: Blueprint for a Healthy Texas.*[109] The Blueprint highlighted a goal to identify, assess and facilitate a successful transition of twenty psychiatrically or medically fragile placements into the community. The goal of the program is to provide pre and post transition services and supports, including short term residential placements to help people with SMI or complex medical needs, who no longer need care in a state hospital, to live in the community.

State hospital team members and LMHAs or LBHAs work together to support a person who is anticipating transitioning out of a state hospital into the community. The LMHA/LBHAs, state hospital transition specialist and state hospital clinicians collaborate to identify people who may be ready to leave a state hospital and find them appropriate step-down placements and supports.

Step-down placements are designed to be short-term (less than one year) to support gradual community re-integration. This helps a person to slowly adjust to living in the community over the course of one year. The program supplements existing community supports and services that the person will receive, such as financial assistance for food, rent and transportation. After moving into the community, the person continues to have access to the state hospital transition specialist to support their transition.

Program Description

Each person in the program receives pre-transition and post transition services from an Intensive Transition Team, which provides intensive behavioral health supports. The Intensive Transition Team includes different staff based on whether a person is residing in a state hospital or in the community. When a person is in a state hospital, the intensive transition team is made up of a state hospital social

[109] https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/hhs-inaugural-business-plan.pdf

worker, psychiatrist, and HHSC transition specialist. After a person moves into the community, the team includes the LMHA/LBHA who provide intensive services.

The step-down home provides services such as intensive case management, coordination, and assistance with activities of daily living. Additional services that may be provided through the program include transition assistance, employment support services, transportation assistance, SUD counseling and support and financial management support.

Pilot participants live in the step-down homes, which have professional staff with specialized training to support the unique needs of people who are leaving a state hospital setting. Step-down homes provide staff 24/7.

Current step-down homes are located in Helen Farabee, Bluebonnet Trails Community Services, and the Harris Center for Mental Health and IDD service areas. Some participating LMHAs are considering expanding the program.

Funding

The pilot is funded through a combination of federal funds, including MHBG, federal MFP Demonstration, ARPA, and state general revenue funds. If shown to be a successful model, sustainable funding sources will need to be identified to expand the program.

Table 1: Funding for the Texas State Hospital Transition Pilot Program, by Funding Source

	Step Down Site	Federal	State	All Funds
FY20	Bluebonnet Trails	$0	$337,240	$337,240
FY20	Helen Farabee	$0	$79,158	$79,158
FY21	Bluebonnet Trails	$1,959,000	$0	$1,959,000
FY21	Helen Farabee	$546,000*	$0	$546,000*
FY22	Bluebonnet Trails-Georgetown	$1,959,000	$0	$1,959,000
FY22	Bluebonnet Trails-Seguin	$975,000	$0	$975,000
FY22	Helen Farabee	$687,028.00	$0	$687,028.00
FY22	Harris Center	$1,230,928	$0	$1,230,928

Outcomes

As of May 2022, the program has helped 25 people transition from a state hospital into the community. These people were likely to remain in the state hospital, absent these services.

Of the 25 people who transitioned into the community, eight people had been previously admitted to a state hospital through a civil commitment and ten had been previously admitted on a forensic commitment. Seven of the 25 people have successfully discharged from the program and are living independently in the community.

Appendix G. Money Follows the Person Behavioral Health Pilot

Background

From 2008 through 2017, Texas operated a Behavioral Health Pilot (BHP) under the federal Money Follows the Person (MFP) Demonstration grant from the Centers for Medicare & Medicaid Services.

BHP was designed to help adult Medicaid clients with SMI to leave nursing facilities and successfully live in the community. Pilot participants also had multiple health challenges, including chronic health conditions, physical disabilities, and substance use disorders (SUD). Many pilot participants had been institutionalized for extended periods of time.

Program Description

BHP services included Cognitive Adaptation Training (CAT), a rehabilitative service designed to help people establish daily routines, organize their environments, and build social skills; relocation assistance; employment services; and SUD services. Services were provided up to six months before discharge and up to one-year post-discharge. Services were delivered by therapists trained in CAT and substance use treatment counselors. BHP interventions were provided in partnership with MCOs, local mental health authorities, relocation specialists, and others in several central Texas counties. BHP participants received HCBS through their STAR+PLUS MCO.

Texas also used MFP-like practices, such as pre and post-discharge CAT services in a small MHBG funded pilot designed to transition people from San Antonio State Hospital (SASH) to the community.

Outcomes

Over 450 people transitioned to the community under the BHP. Outcomes included improved functioning and quality of life on standardized scales including the Quality of Life Scale, the Multnomah Community Ability Scale, and the Social and Occupational Functioning Scale. The gains were sustained after interventions ended. Almost 70 percent of people who completed BHP services remained in the

community, per independent evaluation.[110] Examples of increased independence include getting a paid job at competitive wages, driving to work, volunteering, getting a certificate of high school equivalency, teaching art classes, leading substance use peer support groups, and working towards a college degree. There were significant net cost savings to the Medicaid program (over $24.5 million by 2016).[111]

The SASH pilot also demonstrated promising results over three years, with over 50 percent of 70 participants remaining in the community, even though, unlike BHP participants, they were less likely to have access to other home and community-based supports.[112]

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[110] Bohman, T., Bradley, J., & Wallisch, L. (2016). Money Follows the Person- Behavioral Health Pilot, Year 4 Evaluation: Final Report. The Addiction Research Institute of the Center for Social Work Research, University of Texas at Austin.

[111] Updated MFP BHP Medicaid Cost Analysis, The Addiction Research Institute, Center for Social Work Research, University of Texas at Austin, March 2017

[112] Almost 60 percent did not have Medicaid. Additionally, Medicaid-eligible SASH participants who did not meet nursing facility level of care criteria did not qualify for STAR+PLUS HCBS services.

Appendix H. Overview of Ohio Mental Health Residential Facility Requirements

Table 1 below provides an overview of the requirements for residential facilities in Ohio.[113]

Table 1: Overview of Ohio Mental Health Residential Facility Descriptions, Services and Funding

Residence Category	Housing Description	Services Provided	Funding
Class I Residential Facility	Eight to 10 cottages on a single campus with 10 to 15 people with mental illness per cottage. Short-term facility (six months to one year) with an average length of stay from 30 to 90 days.	• Accommodations • 24-hour supervision • Personal care services for activities of daily living • Nursing • Mental health services	Facilities are certified as CCBHCs. Medicaid can be billed for the full continuum of services. Room and board are funded by an individual's SSI and state general revenue funds.

113 Ohio Mental Health and Addiction Services. (n.d.). Types of Licenses and Certifications. Types of licenses and certifications. Retrieved April 19, 2022, from mha.ohio.gov/supporting-providers/licensure-and-certification/types-of-licenses-and-certifications.

Residence Category	Housing Description	Services Provided	Funding
Class II Residential Facility	Integrated home within neighborhoods with three to 16 people. An average of four to five beds per home. No time limit on stay. Staff or owner are not available 24/7 but must be immediately accessible. Staffing is based on needs of the residents.	• Accommodations • Personal care services • Assistance with self-administration of medication	Room and board are funded by an individual's SSI and state general revenue funds. Local counties levy funding from property taxes.
Class III Residential Facility	Group home with three to five people with mental illness per home.	• Room and board • Transportation	Room and board are funded by an individual's SSI and state general revenue funds. Local counties levy funding from property taxes.

Appendix I. Texas Public Housing Resources

Listed below are existing and potential resources for people exiting the state hospital into the community.

Section 811 Project Rental Assistance Program

The Section 811 Project Rental Assistance program[114] provides project-based rental assistance for extremely low-income, non-elderly people with disabilities—including people with SMI—who also receive community-based supports through Medicaid. A person or household eligible for the program will pay a reduced amount of rent while in the program but cannot take the subsidy with them if they move or are removed from the program. Participating rental properties are in eight major metropolitan areas. LMHAs and LBHAs are referral agents for the program.

Project Access Voucher Program

Project Access[115] helps low-income people with disabilities transition from institutions to the community. Eligible recipients include people transitioning from state funded psychiatric hospitals. The program provides Section 8 Housing Choice Vouchers, which allow people to pay only 30 percent of their income for rent. Permanent supportive housing services may be offered by the LMHA/LBHA to assist the person in finding, securing, and maintaining housing.

Mainstream Vouchers

Mainstream Vouchers[116] are designed to help non-elderly people with disabilities, particularly those who are transitioning out of institutional or other separated settings; at serious risk of institutionalization; currently experiencing homelessness; previously experienced homelessness and currently a client in a permanent supportive housing or rapid rehousing project; or at risk of becoming homeless. Many public housing authorities across the state of Texas have access to

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[114] *Section 811 Project Rental Assistance Program*. (n.d.). Texas Department of Housing and Community Affairs. https://www.tdhca.state.tx.us/section-811-pra/

[115] *Project Access Program*. (n.d.). Texas Department of Housing and Community Affairs. https://www.tdhca.state.tx.us/section-8/project-access/

[116] *Housing Choice Voucher Section 8 Housing*. (n.d.). Texas Department of Housing and Community Affairs. https://www.tdhca.state.tx.us/section-8/

these vouchers and were required to partner with a social service agency to obtain the award.

Supported Housing Rental Assistance Program[117]

LMHAs and LBHAs provide rent and utility assistance to people with SMI, who are homeless or imminently at-risk of becoming homeless, including people leaving HHSC funded psychiatric beds. The program uses a combination of federal MHBG and state general revenue.

Funds are used for rent and utility assistance, deposits, move-in costs, and other one-time or time-limited expenses to keep people housed or moved quickly into housing. Supported Housing Rental assistance funds can be used for up to twelve months of rental assistance based on the person's identified need. Participants are required to develop a transition plan to increase personal income and secure housing without requiring Supported Housing Rental assistance. LMHAs and LBHAs can use these funds to bridge someone to a permanent housing subsidy.

Tenant-Based Rental Assistance[118]

The Tenant-Based Rental Assistance (TBRA) program, administered by TDHCA, funds local governments, LMHAs, and non-profits to provide security and utility deposits and rental subsidies for up to 24 months while the household engages in a self-sufficiency program. TBRA can also be used to bridge someone to a permanent housing subsidy.

[117] *Programs for People who are Homeless or at Risk of Becoming Homeless | Texas Health and Human Services*. (2022). Texas Health and Human Services Commission. https://www.hhs.texas.gov/services/mental-health-substance-use/mental-health-crisis-services/programs-people-who-are-homeless-or-risk-becoming-homeless#:%7E:text=Supported%20Housing%20Rental%20Assistance%20Program,payments%20and%20move%2Din%20costs.
[118] *Tenant-Based Rental Assistance*. (n.d.). Texas Department of Housing and Community Affairs. https://www.tdhca.state.tx.us/home-division/tbra.htm

Permanent Supportive Housing[119]

Permanent Supportive Housing (PSH) is an evidence-based practice originally designed for people experiencing chronic homelessness and a disabling condition. It has shown efficacy for supporting people with SMI. It provides permanent, stable housing coupled with support services along a continuum of intensity based on the person's needs. PSH is primarily funded by HUD for people experiencing chronic homelessness. This automatically precludes people with long stays in the state hospital.

There are two primary types of PSH: project-based and scattered site. Project-based is a congregate model of housing where everyone at a housing location such as an apartment complex has a disabling condition, such as SMI. Scattered site models include people in a fair market apartment complex along with the general community. Both models have proven successful in supporting people with SMI.

Affordable Housing Partnership[120]

The Affordable Housing Partnership is a new collaboration between HHSC and the Texas State Affordable Housing Corporation to provide capital subsidies to eligible developers to set-aside affordable and accessible housing units for qualified persons receiving or eligible for Medicaid Long-Term Services and Supports. People with Project Access vouchers and with Medicaid eligibility are eligible for this housing.

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[119] The United States Department of Housing and Urban Development. (2014, July). *Housing First in Permanent Supportive Housing*. https://www.hudexchange.info/resource/3892/housing-first-in-permanent-supportive-housing-brief/

[120] *Affordable Housing Partnership*. (2022). Texas State Affordable Housing Corporation. https://www.tsahc.org/developers/affordable-housing-partnership