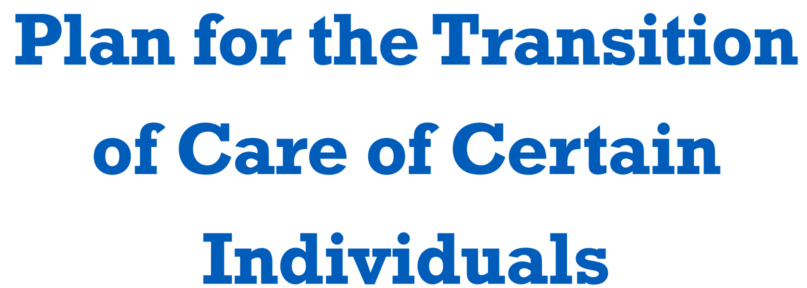

Plan for the Transition of Care of Certain Individuals

As Required by
Texas Government Code, Title 4, Subtitle I, Section 531.09991

Texas Health and Human Services Commission

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TEXAS
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Executive Summary

The *Plan for the Transition of Care of Certain Individuals* Report is submitted pursuant to the Texas Government Code, Title 4, Subtitle I, Section 531.09991. Section 531.09991 requires the Texas Health and Human Services Commission (HHSC), in collaboration with stakeholders, to develop a plan for transitioning from a hospital that primarily provides behavioral health services to a nursing facility [NF] individuals who require:

(1) a level of care provided by a nursing facility; and

(2) a high level of behavioral health supports and services.

The plan must include:

(1) recommendations for providing incentives to providers for the provision of services to individuals, including an assessment of the feasibility of including incentive payments under the Quality Incentive PaymentProgram (QIPP) for those providers;

(2) recommendations for methods to create bed capacity, including reserving specific beds; and

(3) a fiscal estimate, including estimated costs to nursing facilities and savings to hospitals that will result from transitioning individuals.

The statute authorizes HHSC to implement the plan if the commission determines that implementing the plan would increase the amount of available state general revenue.

For purposes of the Transition of Care Plan, HHSC focused the review on individuals who are currently receiving services at a Texas State-owned and -operated Mental Health Hospital. In reviewing the potential clients who might be eligible for a discharge to a nursing facility and for whom a discharge to another setting would not require a court order or involvement, HHSC identified only 10 individuals. As a result, HHSC determined that it is improbable that a transition of these 10 individuals would result in an increase in available state general revenue and the Transition of Care Plan will not be implemented at this time.

1. Introduction

The *Plan for the Transition of Care of Certain Individuals* report provides information pertaining to the identified population falling under selection criteria as directed by Section 531.09991, the identified needs and service requirements of persons currently in an HHSC-operated state hospital that may be appropriate to discharge to an NF, recommendations for incentives to providers for the provision of services, recommendations for methods to create capacity, and fiscal estimates for transitioning these clients from a state hospital to an NF.

2. Background

For purposes of the *Plan for the Transition of Care of Certain Individuals* report, HHSC focused on state hospitals and state hospital patients.

State Hospitals

HHSC operates nine state hospitals on ten campuses across the state, which provide inpatient psychiatric services to adults and youth experiencing acute psychiatric crises or chronic mental health conditions. People served by state hospitals are typically diagnosed with serious mental illnesses (SMI), which is 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.

Since fiscal year 2016, state hospitals have primarily served people who are under a forensic commitment. State hospitals also serve those found incompetent to stand trial and ordered to receive inpatient competency restoration services under the Code of Criminal Procedure, Title 1, Chapter 46B, or found not guilty by reason of insanity and ordered to receive inpatient mental health treatment under Code of Criminal Procedure Chapter 46C.

There is currently a waitlist for state hospital admission due in part to the increased prevalence of mental health needs and the rising population in Texas.

A major factor impacting patient length of stay and overall capacity is the availability of appropriate discharge locations. While most people who stay in state hospitals for extended periods of time are men under the age of 65, an increasing number of people served in state hospitals have complex medical needs that may necessitate an NF level of care upon discharge. Although some NFs do accept and provide care to individuals discharged from state hospitals, many NFs decline to accept these patients due to the patient's lack of funding sources, reliance on anti-psychotic medications, and other various barriers.

State Hospital Transition Teams

The 2024-25 General Appropriations Act, House Bill 1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Rider 52) funded State Hospital Transition Teams as part of the comprehensive strategy to strengthen inpatient capacity and enhance continuity of care. Each state hospital is assigned a discharge specialist, complemented by a statewide coordinator.

In accordance with the Health and Safety Code, Section 534.0535, as amended by Senate Bill 26, 88th Legislature, Regular Session, 2023, the discharge specialists are the state hospital employees designated to provide transition support services. Discharge specialists are tasked with collaborating closely with care teams and community partners to identify suitable placements and support systems for individuals who are deemed ready for discharge and "have been:

(1) admitted to and discharged multiple times from a facility during a 30-day period; or

(2) in the state hospital for longer than 365 consecutive days" (Health and Safety Code, Section 534.0535).

This initiative advances beyond typical continuity of care protocols with the expectation that it will mitigate several obstacles encountered by individuals during their transition back to the community. The discharge specialists primarily focus on complex patient cases with an emphasis on post-discharge placement and support and maintain a small caseload of ten or fewer due to the intensive case management required. As of July 2024, the discharge specialists have facilitated 65 discharges, some of which to NFs, and at least six of the 65 individuals had a length of stay ranging from approximately 10 to 15 years at discharge.

Texas Nursing Facilities

The State of Texas licenses approximately 1,200 private and non-state government-owned NFs. NFs can be certified for Medicaid, Medicare, both Medicaid/Medicare, or private pay. NFs provide services to individuals whose medical condition regularly requires the skills of licensed nurses to maximize resident autonomy, function, dignity, and comfort. NF services are provided to individuals of all ages with physical, intellectual, or developmental disabilities who require regular nursing care or need help with tasks of daily living. Required services provided in an NF include room and board; nursing; medical supplies, equipment, and accessories; over-the-counter drugs; personal-need items; and

social services and activities. Add-on services provided in an NF may include ventilator care, physician-ordered rehabilitative therapies, custom-powered wheelchairs, augmentative communication devices, and emergency dental services.

Individuals admitted to an NF in Texas must be able to meet the medical necessity requirements that include the need for around-the-clock nurse monitoring and require care and services that cannot be provided in a less restrictive environment, such as Home Health or Assisted Living. NFs admit residents for a multitude of chronic and acute conditions, such as:

- Alzheimer's Disease and other related dementias;
- Wandering and elopement type of behaviors related to Alzheimer's and dementia;
- Falls;
- Decline in ability to perform activities of daily living (ADLs) such as bathing, toileting, hygiene, and eating/nutritional management;
- Decline in mobility such that the individual cannot be safely cared for at home;
- Chronic medical conditions such as diabetes, congestive heart failure, chronic obstructive pulmonary disorder, and other conditions requiring 24-hour monitoring; and
- High acuity care needs such as complex wounds, long-term tracheostomy or ventilator care, parenteral/enteral nutrition, and post-acute care.

Individuals with SMI who may benefit from discharging to an NF from a state hospital have ongoing behavioral health needs in addition to the care needs typically addressed in an NF. An NF must have sufficient resources, including specially trained staff, to provide care for individuals with SMI diagnoses. The *Plan for the Transition of Care of Certain Individuals Report* contains HHSC's assessment and recommendations related to NFs creating and expanding capacity for those who may benefit from being discharged from a state hospital to an NF.

3. Patient Profiles

During the summer of 2022, state hospitals developed the Patient Discharge Needs Form (PDNF), which is a form embedded in the state hospital's electronic health record. The PDNF is a data-gathering tool and is not a clinical assessment, determination of discharge readiness, or care plan. The PDNF starts with the question, "Does the patient need continued inpatient hospitalization if appropriate support and monitoring were available outside of the hospital?" If the response is "no," the PDNF prompts responses to a series of questions designed to understand better what setting, monitoring, and supports the patient needs to succeed after discharge as well as potential barriers to discharge. The PDNF is to be completed by the patient's recovery team at every 90-day treatment review. It is typically completed by the patients' social workers and the full recovery team, including a psychiatrist, nurse case manager, psychologist, etc.

HHSC identified 104 patients who may benefit from being discharged to an NF. The basis of these patient profiles is PDNF data pulled on December 15, 2023, which reflects a snapshot of the state hospital patient population. Each of the 104 patients was noted in the PDNF to no longer need continued inpatient hospitalization for clinical treatment reasons if appropriate support and monitoring were available outside of the hospital. However, the ability to actually discharge patients if an appropriate discharge facility was available may be limited by the need to obtain a court order authorizing the discharge. In addition to meeting the criteria that indicate inpatient behavioral health services are no longer necessary, a nursing facility was noted as a potentially appropriate setting for each of these patients.

Provided below is a breakdown of relevant information pertaining to the 104 identified persons. Please note the categories below will overlap, as the individual may fall within multiple categories.

Of the 104 people identified for this evaluation:

- 96 (92.3 percent) have complex medical needs, including, but not limited to:
  - Alzheimer's Disease and other related dementias,
  - Wandering and elopement type of behaviors related to Alzheimer's and dementia,
  - Falls,

    - Decline in mobility such that the individual cannot be safely cared for at home, and
    - Chronic medical conditions such as diabetes, congestive heart failure, chronic obstructive pulmonary disorder, and other conditions requiring 24-hour monitoring.
- 91 (87.5 percent) need assistance with ADLs,
- 82 (78.8 percent) have been a patient for at least one year as of the date the data was pulled,
- 76 (73.1 percent) have a primary diagnosis of schizophrenia or schizoaffective disorder,
- 50 (48.1 percent) were under 65 years of age and subject to the institutions of mental diseases (IMD) exclusion as of the date the data was pulled, and
- 35 (33.7 percent) need and do not have a guardian to consent on their behalf to be discharged.

Commitment and Legal Status

Beyond an individual's diagnosis and treatment needs, commitment type and legal status are also a factor that can impact discharge. State hospitals serve a small number of individuals who are voluntarily receiving treatment and primarily serve individuals involuntarily admitted under a civil commitment or admitted under a forensic commitment after being found incompetent to stand trial or not guilty by reason of insanity.

State hospitals may discharge patients to community settings who were being served under forensic or civil commitments. However, it requires coordination between the local mental health authority (LMHA), state hospital, and community provider (e.g., NF provider), and ultimately approval from the court of commitment. There are fewer barriers to transferring individuals to NFs who are receiving treatment voluntarily. In those cases, the transfer would be subject to the consent of only the individual or their legally authorized representative (LAR).

Of the 104 patients identified who may benefit from being discharged to an NF:

- 53 patients (51 percent) were considered a danger to themselves or others or at risk of deterioration resulting from their mental illness and civilly committed to inpatient mental health services pursuant to the Texas Health and Safety Code, Chapter 574;

- 35 patients (33.7 percent) were found incompetent to stand trial and ordered to receive competency restoration services, pursuant to the Texas Code of Criminal Procedures, Chapter 46B;
- 6 patients (5.8 percent) were found not guilty by reason of insanity and ordered to receive inpatient treatment pursuant to the Texas Code of Criminal Procedures, Chapter 46C (Tex. Code Crim. Proc. ch. 46C, 2023) and the Texas Penal Code, Chapter 8 (Tex. Penal Code ch. 8, 2023).
- 10 patients (9.6 percent) were admitted voluntarily pursuant to the Texas Health and Safety Code, Chapter 572; and

Individuals currently under a forensic inpatient commitment would either be:

- Modified to a forensic outpatient commitment subject to their outpatient management plan approved by the court; or
- In some circumstances, the court may drop applicable charges, and the patient would be admitted to a nursing facility subject to the consent of themselves or their LAR.

An additional consideration is whether an individual has been determined to be manifestly dangerous. According to Texas Administrative Code (TAC) (2024), "manifestly dangerous" is the term used to describe an individual who, despite receiving appropriate treatment, including treatment targeted to the individual's dangerousness, remains likely to endanger others and requires a maximum security environment in order to continue treatment and protect public safety (Tex. Admin. Code §25.415(303), 2024). These patients are served in a maximum-security unit (MSU). Following a finding by the state hospital dangerousness review board (DRB), they would first be transferred to a non-maximum-security unit (non-MSU) before being discharged. At the time of the data pull in December 2023, none of the 104 identified patients were being served in an MSU. However, one patient was transferred from a non-MSU to an MSU in the months following the data pull.

The average length of stay for the 104 patients at the time the data was pulled was approximately five years. In contrast, the typical average length of stay for an adult receiving services voluntarily or under a civil commitment in fiscal year 2023 was 86 days (less than three months) and 346 days (less than a year) for an adult receiving services under a forensic commitment. Therefore, the population of 104 patients remains in a state hospital for 5 to 20 times longer than the typical state hospital patient.

Due to the outside factors, such as court authorization, to discharge a person who is involuntarily committed to a state hospital, it is prudent to assume that HHSC would be able to transition the 10 voluntarily admitted patients, if a suitable discharge was available.

Hospital Setting Services Before Transition

Services the identified patients received while in the state hospital vary based on a person's specific diagnoses and needs. The following psychiatric, professional, and therapeutic services serve to establish a basis for the potential ongoing treatment needs of individuals discharged to an NF:

- Antipsychotic Medication and Medication Administration
- Psychological Testing and Evaluation
- Psychotherapy
- Physical Therapy Evaluation and Activities
- Occupational Therapy Evaluation and Activities
- Speech-Language Pathology Evaluation and Activities
- Individual Therapy
- Rehabilitation Therapy
- Recreational Therapy
- Music Therapy
- Dance Therapy
- Art Therapy

When state hospital recovery teams determine if an NF is an appropriate setting for discharge, and NF providers determine acceptance or denial to their facility, the person's diagnosis, needs, and legal situation are all considered.

4. Stakeholder Feedback

Government Code, Section 531.09991 requires HHSC to consult with NF providers in the development of this transition plan. In June 2024, HHSC held a meeting with representatives from the following three nursing facility associations: The Coalition of Independent Nursing Home Providers, LeadingAge Texas, and The Texas Health Care Association (THCA). The meeting included representatives from several HHSC areas and departments, including the Provider Finance Department (PFD), Medicaid and Children's Health Insurance Program [CHIP] Services (MCS), and Health and Specialty Care System (HSCS).

During the meeting, HHSC provided a general overview of the requirements under the Government Code and the results of the agency's preliminary internal evaluation. NF association representatives from the Independent Nursing Home Coalition identified three objectives that HHSC would need to ensure for NF providers to provide services for persons transferred from state hospitals, including:

- Adequate and appropriate funding,
- An expedited process for determining Medicaid eligibility for this population, and
- Regulatory understanding and acknowledgment of this population.

Adequate and Appropriate Funding

Stakeholders indicated they would be unable to serve these individuals without adequate and appropriate funding. They requested reimbursement be appropriate for required services, staff support, and any additional facility or operations costs not contemplated in the current Medicaid daily care reimbursement rates.

Per representatives from LeadingAge, THCA, and the Independent Nursing Home Coalition, an add-on payment or special reimbursement class for a separate wing within an existing nursing facility due to economies of scale is needed; providers assume that this would require up to 16 beds (as above 16 beds may trigger a review of the facility to see if it should be categorized as an IMD). Given the small number of individuals who may be able to be discharged and the small likelihood that all these individuals would want to be discharged to a single facility, it is unlikely that the economy of scale desired would be reached.

HHSC included a fiscal estimate in this report based on a preliminary NF cost per day to serve these individuals.

Expedited Process for Determining Medicaid Eligibility

Stakeholders identified a need for a different expedited eligibility process for these discharge-eligible patients. They indicated that it usually takes 60 to 90 days for a new applicant to obtain Medicaid eligibility and NFs consider Medicaid eligibility delays a significant barrier for taking these patients. Stakeholders indicated other states have an expedited eligibility process for these individuals that HHSC may want to evaluate. Texas Medicaid does not currently have an expedited process for transitioning individuals from a behavioral health (BH) setting to an NF.

Currently, a person transitioning from a state hospital to an NF would have to apply for NF Medicaid. To be determined eligible for NF Medicaid, an applicant would have to submit an H1200 (Application for Assistance) and meet the requirements for a Medicaid-eligible NF. These requirements include the individual's resource limit, income limit, being 65 or older or meeting Social Security Administration's (SSA) definition of disability, having an approved medical necessity, having a minimum 30-day stay in the NF, etc.

A person who does not already have a disability through Social Security (SS) will have to apply with the SSA. HHSC would not be able to decide until 90 days after the SS disability application has been submitted. Medicaid for the Elderly and People with Disabilities D-2500, Supplemental Security Income (SSI) Applicants and Retroactive Coverage, and Federal regulations prohibit a state from making a disability decision that conflicts with an SSA decision. The HHSC Disability Determination Unit (DDU) cannot make an independent decision until all appeals to SSA regarding the date of disability onset for both Retirement, Survivors, and Disability Insurance (RSDI) Title II and SSI Title XVI are settled.

Regulatory Understanding and Acknowledgment

Stakeholders requested regulatory understanding and acknowledgement for this population given the resident complexity. They indicated that NFs have many unique regulatory requirements for which noncompliance can result in significant fines and penalties. Regulatory recognition needs to account for the difficulties of

serving this population, such as separate certification for providers who serve this population. Stakeholders likewise communicated that NF participation should be voluntary, that state hospital patients should be appropriately screened for potential physical, behavioral, and legal barriers to entry, and that individuals should be discharged back to state hospitals at an NF's discretion.

NFs must comply with state and federal regulations related to the provision of care and services. NFs must conduct and document a facility-wide assessment, in accordance with 42 Code of Federal Regulations (CFR) Section 483.71, "to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and during emergencies." The assessment must address or include:

- The facility's resident population, including the number of residents and their care needs;
- The staff competencies and skill sets necessary to provide the level and type of care necessary;
- The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
- Any ethnic, cultural, or religious factors that may potentially affect the care provided.

NFs must not admit, nor are they required to admit, a resident for whom they cannot provide care as determined by the facility-wide assessment. NFs that admit residents with SMI or other care needs do so with the expectation that the NF will be compliant with all applicable state and federal requirements.

HHSC recognizes the challenges of serving this population but cannot abstain from enforcing state and federal requirements for NFs. If an NF provider determined acceptance of an individual to their facility, the NFs would be responsible for ensuring that state hospital patients are appropriately screened for potential physical, behavioral, and legal barriers to entry.

In regard to the individuals being discharged back to state hospitals at an NF's discretion, NFs must adhere to state and federal regulations applicable to the admission, transfer, and discharge of an NF resident, in accordance with 42 CFR Section 483.15 and Title 26 Texas Administrative Code (26 TAC) Chapter 554, Subchapter F. Regulations about admission, transfer, and discharge do not differentiate based on where a resident was previously living. Criteria for admission

to a state mental health facility or a facility with a contracted psychiatric bed are outlined in 26 TAC Section 306, Subchapter D. HHSC cannot ensure that individuals are easily discharged back to state hospitals at an NF's discretion because that could be deemed as potential noncompliance with state and federal requirements.

5. Quality Incentive Payment Program

Quality Incentive Payment Program (QIPP) is a state-directed payment program (DPP) for Texas NFs serving residents enrolled in the STAR+PLUS Medicaid managed care program. The program is governed by regulations set forth in 42 CFR Section 438.6(c) and must be approved by the Centers for Medicare and Medicaid Services (CMS). Enrolled NFs earn payments for meeting performance targets and quality requirements.

CMS approves QIPP as a value-based payment system, which requires all payments in the program to be based on improvement-over-self, achievement of program-wide performance targets, or both. Introducing structure measures or other administrative requirements, such as requiring dedicated beds for individuals transferred from a state hospital or related admission incentives, could jeopardize CMS approval and would be inconsistent with the federal regulations that QIPP is authorized to exist under. Moreover, for state fiscal year 2025 and beyond, HHSC has committed to using nationally recognized quality measures and data sources. Developing state-designed measures and reporting systems would put the program at risk.

Based on federal requirements, the QIPP for NFs is not suited to specifically incentivize NFs to accept or reserve beds for members transferring from a state hospital.

6. Methods to Create Bed Capacity

Mandatory Program to Reserve Beds

There are challenges with creating recommendations for methods to create bed capacity, including reserving specific beds within the facility. NFs are required to use Medicaid beds on a first come first served basis if the facility has an available bed and can adequately support the NF level of care needed by the Medicaid-eligible individual (Tex. Admin. Code § 554.501(a)-(d), 2024; 42 C.F.R. § 483.15(a), 2024; Tex. Admin. Code § 554.501(e), 2024; 42 C.F.R. § 483.15(a)(6), 2024). Further, an NF is not required to admit every prospective resident. NFs can choose which residents they admit based on the facility assessment. Furthermore, NFs cannot be required to accept every potential resident in this program if they cannot adequately support an individual with SMI (Tex. Admin. Code § 554.904, 2024; 42 C.F.R. § 483.40, 2024; 42 C.F.R. § 483.70(e), 2024; SOM Appendix PP, F622, 2024).

State and federal rules require NFs to develop bed-hold policies for existing residents who leave the facility to a non-NF level of care setting, such as a hospital or for a therapeutic home visit. These policies must be consistent with state and federal rules and be explained to the resident or their representative in writing before leaving the NF (Tex. Admin. Code § 554.503(a)-(b), 2024; 42 C.F.R. § 483.15(d), 2024). The policy must provide that a resident whose hospitalization or therapeutic leave exceeds the bed-hold period under the State Plan (three days for a therapeutic home visit or upon admission to a hospital) (Tex. Admin. Code § 554.2603, 2024; Tex. Admin. Code § 554.2615, 2024; 42 C.F.R. § 483.15(e), 2024) be permitted to return to the facility and the resident's "previous room, if available, or return to the facility immediately upon the first availability of a bed in a semi-private room" if the resident still requires NF level of care and is eligible for Medicaid (Tex. Admin. Code § 554.503(c)-(d), 2024; 42 C.F.R. § 483.15(d), 2024; 42 C.F.R. § 483.15(e)(i), 2024).

Under the bed-hold rules, an NF is permitted to charge the resident or responsible party a bed-hold fee not to exceed the resident's daily rate paid by Medicaid. The resident or responsible party may choose not to enter into a pay-to-hold bed agreement (Tex. Admin. Code § 554.503(e), 2024; 42 C.F.R. § 483.15(e), 2024). Individuals unable to afford the bed-hold fee may choose not to enter into a bed-hold agreement.

Bed-hold requirements for existing residents, requiring either the current resident be permitted to return to their previous bedroom or the first available Medicaid-certified bedroom, could mean that holding Medicaid beds for individuals with SMI transitioning out of state hospitals may not be feasible or subject to change without prior notification.

HHSC can expect NFs and applicable stakeholder associations to request reimbursement to hold Medicaid beds for individuals with SMI. NFs would be unlikely to reserve Medicaid beds unless there were no other individuals requesting admission to the facility and occupying the Medicaid beds. Furthermore, the TAC cannot be amended to require NFs to hold Medicaid beds for individuals with SMI if such amendments conflict with state or federal requirements related to bed-hold requirements.

Voluntary Program to Reserve Beds or Establish a Psychiatric Wing

During HHSC's meeting with stakeholders on June 11, 2024, the representatives of the NF associations indicated that some providers (estimated 1 out of 10) may be willing to participate in a program that reserves beds for individuals transferring from state hospitals. However, as described above in the Stakeholder Feedback section, certain conditions should be met. These conditions include adequate and appropriate funding, an expedited process for determining Medicaid eligibility for this population, and regulatory understanding and acknowledgment of this population. Certain stakeholders indicated a reserved bed program is feasible given the low occupancy in NFs in the state. HHSC responded to the stakeholder feedback above.

State-operated Capacity

Since 2017, the Texas Legislature has made historic investments in inpatient psychiatric capacity, in part to rebuild existing state hospitals. This investment has resulted in a growing number of vacant buildings on state hospital campuses. Depending on campus and building availability, there is potential to repurpose space on existing state hospital campuses to serve as state-operated NFs; however, this repurposing may require capital improvements.

Proximity to a state hospital creates potential benefits for a state-operated NF. Proximity could enhance the continuity of care upon discharge and transition,

especially if leveraging the state hospital transition teams. The NF could potentially leverage the auxiliary services on the state hospital campus, such as the warehouse and supplies, laundry, fleet, central kitchen and nutrition services, and access to training and training spaces. CMS has provided guidance that allows for the co-location of hospitals and other healthcare facilities on the same campus (CMS, 2021).

A state-operated NF could also allow a smaller facility of 16 beds or less, thereby avoiding the IMD exclusion for Medicaid-eligible patients who are not yet 65 years of age. Additionally, as a public utility, the state-operated NF could focus on appropriate and timely treatment of the individual without delay due to issues with reimbursement or insurance coverage. Lastly, a state-operated NF would serve as a public safety net and would not issue denials due to psychoactive medication use or a higher level of behavioral health needs.

However, HHSC is unable to estimate the cost to make capital improvements and operate an NF on a state hospital campus because there are no state-operated NFs located on a hospital campus currently in Texas and a full analysis of potential vacant buildings has not been completed.

7. Other Considerations

Preadmission Screening and Resident Review (PASRR)

PASRR is a federally mandated process required for every potential NF admission. The goals of PASRR are to identify individuals with mental illness, intellectual disability, developmental disability, or related conditions; ensure appropriate placement, whether in the community or NF; and ensure individuals receive the needed services for their condition. The PASRR process for SMI can be summarized as follows:

- The PASRR Level 1 (PL1) screening process identifies the potential for a mental illness. A positive PL1 for mental illness requires further investigation via a PASRR Evaluation (PE) conducted by an LMHA.
- If the person is being admitted from a psychiatric facility, the PL1 will almost always be positive, and the PE must be completed before NF admission.
- For anyone with SMI, the PE will include recommendations for specialized services and community-based alternatives where appropriate.
- The NF must certify that they are able to provide the level of care the person requires (including any specialized services not provided through the LMHA).

Individuals identified on the PE as positive for mental illness can receive recommended specialized services to improve or maintain functioning, whether they become an NF resident or live in the community. Mental health specialized services are determined on a case-by-case basis and include services like crisis intervention, psychosocial rehabilitation, and medication training and support. Alternatives to NF care would also be identified and discussed with each individual through the PASRR process. State hospitals must follow the PASRR process as part of NF discharge planning and procedures and receive periodic PASRR training by HHSC.

Olmstead Decision

HHSC's transition plan does not consider housing individuals with SMI in an NF as a preference to home and community-based services (HCBS). If a patient can be served in the community and is eligible for the necessary services, state hospitals

make all efforts to ensure this community-level service occurs. This plan is consistent with the 1999 Olmstead Decision, which holds that people with disabilities (of any age) have a qualified right to receive state-funded support and services in the community rather than institutions. States should serve persons with disabilities, including people with SMI, in community settings rather than institutions when:

- The state's treatment professionals have determined community placement is appropriate;
- Transfer from institutional care to a less restrictive setting is not opposed by the affected person; and
- Placement can be reasonably accommodated, considering the resources available to the state and the needs of others with disabilities.

In part to minimize risks related to Olmstead, Texas operates a federally-mandated PASRR process for all individuals seeking admission to a Medicaid NF.

To further affirm Texas' commitment to serving individuals in the least restrictive, most integrated setting consistent with their needs, the *Plan for the Transition of Care of Certain Individuals* report, as required by Government Code, Section 531.09991, considered state efforts to transition individuals to HCBS. For example, the state is currently implementing the CMS-funded Bridge to STAR+PLUS pilot project in Travis and Bexar counties. This pilot project focuses on adults in state hospitals who meet an NF level of care and provides transition supports (i.e., transition specialist, peer support, temporary rental assistance, help reconnecting to SSI/Medicaid benefits, assistance in locating housing, etc.) through LMHAs to help people rejoin the community, including connection to STAR+PLUS HCBS benefits.

Unfortunately, not all individuals can be successfully served in the community due to their complex needs, even with these efforts. Additionally, state hospitals are typically a more restrictive environment than NFs. The patients identified have stabilized psychiatric needs and co-occurring medical needs on a level that exceeds typical state hospital care and could be better addressed by an NF that specializes in that type of care.

8. Fiscal Evaluation

HHSC evaluated costs to state hospitals to serve the identified 10 individuals residing in state hospitals on their own volition and deemed eligible for discharge. HHSC compared state hospital costs to NF costs to determine the fiscal impact to the state of transitioning the selected population from state hospitals to NFs. Cost estimates at both facility types were made under the following assumptions:

- Some cost categories (e.g., cost of medication and some professional medical and therapeutic charges) can be compared across both facility types, whereas other cost categories (e.g., daily hospital charges, Patient Driven Payment Model (PDPM) component costs at NFs) are unique to each facility type. As such, HHSC treated costs at state hospitals and NFs separately and subsequently compared the estimated daily costs per client at each facility type.
- Cost estimates were calculated as average costs on a per-client, per-day basis. This methodology considers the possibility that the size of the population eligible for transition or the scale of the currently proposed transition program might change, rendering total-cost estimates less useful than a per-client daily average.
- HHSC assumed all individuals were Medicaid-eligible in the state hospital and that they would maintain Medicaid eligibility after transitioning to an NF. HHSC cannot accurately predict if all individuals would be eligible to receive Medicaid services in the state hospital or that they would maintain Medicaid eligibility upon transition to an NF. However, HHSC's fiscal estimate assumes the state would maximize Federal funding available to individuals covered in the transition plan.

Cost Estimate at State Hospitals

The cost estimate for the 10 discharge-eligible patients at state hospitals is based on the average daily cost per patient as reported quarterly to the Legislative Budget Board (LBB). According to the HHSC Key Performance Measures Report, as of the third quarter of fiscal year 2024, the average daily cost per occupied state hospital bed is $831.00, all funds.

State hospital total cost: $831.00

Cost Estimate at Nursing Facilities

Cost estimates for clients' stay in an NF are based on most recently examined NF cost reports data, fiscal year 2024 Medicare PDPM rates, 2023 State Hospitals Cost Report data, and wages data from the Bureau of Labor Statistics (BLS) available at the time of the analysis. All costs are presented per client per day. Cost categories and charges associated with state hospital clients eligible for transition to NF care include:

1. Highest PDPM LTC daily rate (group E1Y): $322.01.

Due to the higher needs of these individuals, requiring trained staff to support individuals with SMI, HHSC used the highest Medicaid PDPM for Long-term Care (LTC) rate, which HHSC plans to implement by September 1, 2025. More information on the assumptions and calculation of the cost estimates can be found in Appendix A.

The PDPM LTC rate does not include Physical Therapy (PT), Occupational Therapy (OT), and Speech and Language Pathology (SLP) services, so HHSC included the Medicare PDPM rate for these services:

2. PDPM Medicare PT/OT/SLP cost: $83.46 (calculated as an unweighted average of each therapeutic service's average daily rate).

HHSC identified the following therapeutic services currently being administered to transition-eligible patients at state hospitals, which are included in NF cost estimates. Some of these services are not currently covered by Medicaid long-term stay benefits provided in Texas. This analysis does not consider the cost of the Medicaid program to either create a new waiver or Medicaid entitlement program.

3. Individual therapy with a licensed professional counselor: $19.44.
4. Rehab therapy with rehab therapy tech (i.e., recovery skills, connecting, healthy lifestyle): $71.95.
5. Recreational therapy with a licensed recreational therapist: $45.25.
6. Music therapy with a licensed music therapist: $11.24.
7. Dance therapy with a dance therapist: $11.24.
8. Art therapy with art therapist: $13.57.
9. Psychiatric Care Physician costs: $7.83.

Additional patient-level cost estimates include:

1. Prescription medication costs: $46.02.
2. Durable Medical Equipment (DME) costs: $1.22.

In addition to providing daily care, including the services and medications mentioned above, the daily cost for a client's stay in an NF should account for accommodations in a secure wing. This specialized area should be properly equipped and staffed with trained personnel to ensure the safety of both residents and staff. This consideration is particularly important for new residents transitioning from state hospitals who have high behavioral needs. The variation of this cost is significant, and HHSC cannot estimate it at this time.

1. Secure wing accommodation cost: $ [undetermined].

The implementation of the transition plan, as requested, will result in increased administrative costs for HHSC. These additional expenses will stem from several factors:

- Providing enhanced support to clients in overcoming barriers to Medicaid eligibility;
- Developing, executing, and managing new contracts specifically designed to serve this population; and
- Other required implementation activities.

These expanded administrative responsibilities are expected to contribute to the overall cost of the transition plan.

2. Additional administrative cost for HHSC: $ [undetermined].

Nursing facility total cost: Minimum of $633.23.

Fiscal Impact per Client per Day

HHSC does not anticipate a savings based on the fiscal impact per client per day evaluation. While there appears to be savings when comparing $831.00 to the identified total costs of $633.23/day, there are undetermined costs outlined above that should be considered. The full fiscal impact of such a transition remains uncertain due to these potentially unaccounted variables.

Daily fiscal impact calculation (AF): $633.23 – $831.00 = ($197.77) + [undetermined costs].

DSH/UC Funding Impact

The Disproportionate Share Hospital (DSH) is a supplemental payment program authorized under section 1923 of the Social Security Act. DSH is an important supplemental payment for eligible hospitals that serve a disproportionately large number of Medicaid and low-income patients. The inclusion of consideration for DSH is important because estimated changes to associated Medicaid costs could impact the state hospital's estimated DSH payment. HHSC is currently appropriated state general revenue that is used to pay most of the per day per client costs at state hospitals. However, HHSC gathers the cost information for the hospitals and applies for DSH funding on behalf of the state. For any allowable costs that can receive federal funding through the Medicaid DSH program, HHSC draws the federal funding to pay for the state hospital costs and transfers an equivalent amount of state general revenue back to the treasury. This "GR-sweep" results in a large number of state hospital costs receiving some level of federal Medicaid reimbursement, even though it is not identified that way through the General Appropriations Act.

Based on an analysis of the DSH cost impact estimate, the estimated DSH funding impact is $3,271,060 total or $896.18 per day per Medicaid-eligible client. There were only eight state hospitals in state fiscal year 2023 that met the Medicaid eligibility criteria. Therefore, there is no DSH impact offset applied for transitioning state hospital residents who were not eligible for Medicaid. HHSC also evaluated if there would be any Uncompensated Care (UC) funding impact. The UC program is a supplemental payment program authorized through the Medicaid Section 1115 demonstration waiver. UC is a supplemental payment for eligible hospitals providing uncompensated uninsured charity care. The inclusion of consideration of UC is important because estimated changes to uninsured charity care costs could impact the state hospital's estimated UC payment.

No UC impact was determined because there were no uninsured charity costs associated with the UC program for the patient population identified for potential transfer. This analysis focuses on cost impacts associated with the identified patient population for the purpose of this report. It does not preclude the fact that additional patients will be admitted to occupy the beds vacated by individuals discharged from state hospitals and admitted to NFs.

However, to qualify for DSH or UC, the state hospital must have a minimal amount of Medicaid utilization each year. Transitioning clients who are Medicaid eligible and enrolled (such as voluntarily committed clients who are over 65) may negatively impact the ability of state hospitals to be DSH- and UC-eligible, thereby costing the state the federal funding that is currently drawn on their behalf. These funds total more than $165 million annually.

Method of Finance (MOF)

Medicaid eligibility is a key factor in determining the funding source for providing care to those individuals. Unless private pay is available, general revenue is the main funding source for services provided to non-Medicaid recipients. The cost of providing care to Medicaid-eligible NF residents would receive a federal match, reducing the cost to the state.

Transitioning patients from a state hospital setting to a nursing facility setting may lead to a potential reallocation of funding towards federal funds, resulting in savings in general revenue, because more individuals may receive Medicaid coverage with eligibility assistance. This shift is attributable to the differences in benefits and available funding between NFs and psychiatric hospitals.

As stated above, there were a limited number of state hospital residents in state fiscal year 2023 who were identified as meeting the Medicaid eligibility criteria. However, Medicaid eligibility is not static and can change for each individual. HHSC cannot accurately predict if all individuals would be eligible to receive Medicaid services upon transition to an NF. The transition plan would include assistance with determining Medicaid eligibility, so the MOF assumption for NF cost is that all individuals will be Medicaid-eligible during their stay in an NF.

The fiscal estimate presented below accounts for patients' Medicaid eligibility during their hospital stay, which applies the federal share percentage of the Federal Medical Assistance Percentage (FMAP) to the hospital cost for those patients (total of 8) and accounts for DSH impact offset associated with FMAP for Medicaid eligibility.

HHSC estimated the fiscal impact for the 10 individuals, as shown in Table 1 below. This estimate is based on a comparison between:

1. The average daily cost of care per patient in a state hospital: $831.00
2. The average daily cost of care per client in an NF: $633.23

The fiscal impact calculation assumes 365 days per fiscal year. It should be noted that the DSH offset is applied to the fiscal impact solely for eight individuals who were Medicaid-eligible during their hospital stay. For a detailed breakdown of the FMAP by cost components for average daily costs, please refer to Appendix A.

Table 1. Estimated Fiscal Impact for State Fiscal Year (SFY) 2026 and SFY 2027.*

	SFY 2026	SFY 2027
General Revenue (GR)	$1,034,483	$1,035,724
Federal Funds (FF)	$1,514,718	$1,513,477
All Funds (AF)	$2,549,201	$2,549,201

Note: *The fiscal impact assumes the following FMAP for SFY 2026: the state share is 40.58%, and the federal share is 59.42%. The fiscal impact assumes the following FMAP for SFY 2027: the state share is 40.63%, and the federal share is 59.37%.*

HHSC has determined it is likely the plan would not increase the amount of available state general revenue. In addition, the estimate does not account for identified costs that could not be determined.

9. Conclusion

HHSC acknowledges a transition from a hospital that primarily provides behavioral health services to a nursing facility could be beneficial for the transitioning client. During HHSC's evaluation, it was noted there were a small number of anecdotal "success" stories. One such success story was evaluated in the context of this report and it was identified it required extensive coordination and collaboration with the client, the client's family, and the NF provider.

HHSC does not anticipate that a plan can be implemented at this time to have a large (or scaleable), repeatable impact that would result in an increase in state general revenue. Rather, HHSC recommends that the State Hospital Transition Teams be continued and potentially expanded to provide the individualized and intensive support necessary for discharge planning for individuals with co-occurring medical needs and SMI diagnoses with the hope that these efforts can continue the success stories that are occurring now.

List of Acronyms

Acronym	Full Name
AF	All Funds
AY	Accounting Year
ADL	Activities of Daily Living
BH	Behavioral Health
BLS	Bureau of Labor Statistics
CFR	Code of Federal Regulations
CHIP	Children’s Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
DDU	Disability Determination Unit
DME	Durable Medical Equipment
DPP	Directed Payment Program
DRB	Dangerousness Review Board
DSH	Disproportionate Share Hospital
FF	Federal Funds
FMAP	Federal Medical Assistance Percentage
FTE	Full-Time Equivalent
GR	General Revenue
HCBS	Home and community-based services
HHSC	Health and Human Services Commission
HSCS	Health and Specialty Care System
IMD	Institutions of Mental Diseases
iQIES	Internet Quality Improvement and Evaluation System
LAR	Legally Authorized Representative
LBB	Legislative Budget Board
LMHA	Local Mental Health Authority
LTC	Long-term Care
MCO	Managed Care Organization
MCS	Medicaid and CHIP Services
MDS	Minimum Data Set
MHPSA	Mental Health Professional Shortage Area
MOF	Method of Finance

Acronym	Full Name
MSU	Maximum-Security Unit
NF	Nursing Facility
NHQI	Nursing Home Quality Initiative
OT	Occupational Therapy
PASRR	Preadmission Screening and Resident Review
PDNF	Patient Discharge Needs Form
PDPM	Patient Driven Payment Model
PDPM LTC	Patient Driven Payment Model for Long-term Care
PFD	Provider Finance Department
PE	PASRR Evaluation
PHE	Public Health Emergency
PL1	PASRR Level 1 screening
PT	Physical Therapy
QIPP	Quality Incentivizing Payment Program
QM	Quality Measures
RSDI	Retirement, Survivors, Disability Insurance
SAMHSA	Substance Abuse and Mental Health Services Administration
SFY	State Fiscal Year
SLP	Speech and Language Pathology
SMI	Serious Mental Illness
SNF	Skilled Nursing Facility
SS	Social Security
SSA	Social Security Administration
SSI	Supplemental Security Income
SSLC	State Supported Living Center
SUD	Substance Use-Disorder
SUPPORT Act	Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act
TAC	Texas Administrative Code
THCA	Texas Health Care Association
UC	Uncompensated Care

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Appendix A. Cost Component Sources

The following sources were consulted to estimate the costs of serving patients at state hospitals (or IMDs) and nursing facilities (NFs). Wage data from the U.S. Bureau of Labor Statistics (BLS) was accessed in March 2024 and is subject to change as national and regional estimates are updated.

1. The average daily cost of care per patient in a state hospital is based on the HHSC Key Performance Measures Report, Third Quarter, Fiscal Year 2024.
2. Daily patient-level professional charges at NFs were estimated by Acute Care under the assumption that the services would be administered by clinicians certified in administering psychiatric, psychological, and mental health services.
3. The highest PDPM LTC rate for group E1Y corresponds with the highest Nursing and NTA case mix indices. Additionally, this group implies that a client has been diagnosed with severe cognitive impairment. Therefore, the rate includes an additional rate component to reimburse an NF for an enhanced level of care related to the resident's cognitive status. The PDPM LTC rates used for estimating NF cost for the transition plan are budget neutral to the current NF program cost and include an additional hold harmless payment of $5.19 per unit of service per the 2024-25 General Appropriations Act, House Bill 1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Rider 25).
4. The Physical Therapy, Occupational Therapy, and Speech and Language Pathology (PT/OT/SLP) Medicare SNF rate was calculated as the grand mean of each therapeutic service average in urban areas (PDPM Medicare SNF Rates CMS-SNF-Final Rule-FY 2024, urban, Table 5): https://public-inspection.federalregister.gov/2023-16249.pdf.
5. Licensed Professional Counselor (mean hourly wage, national estimate, U.S. Bureau of Labor Statistics): Counselors, All Other (bls.gov).
6. Rehabilitation Therapist Technician (mean hourly wage, national estimate, U.S. Bureau of Labor Statistics): Rehabilitation Counselors (bls.gov).
7. Licensed Recreational Therapist/Art Therapist (mean hourly wage, national estimate, U.S. Bureau of Labor Statistics): Recreational Therapists (bls.gov).
8. Dance Therapist/Music Therapist (mean hourly wage, national estimate, U.S. Bureau of Labor Statistics): Therapists, All Other (bls.gov).

9. Psychiatric care cost is based on Medicaid rate for Procedure code 90838 – “Individual Psychotherapy with Evaluation and Management Services, 60 minutes”; assuming an average number of psychiatric staff hours per client per month of 2.43 (calculated based on average salaries data from HSCS, representing psychiatric staff full-time equivalents [FTEs]; and using accounting year [AY] 2023 state hospital average daily census from AY2023 state hospital cost report data provided by HSCS).
10. Medication average daily cost is based on HSCS medication prescription data and Vendor Drug program pricing.
11. DME average daily cost is based on DME costs reported by Medicaid NFs in Texas in state fiscal year 2023.
12. FMAP percentages.

    The fiscal impact assumes the following FMAP for state fiscal year 2026:

    - The state share is 40.58 percent.
    - The federal share is 59.42 percent.

    The fiscal impact assumes the following FMAP for state fiscal year 2027:

    - The state share is 40.63 percent.
    - The federal share is 59.37 percent.
13. FMAP breakdown by cost component (Table 2 and Table 3).

Table 2. Total Hospital Daily Cost FMAP Breakdown.

Cost component	SFY 2026 GR amount	SFY 2027 GR amount	FMAP assumption
Total Hospital Daily Cost (AF)	$ 831.00	$ 831.00	AF
GR amount for Medicaid eligible hospital resident	$ 337.22	$ 337.64	FMAP for Medicaid-eligible
GR amount for Medicaid non-eligible hospital resident	$ 831.00	$ 831.00	No FMAP (100% GR)

Table 3. Total NF Daily Cost FMAP Breakdown.

Cost component	AF amount by component	SFY 2026 GR amount	SFY 2027 GR amount	FMAP assumption
Total NF Daily Cost, including:	$ 633.23	$ 633.23	$ 633.23	AF
NF Daily Rate (changed to highest PDPM LTC Rate (E1Y) including HH add-on)	$ 322.01	$ 130.67	$ 130.83	FMAP as for Medicaid eligible
NF PT/OT/SLP Therapy cost (estimated using PDPM Medicare FY2024 rates)	$ 83.46	$ 33.87	$ 33.91	FMAP as for Medicaid eligible
Individual Therapy with Licensed Professional Counselor	$ 19.44	$ 7.89	$ 7.90	FMAP as for Medicaid eligible
Rehab Therapy with Rehab Therapy Tech (i.e., recovery skills, connecting, healthy lifestyles)	$ 71.95	$ 29.20	$ 29.23	FMAP as for Medicaid eligible
Recreational Therapy with Licensed Recreational Therapist	$ 45.25	$ 45.25	$ 45.25	no FMAP (100% GR)
Music Therapy with Licensed Music Therapist	$ 11.24	$ 11.24	$ 11.24	no FMAP (100% GR)
Dance Therapy with Dance Therapist	$ 11.24	$ 11.24	$ 11.24	no FMAP (100% GR)
Art Therapy with Art Therapist	$ 13.57	$ 13.57	$ 13.57	no FMAP (100% GR)
Psychiatric Care physician cost	$ 7.83	$ 3.18	$ 3.18	FMAP as for Medicaid eligible
Medication (Vendor Drug Program)	$ 46.02	$ 18.67	$ 18.70	FMAP as for Medicaid eligible
Durable Medical Equipment (DME)	$ 1.22	$ 0.50	$ 0.50	FMAP as for Medicaid eligible
Total	**$ 633.23**	**$ 305.28**	**$ 305.55**	

Appendix B. Detailed Stakeholder Feedback

Stakeholders described a funding proposal in which people being transferred from the state hospital to an NF would be classified into three different tiers based on needs, required psychiatric and therapeutic services, and behavioral considerations.

- The first tier would be for individuals who may need more treatment services and staffing support than a typical Medicaid long-term stay resident.
  - Stakeholders suggested an additional $200 per day.
- The second tier would be for individuals who would need to be in a secure environment.
  - Stakeholders suggested an additional $250 to $300 per day.
- The third and highest tier would be for individuals in a crisis who may need one-on-one staff support for a period of time.
  - Stakeholders suggested an additional $400 to $450 per day.

Representatives from LeadingAge likewise stressed the need for appropriate compensation to address staffing concerns, accommodations, and the risks incurred by NFs throughout program implementation.

HHSC is unable to prepare a fiscal estimate at a tiered rate structure without additional utilization assumptions regarding the number of individuals in each tier. The current sample of 104 discharge-eligible hospital patients may not be representative of future patient enrollment. Nor can the levels of commitment among this sample be easily mapped to the proposed tiers under consideration.

Appendix C. Additional Relevant Information

Medicaid Bed Allocation and Certification:

HHSC de-allocates and decertifies Medicaid beds if an NF consistently shows a low monthly census (average occupancy rate below 70 percent) (Tex. Admin. Code § 554.2322(j)(5), 2024). Reserving Medicaid beds for individuals with SMI transitioning out of state hospitals could result in NFs losing Medicaid beds because of low census.

HHSC also de-allocates and decertifies Medicaid beds that are not available to be occupied because bedrooms have been converted to other uses on two consecutive standard surveys (Tex. Admin. Code § 554.2322(j)(1)(B), 2024). Older NFs often do not have needed space for administrative purposes. They will temporarily utilize unoccupied bedrooms for administrative functions such as offices, therapy areas, storage, or other similar non-bedroom uses. NFs reserving beds for individuals with SMI transitioning out of state hospitals may find it necessary to permanently use other non-Medicaid bedroom space for administrative purposes to avoid using a Medicaid bedroom. Permanent use of a non-Medicaid bedroom for administrative purposes would require an NF to reduce the licensed capacity of the facility, resulting in fewer overall beds for current or prospective residents.

NFs with high Medicaid bed occupancy rates may find it challenging to reserve Medicaid beds. NFs with at least a 90 percent occupancy rate for at least 9 of the preceding 12 months can apply to receive a bed allocation increase from HHSC (Tex. Admin. Code § 554.2322(f)(3), 2024). The NF can apply for an increase of no more than 10 percent, rounded to the nearest whole number, of the facility's Medicaid-certified beds. They cannot apply more frequently than nine months from the previous allocation increase. If HHSC creates an SMI waiver or bed allocation methodology through a TAC rule amendment, NFs could be eligible to receive an additional Medicaid bed allocation subject to the conditions for eligibility.

Institution for Mental Diseases (IMD) Exclusion

IMD exclusion is a long-standing policy under Medicaid that prohibits the federal government from providing federal Medicaid funds to states for services rendered to certain Medicaid-eligible individuals who are patients in IMDs (Section

1905(a)(30)(B) of the Social Security Act [SSA]). When a Medicaid-eligible individual aged 21 through 64 is a patient in an IMD, he or she generally cannot receive Medicaid coverage for services provided inside or outside the IMD[a].

The term 'institution for mental diseases' means a hospital, NF, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care, including medical attention, nursing care, and related services (SSA 1905(a)), for persons with mental diseases. Substance use disorders are categorized as mental diseases. The determination of whether a facility is an IMD depends on whether its overall character is that of a facility established and maintained primarily to care for and treat individuals with mental diseases. Examples include a facility licensed or accredited as a psychiatric facility or one in which mental diseases are the current reason for institutionalization for more than 50 percent of its patients. According to the HHSC directory of all licensed and Medicaid NFs and all hospital-based state nursing facilities (SNFs), there are no facilities in Texas with 16 or fewer beds. All NFs (SNF, NF, or SNF and NF) would meet the size criteria to be considered an IMD because of their capacity and size.

The IMD exclusion prevents the federal government from providing federal Medicaid funds to states for services delivered to patients in an IMD aged 21 through 64. However, even with the IMD exclusion, states have pathways to receive federal Medicaid funding for inpatient behavioral health services for individuals aged 21 through 64. For example, states can provide Medicaid coverage for services rendered to patients in facilities that do not meet the definition of an IMD, such as facilities with 16 or fewer beds and facilities where the primary function does not involve providing care to individuals with mental diseases.

Further regulations and guidance from CMS allow for a short-term exception to the IMD exclusion. Section 1013 of the Substance Use-Disorder [SUD] Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act codified regulations from CMS's 2016 final rule that allow states to make payments to Managed Care Organizations (MCOs) for enrollees aged 21 through 64 who are patients in an IMD provided the length of stay is no more than 15 days during the month. The 15-day exception to the IMD exclusion can be utilized as an 'in-lieu-of service' in managed care. In-lieu-of services and settings are described

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[a] Two main exceptions exist to the IMD exclusion:

- Inpatient hospital services and NF services for individuals 65 years of age or older (SSA § 1905(a)(14), 2024)
- Inpatient psychiatric hospital services for individuals under age 21 (SSA § 1905(a)(16), 2024).

under 42 CFR Section 438.3(c)(2). Texas MCOs may provide inpatient services for acute psychiatric conditions in an IMD for up to 15 calendar days per month for members aged 21 through 64 in lieu of providing the services in an acute care inpatient hospital setting.

Impact of the IMD Exclusion on HHSC's Transition Plan

An NF transition plan could potentially be designed to avoid impacts from the IMD exclusion, particularly if the number of individuals transitioning is small. The exclusion would not apply to individuals aged 65 and older. However, individuals aged 65 and older would still be included in calculating the percentage of people admitted to the NF due to an SMI diagnosis. HHSC may need to track NF level data to ensure that no more than 49 percent of residents are admitted to an NF due to an SMI diagnosis (or SUD diagnosis). Also, if an NF is categorized as an IMD, federal matching funds for all Medicaid-eligible residents of the facility aged 21 through 64 would be at risk, not just for those transitioning from a state hospital.

In summary, the most conservative scenario to avoid violating the IMD exclusion would:

- Not include construction of an NF on the grounds of an SSLC or state hospital;
- Not bundle payments for NF and mental health services (to better distinguish "the character" of the NF from that of an IMD); and
- Monitor NFs to ensure that state hospital transfers are made to NFs where less than 50 percent of clients have significant behavioral health needs.

HHSC would need to evaluate how the agency would monitor the NFs to ensure less than 50 percent of the residents have significant behavioral health needs. HHSC would need to develop this process, which may require additional costs to HHSC.

Staffing and Environment Requirements

Another consideration regarding serving people with high behavioral health needs in an NF includes ensuring that NF staff are appropriately trained and equipped with the skills needed to serve this population and that the environment is suitable.

Training for NF direct care staff does not include a curriculum to provide the intensive care required for people with more significant mental health issues. To

meet those higher care needs, NFs would need to develop additional training and add staff that have extensive training in appropriate oversight, educational programs, and supervision of care. Staff serving people in acute psychiatric care hospitals specialize in that level of care; NF staff do not. Alternatively, the individuals identified require a high level of medical care due to their complex needs, which staff serving people in NFs specialize in providing; state hospital staff do not.

NFs report that they struggle to hire enough staff members to provide care for current residents, so some providers may be unable or unwilling to find qualified staff to serve this population. Long-term care providers have faced a nationwide shortage of licensed and certified staff to take care of their existing residents, including those with dementia, and particularly those who exhibit behavioral and psychological symptoms of dementia. With the ever-present rise in acuity levels, facilities are often challenged to provide a higher level of care to meet the standards of CMS and state regulations.

Additionally, CMS has proposed new Minimum Staffing requirements for NFs that were finalized in 2024 (CMS, 2024). In addition to new minimum staffing levels, NFs may be required to staff above baseline levels to address the needs of the resident population based on acuity, such as people with behavioral health conditions requiring additional or more intensive assistance because of their diagnoses. Proper training and maintenance of that training and competency screening for all staff is needed. All staff would require cross-training to be able to step into that special care role if someone is not able to cover their assignment.

The Statewide Behavioral Health Strategic Plan Progress Report for Fiscal Year 2023 shows a continuous national and Texas shortage of behavioral health providers (Texas Statewide Behavioral Health Strategic Plan: Progressive Report, 2023).

Texas reflects national trends of an increased need for behavioral health services. Workforce shortages contribute to access challenges across the state. Most of the state (246 out of 254 counties) is a federally designated mental health professional shortage area (MHPSA) (Texas Department of State Health Services [DSHS], Health Professional Shortage Area [HPSA] Dashboard, 2024). NFs serving this population may find it challenging to ensure an appropriate behavioral health provider to serve these individuals. However, NFs could use telehealth as an alternative to mitigate this issue.

This challenge is shared by state hospitals that have beds offline due to a lack of staffing. Eight of the ten state hospital campuses are in a MHSPA. State hospitals use telehealth to help bridge the gap, mainly for psychiatrists. However, due to the primary treatment and services provided at a state hospital being centered around mental health and the nature of involuntary treatment, there are limits to telehealth. NFs would not be subject to these limitations because the primary focus is centered on physical health.

In addition to staffing considerations, as referenced at the stakeholder engagement session in June 2024, NF providers would need to ensure adequate environmental space for this high-needs population. Residents with significant behavioral challenges may require separation from other NF residents to ensure the health and safety of all individuals. NF associations noted that NF occupancy rates are low enough that there is likely space at many NFs to designate an empty wing to serve this population. NF providers may need to make capital improvements to create a secure wing dedicated to serving residents transitioning from state hospitals.

Quality Measures

Nursing facilities could face a change in their quality measure ratings based on admitting residents with psychiatric diagnoses. Individuals diagnosed with bipolar disorder, major depression, and major anxiety and those taking antipsychotic medications are all counted in the quality measures. They could put an NF at risk of higher regulatory scrutiny at both the state and federal levels. Residents with the specific diagnoses and acuity levels identified in this population are expected to impact certain Minimum Data Set (MDS) quality measures. Three of the measures are included in the QIPP. One of the measures is part of the CMS Five-Star Rating system, the public-facing platform that reports on quality levels in nursing facilities nationwide. Relevant MDS measures include:

- *Percent of Residents Who Used Antianxiety or Hypnotic Medication (Long Stay) (CMS ID: N036.03)*: Any resident who uses antianxiety or hypnotic medication is counted in the numerator of this measure regardless of diagnosis because these medications are generally contraindicated for individuals of the median nursing-facility age. Residents identified by the data without such contraindications would nevertheless be counted in the numerator. This measure is included in QIPP Component 3.
- *Percent of Residents Who Have Depressive Symptoms (Long Stay) (CMS ID: N030.03)*: Residents identified by the data could be counted in the numerator. This measure is included in QIPP Component 3.

- Percent of Residents Who Were Physically Restrained (Long Stay) (CMS ID: N027.02)
- *Prevalence of Antianxiety/Hypnotic Use (Long Stay) (CMS ID: N033.03)*: This measure differs from N036.03 in that it excludes residents with certain diagnoses from the numerator: Schizophrenia, psychotic disorder, bipolar disorder, Tourette's syndrome, Huntington's disease, and hallucinations. This measure is a state surveyor measure and is not part of the Nursing Home Quality Initiative (NHQI). As such, it is not reported on Care Compare and is only available on the Internet Quality Improvement and Evaluation System (iQIES) Quality Measures (QM) reports.
- *Prevalence of Behavior Symptoms Affecting Others (Long Stay) (CMS ID: N034.02):* Residents identified by the data could count in the numerator. This measure is a state surveyor measure and is not part of NHQI. As such, it is not reported on Care Compare and is only available on the iQIES QM reports.
- *Percent of Residents Who Received an Antipsychotic Medication (Long Stay) (CMS ID: N031.04)*: This is the only measure with a potential impact that factors into the facilities' Five-Star Rating on the Care Compare website managed by CMS. However, individuals who have schizophrenia, Tourette's syndrome, or Huntington's disease are not counted in the numerator. Thus, residents with any of those official diagnoses would not impact the performance result. This measure is included in QIPP Component 1.

Impact of Antipsychotic Medication on NF Quality Measures

CMS and HHSC require all NFs to ensure that residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition diagnosed and documented in the clinical record (Tex. Admin. Code § 554.1501, 2024; 42 C.F.R. § 483.45(e), 2024). Psychotropic drugs include categories of medications such as anti-psychotic, anti-depressant, anti-anxiety, and hypnotic, as well as any medication not classified under these categories but whose use appears to be a substitution for another psychotropic medication rather than for the original or approved indication. NFs are also required to use the lowest effective dose and implement a gradual dose reduction for all residents.

Using psychoactive medications by themselves will not reduce an entire star in the provider's ratings. Both the long and short stay measures are combined with other

quality measures that are each calculated into one composite category within those measure types. The medications could only be a percentage reduction in the total score for that specific grouping. For example, antipsychotic short-stay measures may be counted as one-eighth of the grouping. If that NF has a high utilization of antipsychotic medications, they could take a one-eighth reduction in that overall rating. The determination that Schizophrenia has been diagnosed incorrectly on a Schizophrenia Audit or Survey is the only way an entire star rating is dropped.

CMS has been conducting schizophrenia surveys to ensure that the diagnosis is being used appropriately in NFs. Clients who enter an NF with a schizophrenia diagnosis are not counted as part of the quality measure, and any antipsychotic medications do not have a negative impact on the facility's overall quality measure ratings. Considering 76 (73.1 percent) of the 104 patients identified have a primary diagnosis of schizophrenia or schizoaffective disorder, NFs may be more willing to accept them if they were fully aware that the person would not negatively impact ratings.

Although NFs are also required to use the lowest effective dose and implement a gradual dose reduction for all residents, patients discharged from a state hospital and transferred to an NF must not be unintentionally destabilized.

Prevalence of Mental Health

Texas is the nation's second-most populous state and is the fourth fastest-growing state with the highest percentage of growth by county (U.S. Census Bureau, n.d.). According to the Office of the State Demographer, Texas' population is estimated to have grown 7.5 percent in the last seven years, from 28.29 million in 2017 to what is anticipated to be over 30.5 million in 2024 (Texas Demographic Center [TDC], n.d.).

The growth of Texas's population coincides with an increase in the prevalence of mental illness among both adults and youth. According to data collected by the Substance Abuse and Mental Health Services Administration (SAMHSA), 17 percent of adult Texans were estimated to have a mental illness for the 2013-2014 reporting period (SAMHSA, 2015, Table 24). This estimate increased to approximately 22 percent for the 2021-2022 reporting period and almost doubled for the 18 to 25 age subset, reaching over 33 percent (SAMHSA, 2024, Table 31).

Considering the increased population and prevalence of mental illness in Texas, NFs should begin preparing to care for people with behavioral health needs. As the

population ages and begins to require an NF level of care, NFs will inevitably see an increased prevalence of mental illness within their client population.