

MMHPI Appendix:

**The Texas 1915(i) Program: Overview,
Current Use, and Barriers**

Not Yet Peer Reviewed

Table of Contents

History of the Texas 1915(i) Program	3
Amendments to the Program Over Time.....	4
Services Available Under the Program	4
Federal Regulations Impacting Implementation of 1915(i) Services	5
Eligible Beneficiaries Under the Program.....	5
The Texas HHSC Home and Community Based Services–Adult Mental Health Project	6
State Hospital Utilization of 1915(i)	7
Successful Uses in Texas: Example of the North Texas Behavioral Health Authority	8
Barriers to Expanded Use.....	8

History of the Texas 1915(i) Program

Section 6086 of the Deficit Reduction Act of 2005 (DRA) created section 1915(i) of the Social Security Act to fund home and community-based services (HCBS) through an optional state plan service. This new authority began in January 2007 and authorized states to fund HCBS when a person meets a needs-based level of care that is lower than institutional care admission criteria.¹ The 1915(i) authority allows for people to be diverted from institutional stays or discharged back to their community more quickly. Community care reduces Medicaid costs and leads to better outcomes if targeted to appropriate at-risk populations who might otherwise be institutionalized.

Prior to the enactment of the DRA, states provided a wide range of home and community-based services by relying on 1915(c) waivers. These waivers allow states to limit the beneficiaries of 1915(c) HCBS by capping 1915(c) enrollments at a fixed number of participants at any given time. This means that everyone who qualifies for the services may not receive them.² Waivers also permit states to target HCBS to specific geographic areas and groups of beneficiaries.

Another aspect of 1915(c) waivers that limits services is their cost-neutrality requirement. The total aggregate cost of services provided under each 1915(c) waiver cannot exceed the cost of care the person would have received otherwise in a Medicaid-reimbursed institution (e.g., general hospital, nursing facility, or intermediate care facilities for people with intellectual and developmental disabilities [ICF-IDD] for adults, and psychiatric hospitals for youth under the age of 22 years and over the age of 64). Because Medicaid does not fund care for people age 22 to 64 years who reside in institutions for mental diseases (IMDs),³ few states have been able to fund HCBS for adults with serious mental illness (SMI). Connecticut and Colorado are the notable exceptions – they are able to justify the use of HCBS for adults with SMI because they have large number of adults with mental illness in nursing facilities.⁴

Section 1915(i) of the Social Security Act allows states to cover home and community-based services without obtaining a 1915(c) waiver. The 1915(i) authority gives states an option to serve beneficiaries who do not require an institutional level of care. In addition, the authority does not include a cost-neutrality requirement, allowing adults with SMI to qualify for HCBS without needing to be eligible for an admission to a nursing facility, general hospital, or ICF-IDD.⁵ The initial 1915(i) authority was very restrictive and not utilized well by states. For example, the original authority did not permit states to target benefits to specific population groups, offer HCBS beyond a limited statutory list,⁶ or provide coverage for people living over 150% of the federal poverty level (FPL).

Amendments to the Program Over Time

The Affordable Care Act (ACA)⁷ amended the 1915(i) authority in an effort to expand its utilization among states. As noted in the Center for Medicare and Medicaid Services' (CMS) State Medicaid Director letter (SMDL #10-015), "In order to promote State utilization of 1915(i), the ACA includes changes that enable states to target HCBS to particular groups of people, to make HCBS accessible to more people, and to ensure the quality of the HCBS."⁸

Under the ACA, the following changes became effective on October 1, 2010:

- States may impose need-based eligibility criteria and have total budgeted numbers of people that can be served under those criteria. Once the budgeted number of people is reached, the state may tighten the needs-based eligibility criteria for future enrollment. Current enrollees are entitled to remain on the program.
- HCBS must be implemented on a statewide basis.
- States may provide targeted benefits or service packages designed for specific population groups, such as those with physical disabilities and chronic mental illnesses. However, such targeting is valid only for five years, after which time the state must submit a renewal request to continue the targeting.
- States may provide services to people with incomes up to 300% of the supplementary security income (SSI) federal benefit rate (FBR) if there is a 1915(c) waiver that would cover those populations.
- In addition to services that the 1915(i) benefit was already permitted to provide, states may offer "such other services requested by the State as the Secretary may approve."

Services Available Under the Program

Today, states may offer a wide variety of services under the 1915(i) authority. Each state may define targeting and risk criteria based on diagnosis and characteristics of the population as well as functional eligibility criteria based on need, as long as the needs criteria are less stringent than institutional admission criteria. The authority often provides a combination of long-term services and acute care medical services that are not otherwise covered in the Medicaid state plan. For adults with SMI, these services often include case management, additional home health aide services, personal care, adult day health, habilitation, respite care services day treatment, other partial hospitalization services, psychosocial rehabilitation services, clinical services, and other services.⁹

Federal Regulations Impacting Implementation of 1915(i) Services

CMS finalized HCBS regulations at 42 CFR Part 441, Subpart M¹⁰ on January 16, 2014. The regulation outlines that states with 1915(i) authorities that target specific populations must submit a renewal of their Medicaid state plan amendment (SPA) to the CMS every five years for approval. As part of the renewal submission process, states must agree to comply with several HCBS assurances:

- Establish a process to ensure that assessments and evaluations are unbiased. This generally requires an assessment independent of the provider who will be delivering the services.
- Ensure that the benefit is available to all eligible people within the state.
- Provide adequate and reasonable provider standards to meet the needs of the target population.
- Ensure that HCBS are provided in accordance with a person-centered service plan.
- Establish a quality assurance, monitoring, and improvement strategy for the benefit.¹¹

CMS regulations require that eligibility assessors meet conflict of interest requirements. Texas has been granted some relief from these requirements under its 1915(i) authority in rural areas, where there are few providers. States must implement an HCBS quality improvement strategy that includes a continuous quality improvement process, measurement of program performance, and expertise in key areas of care: Medicaid agency authority, including HCBS settings; level of need assessments; qualifications of providers; service plan development; health and welfare of participants; and financial accountability.

Eligible Beneficiaries Under the Program

State Medicaid agencies must submit a SPA to CMS for review and approval to establish a 1915(i) HCBS benefit.¹² As of May 2015, there were 23 approved 1915(i) SPAs that were available for review.¹³ The following list provides a summary of services provided to four broad categories of beneficiaries:¹⁴

- Children with mental health disorders generally receive therapy for themselves and their families as well as family support (four states).
-

- Children with other conditions generally receive personal care support, habilitative services, and community support (four states).
- Adults with mental health and substance use disorders generally receive care coordination, habilitative services, adult day care services, psychosocial rehabilitation, and supported employment (seven states).
- Adults with other conditions generally receive habilitative services, personal care services, transportation, and case management (eight states).¹⁵

The 1915(i) benefit approved for the state of Texas reimburses services provided by various local mental health authorities (LMHAs) through the Texas Health and Human Services Commission (HHSC). The participants originally targeted in the 1915(i) benefit were those who resided at a state hospital for a long period of time and no longer met institutional level of care criteria. The 1915(i) benefit is a statewide program; however, only recently has the state begun to provide services in College Station, Texana, and East Texas. Until there is a statewide network of providers, participants in rural areas still rely exclusively on the use of hospitals.

The Texas HHSC Home and Community Based Services–Adult Mental Health Project

The Texas Health and Human Services Commission’s (HHSC) HCBS–Adult Mental Health (AMH) 1915(i) program supports the recovery of adults living with SMI by providing a wide range of services to ensure a person’s successful reintegration into their preferred community. The program’s primary goal is to fill in the gaps between institutional and crisis care, making it comparable to the Youth Empowerment Services (YES) Waiver,¹⁶ but instead targeting adults. HCBS–AMH services may be provided in individual homes or apartments, assisted living facilities, and small community-based residences.

HHSC has been slow to ramp up the HCBS–AMH 1915(i) program, at least in part because CMS has been delayed in approving the program and its subsequent amendments. The application for this program was submitted on July 22, 2014, but CMS did not approve the authority until October 13, 2015, and did not allow enrollment to begin until September 1, 2015. The program was originally slated to serve 100 people who were transitioning out of state hospitals. On May 20, 2016, the state submitted an amendment to expand the program beyond the original population of state hospital patients to include an additional 650 people who have SMI and have been institutionalized. However, CMS did not approve the amendment until December 18, 2017.

The program began enrollment in 2015. Since the approval of the additional targeted population, the program has exceeded its original 100-person target and currently serves approximately 150 enrollees, far short of the expanded maximum number. Since approval, a slow rate of provider enrollment has been the primary barrier to expanding the program.

State Hospital Utilization of 1915(i)

There are several ways for people to be referred to the HCBS–AMH program. Referrals primarily come from state hospitals that have adult residents who no longer meet institutional admission criteria. Under the 1915(i) authority, beneficiaries work with a recovery manager three days a week, obtain assistance with employment integration, and may receive transportation assistance to and from community activities. Additionally, each beneficiary's recovery plan is reviewed every 90 days to identify any unanticipated gaps in care. People participating in the 1915(i) program may access the following services, as needed:

- Transition Assistance Services (TAS),
- HCBS Psychosocial Rehabilitation Services,
- Adaptive Aids,
- Employment Services,
- Transportation,
- Community Psychiatric Supports and Treatment (CPST),
- Peer Support,
- Host Home/Companion Care,
- Supervised Living Services,
- Assisted Living Services,
- Supported Home Living,
- Respite Care,
- Home-Delivered Meals,
- Minor Home Modifications,
- Nursing,
- Substance Use Disorder (SUD) Services, and
- Home and Community-Based Services–Adult Mental Health (HCBS–AMH) Recovery Management.

The HCBS–AMH program is targeted to populations for whom institutional care is no longer appropriate. Participants should be willing to live in the community and be safely served with the array of available home and community-based services. For example, patients found not guilty by reason of insanity (NGRIs) who have been continuously hospitalized and stable for at least

one year might be appropriate candidates for this program. There have been 20 to 25 NGRIs enrolled in HCBS in the last year. Providing HCBS for this population may increase the availability of state hospital beds to serve people with more severe needs.

In other instances where NGRIs have been discharged to outpatient services without HCBS, the county has often requested that the person live in an assisted living facility. Assisted living facilities are not age appropriate discharge destinations for people in their 20s and 30s, especially if there are multiple residents in each a room.

Successful Uses in Texas: Example of the North Texas Behavioral Health Authority

The North Texas Behavioral Health Authority (NTBHA) has found success in using HCBS for the adult SMI population being discharged from the state hospital. The main successes have resulted from excellent communication and extensive outpatient management plans.

One particularly beneficial communication strategy has been a monthly telephone call between Dallas district attorneys (DAs), the liaison between the jail and judges, and personnel providing services. On the call, the group discusses:

- The patient's desire and ability to live in the community,
- The judges' concerns to alleviate potential barriers in enrolling each patient,
- The treatment goals of each person so that treatment may be adjusted accordingly, and
- Case reviews of patients who may be discharged from the state hospital and who are potentially interested in enrolling in HCBS.

Because many people are admitted to state hospitals under court orders, judges can create barriers to discharging patients. However, open and consistent communication that allows judges to play an active role in the process provides a viable method for overcoming discharge barriers. MMHPI recommends that improved communication be prioritized, for example establishment of a monthly call for all metropolitan areas utilizing HCBS that involves district attorneys, judges, state hospital personnel, and treatment teams providing the services.

Barriers to Expanded Use

Though 1915(i) is currently being implemented across the nation and within the state of Texas, there are barriers that impede more efficient and effective use of its benefits, such as:

- The 1915(i) benefit is not well packaged as supplemental services to support community living. People may perceive that the 1915(i) program will replace existing services, such as Assertive Community Treatment (ACT), rather than provide an added benefit to services that are currently in place. Rebranding the 1915(i) program to express its advantages as a

wraparound benefit of services, as well as clarifying its perceived shortcomings, may be beneficial.

- Stringent provider qualifications create a barrier to provider participation. The 1915(i) authority was written to only allow enrollment of an HCBS provider agency that meets the minimum eligibility and standards for HCBS–AMH provider criteria. The state used restrictive provider qualifications to address budget considerations and meet the need to maintain very low enrollment in this program (i.e., only 100 people could participate in the program up until December of 2017). Now that the state wishes to expand the program, the provider qualifications need to be reexamined. There is no need to limit provider participation in an area to a single comprehensive provider who can provide all services in the 1915(i) benefit. When additional populations were added to the 1915(i) authority, the provider qualifications should have been relaxed to allow all qualified providers to participate, including providers in the 1915(c) waivers, mental health care programs, and the Money Follows the Person program.
- The 1915(i) program is not integrated with other similar programs such as the 1915(c) waivers, the former Money Follows the Person program, and mental health care under managed care contracts. Restructuring the 1915(i) benefit to be integrated with the rest of the service delivery system would allow it to become a tool for institutions and managed care organizations (MCOs) to facilitate the use of cost-effective supports that enable people to remain in the community, be diverted from institutional placement, and transition back to the community from institutional stays more easily.
- Coordination of care is difficult for people who are eligible for the HCBS–AMH program but do not have HCBS providers in the area where they reside.
- People with a serious dual diagnosis may need a combination of state plan and HCBS services, such as intensive outpatient care along with the HCBS–AMH supportive services.
- The Outreach, Screening, Assessment, and Referral Centers (OSAR) screening tool, which aids in determining release eligibility for people with SUD, is based on activities people have participated in within the last 30 days. Such time-sensitive questions do not appropriately assess people who have been receiving long-term care within an institution; the screening tool creates the opportunity for many false negatives. There is a need for a different tool for forensic patients that adjusts for long-term care and measures issues beyond patterns of SUD.
- The Adult Needs and Strengths Assessment (ANSA) is the eligibility tool that is used to determine if people meet the needs-based criteria under the 1915(i) – the waiver requires that the ANSA be used and that people meet the criteria approved by CMS in the state plan amendment. People who do not meet the eligibility criteria are not considered a target population for the 1915(i) program. However, the ANSA process may need to be reviewed to better assess people who have received long-term care within an institution.
- States must comply with a lengthy set of HCBS assurances and extensively monitor the program.
- When people on clozapine – a drug used to treat schizophrenia or schizoaffective disorder – are discharged under the 1915(i) program, there is a high propensity for the drug to be mishandled by medical professionals because of the complexities of administering this drug

to patients who are transitioning from institutional care to the community. More stringent protocols need to be established for the transition of care for people on clozapine to ensure that the drug is being properly administered and to help people in this population successfully reintegrate into the community.

The 1915(i) benefit has provided states across the nation with new opportunities to provide Medicaid beneficiaries with HCBS. While there is a need to significantly increase the number of states that implement this program, Texas has utilized the 1915(i) to reimburse HCBS services, with its primary referral source being state hospitals. For Texas to achieve further success, as measured by the number of enrollees as well as the success of patients reintegrating into their communities, many challenges must be overcome. Addressing the barriers described above may help Texas provide vulnerable populations with increased access to needed community-based services.