



**TO:** Health and Human Services Commission  
Executive Council

**DATE:** February 22, 2018

**FROM:** Tamela Griffin, Medicaid/CHIP Services

**AGENDA ITEM: 2.f**

**SUBJECT:** Medicaid Mental Health Targeted Case Management and Mental Health Rehabilitative Services and Managed Care

**BACKGROUND:**  Federal  Legislative  Other: Program Initiative

The Texas Health and Human Services Commission proposes new Texas Administrative Code (TAC), Title 1, Part 15, Chapter 353 (Medicaid Managed Care), Subchapter P; and TAC, Title 1, Part 15, Chapter 354 (Medicaid Health Services) Subchapter M relating to Targeted Case Management (TCM) and Mental Health Rehabilitative Services (MHR).

Senate Bill (S.B.) 58, 83rd Legislature, Regular Session, 2013, carved two Medicaid state plan mental health benefits that had been provided solely by the local mental health authorities (LMHAs) into managed care: Mental Health Targeted Case Management and Mental Health Rehabilitative Services. Effective September 1, 2014, Medicaid managed care organization-contract providers, in addition to LMHAs, were allowed to deliver these benefits.

The proposed new rules provide guidance on the delivery of these services in Medicaid managed care and delineate required criteria for providers of the services.

New TAC, Title 1, Part 15, Chapter 353 (Medicaid Managed Care), Subchapter P, formalizes existing MCO contract provisions, describing responsibilities of the MCOs related to information systems and medical records; patient safety, rights, and protections; provider staff member competency; and provider credentialing requirements.

Consistent with existing policy, new TAC, Title 1, Part 15, Chapter 354 (Medicaid Health Services), Subchapter M, defines each of the currently available services, components of the services, eligibility to receive these services, the processes required to become eligible for services, and process for continued eligibility for services.

**ISSUES AND ALTERNATIVES:**

There are no issues and alternatives.

**STAKEHOLDER INVOLVEMENT:**

A draft of the proposed rules was shared with members of the Behavioral Health Advisory committee on August 8, 2017, and sent to external stakeholders on July 24, 2017, providing an opportunity for submission of comments prior to proposal. Comments received from the Texas Council of Community Centers, Hogg Foundation for Mental Health, Meadows Foundation, were taken into consideration and modifications made to ensure consistency in definitions; clarify the settings in which psychosocial rehabilitative services can be provided; incorporate certain provisions from S.B. 74, 85th Legislative Session; and emphasize recovery. Requests for specificity regarding Medicaid service billing and utilization management guidelines are being addressed through revisions to the Uniform Managed Care Contract and Uniform Managed Care Manual.

**FISCAL IMPACT:**

None

**SERVICES IMPACT STATEMENT:**

The anticipated public benefit will be to provide managed care organizations and contracted mental health TCM and MHR comprehensive provider agencies with necessary guidance on the delivery of these two services to ensure the services are delivered appropriately.

**RULE DEVELOPMENT SCHEDULE:**

February 15, 2018	Medical Care Advisory Committee
February 22, 2018	Present to HHSC Executive Council
March 2018	Publish proposed rules in <i>Texas Register</i>
August 2018	Publish adopted rules in <i>Texas Register</i>
August 2018	Effective date

## PROPOSED PREAMBLE

The Texas Health and Human Services Commission (HHSC) proposes new Title 1, Part 15, Chapter 353 (Medicaid Managed Care), Subchapter P, concerning Mental Health Targeted Case Management and Mental Health Rehabilitation.

## BACKGROUND AND PURPOSE

Senate Bill (S.B.) 58, 83rd Legislature, Regular Session, 2013, added two Medicaid State Plan mental health benefits, mental health targeted case management (TCM) and mental health rehabilitative (MHR) services, to Medicaid managed care. Prior to S.B. 58, the local mental health authorities (LMHAs) operated under the Texas Department of State Health Services were the sole providers of these services. Effective September 1, 2014, Medicaid managed care organization contracted providers of mental health TCM and MHR services, in addition to LMHAs, were allowed to deliver these benefits. HHSC is proposing these rules to provide managed care organizations and contracted mental health TCM and MHR comprehensive provider agencies with necessary guidance on the delivery of these two services to ensure the services are delivered appropriately.

## SECTION-BY-SECTION SUMMARY

Proposed new §353.1401, Purpose, sets forth the purpose of the subchapter.

Proposed new §353.1403, Definitions, defines words and terms used throughout the subchapter.

Proposed new §353.1405, Managed Care Organization Responsibilities, sets forth Medicaid managed care organization responsibilities in providing mental health TCM and MHR through comprehensive provider agencies.

Proposed new §353.1407, Information Systems and Medical Records Systems, sets forth requirements related to management information systems, medical records, documentation retention, and disaster recovery plans for information resources.

Proposed new §353.1409, Patient Safety, Rights, and Protections, requires effective communication with individuals receiving TCM or MHR services and cross references other rules regarding patient safety, rights, and protections with which MCOs and comprehensive provider agencies must comply.

Proposed new §353.1411, Access to Mental Health Services, outlines requirements for a comprehensive provider agency's telephone system access as well as crisis services access during non-business hours.

Proposed new §353.1413, Staff Member Competency, outlines the knowledge and training requirements for comprehensive provider agency staff members.

Proposed new §353.1415, Staff Member Credentialing, outlines the specific minimum qualifications for specific staff member positions.

Proposed new §353.1417, Comprehensive Provider Agency Requirements for Staff Member Credentialing and Appeals, outlines the requirements for a comprehensive provider agency's credentialing process, including appeals, and gives comprehensive provider agencies the option to use the managed care organization's credentialing and appeals process.

Proposed new §353.1419, Supervision Requirements, outlines requirements for staff member supervision, including specific requirements based on licensure or staff member position.

#### FISCAL NOTE

Greta Rymal, Deputy Executive Commissioner for Financial Services, has determined that for each year of the first five years the proposed rules are in effect, there will be no fiscal implications to state or local governments as a result of enforcing and administering the rules as proposed.

#### GOVERNMENT GROWTH IMPACT STATEMENT

HHSC has determined that during the first five years that the rules will be in effect:

- (1) the proposed rules will not create or eliminate a government program;
- (2) implementation of the proposed rules will not affect the number of employee positions;
- (3) implementation of the proposed rules will not require an increase or decrease in future legislative appropriations;
- (4) the proposed rules will not affect fees paid to the agency;
- (5) the proposed rules will create a new rule;
- (6) the proposed rules will not expand, limit, or repeal an existing rule (in the sense that those required to comply will be required to do less or more based on the proposal); and

(7) the proposed rules will not change the number of individuals subject to the rule.

HHSC has insufficient information to determine the proposed rules' effect on the state's economy.

#### SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT ANALYSIS

HHSC has determined that there will be no adverse economic effect on small businesses, micro businesses, or rural communities to comply with the proposed rules, as they will not be required to alter their business practices as a result of the proposed rules.

#### ECONOMIC COSTS TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT

There are no anticipated economic costs to persons who are required to comply with the rules as proposed.

There is no anticipated negative impact on local employment.

#### COSTS TO REGULATED PERSONS

Texas Government Code, §2001.0045 does not apply to these rules because the rules are necessary to protect the health, safety, and welfare of the residents of Texas and do not impose a cost on regulated persons.

#### PUBLIC BENEFIT

Stephanie Muth, State Medicaid Director, has determined that for each year of the first five years the rules are in effect, the public will benefit from the adoption of the rules. The anticipated public benefit will be to provide managed care organizations and contracted mental health TCM and MHR comprehensive provider agencies with necessary guidance on the delivery of these two services to ensure the services are delivered appropriately.

#### TAKINGS IMPACT ASSESSMENT

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

## PUBLIC COMMENT

Written comments on the proposal may be submitted to Penny Larkin, Senior Policy Advisory, 4900 North Lamar, Mail Code 1045, Austin, TX 78751; by fax to (512)-487-3455; or by e-mail to [HHSRulesCoordinationOffice@hhsc.state.tx.us](mailto:HHSRulesCoordinationOffice@hhsc.state.tx.us) within 30 days of publication of this proposal in the *Texas Register*.

To be considered, comments must be submitted no later than 30 days after the date of this issue of the *Texas Register*. The last day to submit comments falls on a Sunday; therefore, comments must be: (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) faxed or e-mailed by midnight on the last day of the comment period. When faxing or e-mailing comments, please indicate "Comments on Proposed Rule 1R024" in the subject line.

## STATUTORY AUTHORITY

These new rules are proposed under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority, and Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas.

The proposed new rules implement Texas Human Resources Code, Chapter 32, and Texas Government Code, Chapter 531. No other statutes, articles, or codes are affected by this proposal.

This agency hereby certifies that this proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

TITLE 1                   ADMINISTRATION  
PART 15                 TEXAS HEALTH AND HUMAN SERVICES COMMISSION  
CHAPTER 353         MEDICAID MANAGED CARE  
SUBCHAPTER P        MENTAL HEALTH TARGETED CASE MANAGEMENT AND  
                              MENTAL HEALTH REHABILITATION

**§353.1401. Purpose.**

(a) The purpose of this subchapter is to establish requirements for providing mental health targeted case management and mental health rehabilitative services through Medicaid managed care. This subchapter applies to managed care organizations and the comprehensive provider agencies of mental health targeted case management and mental health rehabilitative services.

(b) Managed care organizations and comprehensive provider agencies providing mental health targeted case management and mental health rehabilitative services under this subchapter must meet the applicable requirements outlined in Chapter 354, Subchapter M, of this title (relating to Mental Health Targeted Case Management and Mental Health Rehabilitation).

**§353.1403. Definitions.**

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

(1) Adult--An individual who is age 21 or older.

(2) CFP--Certified Family Partner. A person who meets the credentialing requirements in §353.1415(d) of this subchapter (relating to Staff Member Credentialing).

(3) CFR--Code of Federal Regulations.

(4) Child or youth--An individual who is under age 21.

(5) Clinical supervision--An LPHA's or QMHP-CS's oversight of a staff member who delivers mental health targeted case management and mental health rehabilitative services to ensure that services are clinically appropriate and in compliance with this subchapter.

(6) Community data--Additional information gathered during the uniform assessment.

(7) CSSP--Community services specialist. A staff member of a local mental health authority who has documented full-time experience in the provision of mental health targeted case management and mental health rehabilitative services prior to August 31, 2004. See definition in 25 TAC §412.303 (relating to Definitions).

(8) Comprehensive provider agency--An entity that provides or subcontracts for the delivery of the full array of mental health targeted case management and mental health rehabilitative services set forth in Chapter 354, Subchapter M of this title (relating to Mental Health Targeted Case Management and Mental Health Rehabilitation), with the exception of §354.2715 of this title (relating to Day Programs for Acute Needs).

(9) Credentialing--A process by which the comprehensive provider agency reviews and approves a staff member's educational background, work experience, and licensure status (as applicable) to ensure that the staff member meets requirements for service provision. The process includes primary source verification of credentials, establishing and applying specific criteria and prerequisites to determine the staff member's initial and ongoing competency, and assessing and validating the staff member's qualifications to deliver care.

(10) HHSC--The Texas Health and Human Services Commission, or its designee.

(11) Individual--A person seeking or receiving mental health targeted case management, mental health rehabilitative services, or both under this subchapter.

(12) Intensive case management--A level of mental health targeted case management that includes a focused effort to coordinate community resources, uses an evidence-based wraparound planning process to address a child's or youth's unmet needs across life domains, and assists a child or youth in gaining access to necessary care and services appropriate to the child's or youth's needs.

(13) Intensive case management plan--A written document that is part of the medical record for a child or youth receiving intensive case management and is developed by a case manager, in collaboration with the child or youth and the child's or youth's LAR or primary caregiver, that identifies services needed by the child or youth and sets forth a plan for how the child or youth may gain access to the identified services.

(14) LAR--Legally authorized representative. A person authorized by law to act on behalf of an individual with regard to a matter described in this subchapter, including a parent, guardian, or managing conservator of a minor, or the guardian of an adult.

(15) Life domains--Areas of life, including safety, health, emotional, psychological, social, educational, cultural, and legal.

(16) LPHA--Licensed Practitioner of the Healing Arts. A staff member who is:

(A) a physician;

(B) a licensed professional counselor;

(C) a licensed clinical social worker;

(D) a licensed psychologist;

(E) an advanced practice registered nurse;

(F) a physician assistant; or

(G) a licensed marriage and family therapist.

(17) Management information system--An information system designed to plan, organize, staff, direct, and control the operations and clinical decision-making of a managed care organization or comprehensive provider agency.

(18) Medication training and support services--Medication training and support services consist of education and guidance about medications and their possible side effects.

(19) Mental health rehabilitative services--Services that are individualized, age-appropriate, and provide training and instructional guidance that restore an individual's functional deficits due to serious mental illness or serious emotional disturbance. The services are designed to improve or maintain the individual's ability to remain in the community as a fully integrated and functioning member of that community.

(20) Mental health targeted case management--Services furnished to assist individuals with severe mental illness and functional impairments or

serious emotional disorders and functional impairments to gain access to needed medical, social, educational, and other services.

(21) Peer provider--Staff with lived experience with a mental health condition who meet the credentialing requirements in §353.1415(c) of this subchapter.

(22) Pharmacological management--In-depth management of psychopharmacological agents to treat an individual's mental health symptoms.

(23) Primary caregiver--A person 18 years of age or older who has:

(A) actual care, control, and possession of a child or youth; or

(B) assumed responsibility for providing shelter and care for an adult.

(24) Psychiatric diagnostic evaluation--An integrated biopsychosocial assessment, including history, mental status, and recommendations.

(25) QMHP-CS--Qualified Mental Health Professional-Community Services. Staff who meet the credentialing requirements in §353.1415(a) of this subchapter.

(26) Re-credentialing--The periodic process of reevaluating a staff member's competency and qualifications.

(27) Recovery--A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

(28) Recovery or treatment plan (recovery/treatment plan)--A written plan that:

(A) is developed with the individual, the LAR if required, and a QMHP-CS or LPHA;

(B) is completed in conjunction with the uniform assessment;

(C) is amended at any time based on an individual's needs;

(D) guides the recovery process and fosters resiliency;

(E) identifies the individual's changing strengths, capacities, goals, preferences, needs, and desired outcomes; and

(F) identifies services and supports to meet the individual's goals, preferences, needs and desired outcomes.

(29) Referral and linkage--Activities that help link an individual with medical, social, educational, and other providers that are capable of providing needed services.

(30) Staff member--Comprehensive provider agency personnel, including a full-time or part-time employee, contractor, or intern, but excluding a volunteer.

(31) Strengths-based--The concept used in service delivery that identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of the individual, LAR, or primary caregiver, and family, their community, and other team members. The focus is on increasing functional strengths and assets rather than on the elimination of deficits.

(32) UA--Uniform assessment. A required assessment that assists in determining the medical necessity of services. For adults, the UA includes the Adult Needs and Strengths Assessment (ANSA), community data, relevant rating scales, diagnostic information, and any other state-required assessment tools and procedures. For children or youth, the UA includes the Child and Adolescent Needs and Strengths (CANS) assessment, community data, relevant rating scales, diagnostic information, and any other state-required assessment tools and processes.

(33) Utilization management guidelines--Guidelines developed by HHSC that establish the type, amount, and duration of mental health targeted case management services and mental health rehabilitative services for each individual.

(34) Wraparound Planning Process--A strengths-based approach used in intensive case management to develop an intensive case management plan that addresses the child's or youth's unmet needs across life domains.

### **§353.1405. Managed Care Organization Responsibilities.**

(a) A managed care organization (MCO) must ensure that each contracted comprehensive provider agency meets the requirements established in this subchapter.

(b) An MCO must develop policies, procedures, and contract requirements to ensure that contracted comprehensive provider agencies adhere to the requirements in this subchapter.

(c) An MCO must not approve or contract with a comprehensive provider agency as a provider of mental health targeted case management and mental health rehabilitative services unless the comprehensive provider agency:

(1) is enrolled as a Texas Medicaid provider in accordance with §352.7 of this title (related to Applying for Enrollment);

(2) attests in the application to the MCO and agrees in the contract to comply with applicable state and federal regulations, rules, policies, and procedures relating to mental health targeted case management and mental health rehabilitative services;

(3) agrees to comply with applicable state and federal laws governing participation of providers in the Medicaid program;

(4) agrees to submit accurate and complete cost reports in accordance with applicable HHSC requirements;

(5) has never been disqualified from being a Medicaid provider;

(6) is not listed on the HHSC Inspector General's Excluded Individual Listing;

(7) provides or subcontracts for the full array of mental health targeted case management and mental health rehabilitative services listed in Chapter 354, Subchapter M, of this title (relating to Mental Health Targeted Case Management and Mental Health Rehabilitation), with the exception of §354.2715 of this title (relating to Day Programs for Acute Needs (DPAN)); and

(8) has staff that are credentialed in accordance with §353.1415 of this subchapter (relating to Staff Member Credentialing).

(d) If an MCO contracts with a comprehensive provider agency to provide mental health targeted case management and mental health rehabilitative services specific to children who are at risk of juvenile justice involvement, expulsion from school, displacement from the home, hospitalization, residential treatment, or serious injury to self, others, or animals, the MCO must ensure the comprehensive provider agency has a referral arrangement with a Texas Medicaid enrolled provider within the MCO network that has the ability to otherwise meet the needs of the child and that can provide the services to the child without interruption in services and without otherwise affecting the child's access to care.

**§353.1407. Information Systems and Medical Records Systems.**

(a) Management information system. Managed care organizations (MCOs) and comprehensive provider agencies must ensure their management information systems provide timely, accurate, and accessible information that supports clinical, administrative, and fiscal decision-making.

(b) Maintenance of medical records. MCOs and comprehensive provider agencies must ensure:

(1) protection against unauthorized access, disclosure, modification, or destruction of medical records, whether accidental or deliberate;

(2) the availability, integrity, utility, authenticity, and confidentiality of information within the medical record;

(3) a current, organized, legible, and comprehensive records system that:

(A) conforms to good professional practice;

(B) permits effective clinical review and audit; and

(C) facilitates prompt and systematic retrieval of information;

(4) a medical records system with sufficient redundancy to ensure access to individual records; and

(5) a medical records system that ensures compliance with applicable federal and state laws, rules, and regulations, including the Health Insurance Portability and Accountability Act and 42 CFR Part 2.

(c) Documentation retention. A comprehensive provider agency must maintain all records necessary to fully disclose the services delivered. These records must be retained for a period of ten years from the date of the service, or until all audit questions are resolved, whichever is longer. Records and supporting information regarding any payment of claims, as well as premises access, must be made available to HHSC, HHSC OIG, the federal Health and Human Services, the State Auditor's Office, or any person acting on behalf of such entity, upon request.

(d) Disaster recovery plan. A comprehensive provider agency must maintain a written disaster recovery plan for information resources in order to ensure service continuity, and must implement the plan as necessary.

**§353.1409. Patient Safety, Rights, and Protections.**

(a) Each comprehensive provider agency and staff member must adhere to the following rules regarding patient safety, rights, and protections even if the comprehensive provider agency is not a type of entity specified in the rule:

(1) 25 TAC §404.154 (relating to Rights of All Persons Receiving Mental Health Services);

(2) 25 TAC §404.165 (relating to Staff Member Training in Rights of All Persons Receiving Mental Health Services);

(3) 25 TAC §412.312 (relating to Environment of Care and Safety);

(4) 25 TAC §412.313 (relating to Rights and Protection);

(5) 25 TAC §412.315 (relating to Medical Records System);

(6) 25 TAC Chapter 415 (relating to Provider Clinical Responsibilities--Mental Health Services), Subchapter F (relating to Interventions in Mental Health Services); and

(7) 40 TAC §711.201 (relating to What is Your Duty to Report If You Are a Direct Provider or Service Provider?).

(b) A comprehensive provider agency must ensure effective communication with each individual and LAR, if applicable, in an understandable format as appropriate to meet the needs of each individual, which may require the use of:

(1) interpretative services;

(2) translated materials; or

(3) staff who can effectively respond to the cultural and language needs of an individual and LAR, if applicable.

(c) A comprehensive provider agency must obtain a criminal history background check on each staff member and applicant to whom an offer of employment is made if the responsibilities of the position include personal contact with an individual receiving services, in order to ensure that individuals do not come in contact with and are not provided services by a staff member who has a conviction for any of the criminal offenses listed in

Texas Health and Safety Code §250.006, or for any criminal offense that the comprehensive provider agency has determined to be a contraindication to employment.

**§353.1411. Access to Mental Health Services.**

(a) Telephone system access. A comprehensive provider agency must ensure the availability of a telephone system that allows individuals to contact the comprehensive provider agency through a toll-free number that must:

(1) be answered by a person without being answered by telephone answering equipment at least on business days during normal business hours, except:

(A) on national holidays;

(B) due to uncontrollable interruption of service; or

(C) with prior approval of HHSC;

(2) have sufficient staff to operate efficiently;

(3) collect, document, and store detailed information, including special needs information, on all telephone inquiries and calls;

(4) during times other than those described in paragraph (1) of this subsection, provide electronic call answering methods that:

(A) include an outgoing message providing a toll-free crisis hotline telephone number in languages relevant to the service area; and

(B) allows callers to leave a message; and

(5) return routine calls before the end of the next business day for all messages left during non-business hours.

(b) Crisis services access during non-business hours. The comprehensive provider agency must assist individuals in their care to access crisis services outside of business hours by documenting in each individual's recovery/treatment plan:

(1) how the individual will access emergency medical and psychiatric crisis services during non-business hours;

(2) a list of all crisis resources that are easily accessible to the individual;  
and

(3) the toll-free telephone number to access crisis services.

**§353.1413. Staff Member Competency.**

(a) Prior to providing services or accessing an individual's confidential information, the comprehensive provider agency must ensure that each staff member:

(1) can provide services within the scope of the staff member's license, job description, or contract specification;

(2) has completed required training modules as identified by the State;  
and

(3) has the following minimum competencies:

(A) an understanding of the nature of severe mental illness and serious emotional disturbances;

(B) an understanding of the developmental needs of an adult, child, or youth;

(C) the ability to interact appropriately with an individual who has a physical disability;

(D) the ability to respond to an individual's linguistic and cultural needs through knowledge of customs, beliefs, and values of various, racial, ethnic, religious, and social groups;

(E) identification of an individual experiencing a crisis and the process for accessing crisis services;

(F) knowledge of appropriate actions to take in managing a crisis;

(G) the ability to complete the uniform assessment;

(H) the ability to understand and apply the utilization management guidelines;

(I) knowledge of available resources within the local community;

(J) an understanding of the dignity and rights of an individual, as described in 25 TAC §404.154 (relating to Rights of All Persons Receiving Mental Health Services) and 25 TAC §404.163 (relating to Communication of Rights to Individuals Receiving Mental Health Services);

(K) the ability to identify, prevent, and report abuse, neglect, and exploitation, in accordance with 40 TAC Chapter 705 (relating to Adult Protective Services) and Chapter 711 (relating to Investigations of Individuals Receiving Services from Certain Providers);

(L) knowledge of individual confidentiality and relevant state and federal laws affecting confidentiality of medical records, including Title 42 CFR Part 2;

(M) knowledge of professional ethics and standards of conduct;

(N) knowledge of proper documentation of services provided;

(O) understanding exposure control of blood borne pathogens; and

(P) the ability to respond to severe weather, disasters, and bioterrorism.

(b) For a staff member whose primary duties include individual service contacts and interactions, the comprehensive provider agency must ensure that the staff member has adequate knowledge of:

(1) cardio pulmonary resuscitation (CPR);

(2) first aid;

(3) safe management of verbally and physically aggressive behavior;

(4) use of assistive technology, such as communication devices, with individuals who are deaf or hard of hearing;

(5) seizure assessment and response;

(6) infection control;

(7) how to recognize, report, and record side effects, contraindications, and drug interactions of psychoactive medication;

(8) assessment and intervention with children, youth, and families; and

(9) clinical specialties directly related to the services to be performed.

(c) A staff member who provides mental health targeted case management must also have:

(1) knowledge of strategies for advocating effectively on behalf of individuals;

(2) the ability to document the mental health targeted case management services described in §354.2655 of this title (relating to Case Management Services); and

(3) knowledge gained from the completion of training modules as identified by the State.

(d) A staff member who provides intensive case management, before providing services to children and youth, must complete training approved by HHSC on the wraparound planning process and demonstrate understanding of the wraparound planning process.

(e) A staff member who routinely provides or supervises the provision of mental health targeted intensive case management to a child or youth must receive training and demonstrate competency in the aspects of a child's or youth's growth and development (including physical, emotional cognitive, educational and social) and the treatment needs of a child or youth.

(f) Additional competencies for providers of mental health rehabilitative services.

(1) A comprehensive provider agency must ensure that a staff member who provides mental health rehabilitative services is trained in the rehabilitative practice techniques related to:

(A) medication training and support services;

(B) skills training and development; and

(C) psychosocial rehabilitation.

(2) A comprehensive provider agency must ensure that staff members who provide or supervise the provision of mental health rehabilitative services receive initial training in:

(A) the nature of serious mental illness and serious emotional disturbance;

(B) the concepts of recovery and resilience;

(C) the rehabilitative practice techniques found in curricula, program practices, and protocols;

(D) the prevalence of physical health risk factors; and

(E) other training modules as identified by the State.

### **§353.1415. Staff Member Credentialing.**

(a) Qualified Mental Health Professional-Community Services (QMHP-CS). A staff member must meet at least one of three minimum requirements to be credentialed as a QMHP-CS:

(1) The staff member has at least a bachelor's degree from an accredited college or university and a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention.

(2) The staff member is a registered nurse.

(3) The staff member is a Licensed Practitioner of the Healing Arts (LPHA).

(b) Community Services Specialist (CSSP). The minimum requirements to credential a staff member as a CSSP for the provision of mental health case management are described in 25 TAC §412.303 (relating to Definitions).

(c) Peer Provider. The minimum requirements to credential a staff member as a peer provider are that the staff member has:

(1) a high school diploma or high school equivalency certificate issued in accordance with the law of the issuing state;

(2) at least one cumulative year of receiving mental health services; and

(3) demonstrated competency in the provision and documentation of mental health rehabilitative services, supported employment, or supported housing.

(d) Certified Family Partners (CFPs). The minimum requirements to credential a staff member as a CFP include verifying that the staff member:

(1) is 18 years of age or older;

(2) has a high school diploma or high school equivalency certificate issued in accordance with the law of the issuing state;

(3) has at least one year of personal experience as a parent or LAR raising a child or youth with serious emotional disturbance or mental illness;

(4) has at least one year of personal experience as a parent or LAR navigating a child-service system (e.g., mental health, juvenile justice, social security, or special education); and

(5) has successfully completed and passed the State-approved certification process.

**§353.1417. Comprehensive Provider Agency Requirements for Staff Member Credentialing and Appeals.**

(a) A comprehensive provider agency must:

(1) justify in writing and document in a staff member's personnel file support of the staff member's qualifications to provide mental health targeted case management and mental health rehabilitative services based on credentialing requirements listed in §353.1415 of this division (relating to Staff Member Credentialing); and

(2) regularly monitor each staff member's demonstrated competency throughout the staff member's tenure.

(b) A comprehensive provider agency must:

(1) credential each staff member in a timely fashion; and

(2) have a process for staff members to appeal credentialing decisions.

(c) A comprehensive provider agency may choose to use the managed care organization's credentialing and appeals processes for licensed staff, QMHP-

CSs, CSSPs, peer providers, family partners, and utilization management positions.

**§353.1419. Supervision Requirements.**

(a) Policies and procedures. The comprehensive provider agency must develop and implement written policies and procedures for supervision of all applicable levels of staff members providing services to individuals.

(b) Licensed staff member supervision. All licensed staff members must be supervised in accordance with applicable law and rules.

(c) Clinical supervision.

(1) Clinical supervision must be provided by an LPHA or a QMHP-CS.

(2) The supervising LPHA or QMHP-CS must conduct at least monthly documented meetings with each staff member being supervised.

(3) For staff members providing mental health rehabilitative services, the supervising LPHA or QMHP-CS must be an employee of the comprehensive provider agency and conduct a documented observation of the staff member providing mental health rehabilitative services at a frequency determined by the supervisor based on the staff member's skill level.

(4) For staff members providing mental health targeted case management, the supervising QMHP-CS must:

(A) be an employee of the comprehensive provider agency;

(B) demonstrate competency in mental health targeted case management evidenced-based practices; and

(C) demonstrate competencies outlined in §353.1413 of this subchapter (relating to Staff Member Competency).

(d) QMHP-CS supervision. A QMHP-CS's designated clinical duties must be clinically supervised by:

(1) a QMHP-CS; or

(2) an LPHA if the QMHP-CS is clinically supervising another QMHP-CS for the provision of mental health targeted case management and mental health rehabilitative services.

(e) CSSP supervision. A CSSP's designated clinical duties must be clinically supervised by a QMHP-CS. The CSSP must have access to clinical consultation with an LPHA when necessary.

(f) CFP supervision. A CFP must be directly supervised by a QMHP-CS who has at least one year's experience in the HHSC-approved recovery and resilience protocol.

(g) Peer provider supervision.

(1) A peer provider's designated clinical duties must be under the direct clinical supervision of an LPHA.

(2) The supervising LPHA must conduct at least monthly documented meetings with each peer provider being supervised.

(3) The supervising LPHA must conduct and document an additional monthly observation of each peer provider providing mental health rehabilitative services.

(h) Peer review. The comprehensive provider agency must implement a peer review process for licensed staff members that:

(1) promotes sound clinical practice consistent with the HHSC-approved resiliency and recovery protocol;

(2) promotes professional growth; and

(3) complies with applicable state laws and rules.

(i) Documentation. All clinical supervision must be documented.

## PROPOSED PREAMBLE

The Texas Health and Human Services Commission (HHSC) proposes new Title 1, Part 15, Chapter 354 (Medicaid Health Services) Subchapter M, concerning Mental Health Targeted Case Management and Mental Health Rehabilitation.

## BACKGROUND AND PURPOSE

Senate Bill (S.B.) 58, 83rd Legislature, Regular Session, 2013, added two Medicaid State Plan mental health benefits, mental health targeted case management (TCM) and mental health rehabilitative (MHR) services, to Medicaid managed care. Prior to S.B. 58, the local mental health authorities (LMHAs) operated under the Texas Department of State Health Services were the sole providers of these services. Effective September 1, 2014, Medicaid managed care organization contracted providers of mental health TCM and MHR services, in addition to LMHAs, were allowed to deliver these benefits. HHSC is proposing these rules to provide managed care organizations and contracted mental health TCM and MHR comprehensive provider agencies with necessary guidance on the delivery of these two services to ensure the services are delivered appropriately.

## SECTION-BY-SECTION SUMMARY

### *Division 1, General Provisions*

Proposed new §354.2601, Purpose and Applicability, sets forth the purpose and applicability of the subchapter.

Proposed new §354.2603, Definitions, defines words and terms used throughout the subchapter.

Proposed new §354.2605, Fair Hearings and Appeal Processes, outlines appeal options for an individual requesting or receiving TCM or MHR services, through either an HHSC fair hearing or the managed care organization's appeal process.

Proposed new §354.2607 Assessment and Service Authorization, outlines comprehensive provider agency requirements for assessment, diagnosis, and managed care organization authorization prior to providing services to an individual under this subchapter.

Proposed new §354.2609, Recovery/Treatment Planning, Recovery/Treatment Plan Review, and Discharge Summary, outlines

requirements for recovery/treatment planning, review of recovery/treatment plans, and discharge summaries.

Proposed new §354.2611, Pharmacological Management, Psychiatric Diagnostic Evaluations, and Psychotherapy, outlines comprehensive provider agency requirements for pharmacological management and psychiatric diagnostic evaluations and psychotherapy

Proposed new §354.2613, Related to Criminal History Background Checks, outlines requirements for conducting criminal history background checks.

### *Division 2, Mental Health Targeted Case Management*

Proposed new §354.2651, Eligible Individuals, outlines who is eligible to receive mental health targeted case management.

Proposed new §354.2653, Continued Eligibility, outlines reassessment and reauthorization requirements for individuals receiving mental health targeted case management.

Proposed new §354.2655, Mental Health Targeted Case Management Services, outlines the services included in mental health targeted case management, including routine case management and intensive case management.

Proposed new §354.2657, Documentation Requirements, outlines the documentation requirements for mental health targeted case management, including specific requirements related to routine case management, intensive case management, and crisis services.

Proposed new §354.2659, Exclusions, lists the services not covered by mental health targeted case management and the services included in the Medicaid rate for mental health targeted case management.

### *Division 3, Mental Health Rehabilitation*

Proposed new §354.2701, Eligible Individuals, outlines who is eligible to receive mental health rehabilitation.

Proposed new §354.2703, Continued Eligibility, outlines reassessment requirements for individuals receiving mental health rehabilitation.

Proposed new §354.2705, Mental Health Rehabilitative Services, lists the services included in mental health rehabilitative services.

Proposed new §354.2707, Crisis Intervention Services, describes and outlines requirements for crisis intervention services.

Proposed new §354.2709, Medication Training and Support Services, describes and outlines requirements for medication training and support services.

Proposed new §354.2711, Psychosocial Rehabilitative Services, describes and outlines requirements for psychosocial rehabilitative services.

Proposed new §354.2713, Skills Training and Development Services, describes and outlines requirements for skills training and development services.

Proposed new §354.2715, Day Programs for Acute Needs, describes and outlines requirements for a day program for acute needs.

Proposed new §354.2717, Exclusions, lists the services not covered by mental health rehabilitation services.

#### FISCAL NOTE

Greta Rymal, Deputy Executive Commissioner for Financial Services, has determined that for each year of the first five years the proposed rules are in effect, there will be no fiscal implications to state or local governments as a result of enforcing and administering the rules as proposed.

#### GOVERNMENT GROWTH IMPACT STATEMENT

HHSC has determined that during the first five years that the rules will be in effect:

- (1) the proposed rules will not create or eliminate a government program;
- (2) implementation of the proposed rules will not affect the number of employee positions;
- (3) implementation of the proposed rules will not require an increase or decrease in future legislative appropriations;
- (4) the proposed rules will not affect fees paid to the agency;
- (5) the proposed rules will create a new rule;
- (6) the proposed rules will not expand, limit, or repeal an existing rule; and
- (7) the proposed rules will not change the number of individuals subject to the rule.

HHSC has insufficient information to determine the proposed rules' effect on the state's economy.

#### SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT ANALYSIS

HHSC has determined that there will be no adverse economic effect on small businesses, micro businesses, or rural communities to comply with the proposed rules, as they will not be required to alter their business practices as a result of the proposed rules.

#### ECONOMIC COSTS TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT

There are no anticipated economic costs to persons who are required to comply with the rules as proposed.

There is no anticipated negative impact on local employment.

#### COSTS TO REGULATED PERSONS

Texas Government Code, §2001.0045 does not apply to these rules because the rules are necessary to protect the health, safety, and welfare of the residents of Texas and do not impose a cost on regulated persons.

#### PUBLIC BENEFIT

Stephanie Muth, State Medicaid Director, has determined that for each year of the first five years the rules are in effect, the public will benefit from the adoption of the rules. The anticipated public benefit will be to provide managed care organizations and contracted mental health TCM and MHR comprehensive provider agencies with necessary guidance on the delivery of these two services to ensure the services are delivered appropriately.

#### TAKINGS IMPACT ASSESSMENT

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

#### PUBLIC COMMENT

Written comments on the proposal may be submitted to Penny Larkin, Senior Policy Advisor, 4900 North Lamar, Mail Code 1045, Austin, TX 78751;

by fax to (512)-487-3455; or by e-mail to HHSRulesCoordinationOffice@hhsc.state.tx.us within 30 days of publication of this proposal in the *Texas Register*.

To be considered, comments must be submitted no later than 30 days after the date of this issue of the *Texas Register*. The last day to submit comments falls on a Sunday; therefore, comments must be: (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) faxed or e-mailed by midnight on the last day of the comment period. When faxing or e-mailing comments, please indicate "Comments on Proposed Rule 1R024" in the subject line.

#### STATUTORY AUTHORITY

These new rules are proposed under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority, and Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas.

The proposed new rules implement Texas Human Resources Code, Chapter 32, and Texas Government Code, Chapter 531. No other statutes, articles, or codes are affected by this proposal.

This agency hereby certifies that this proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

TITLE 1 ADMINISTRATION  
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION  
CHAPTER 354 MEDICAID HEALTH SERVICES  
SUBCHAPTER M MENTAL HEALTH TARGETED CASE MANAGEMENT AND  
MENTAL HEALTH REHABILITATION  
DIVISION 1 GENERAL PROVISIONS

**§354.2601. Purpose and Applicability.**

(a) The purpose of this subchapter is to establish requirements for providing mental health targeted case management and mental health rehabilitative services throughout Medicaid, including the managed care and the fee-for-service models.

(b) This subchapter applies to managed care organizations and comprehensive provider agencies delivering mental health targeted case management and mental health rehabilitative services under Chapter 353, Subchapter P, of this title (relating to Mental Health Targeted Case Management and Mental Health Rehabilitation).

**§354.2603. Definitions.**

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

(1) Adult--An individual who is age 21 or older.

(2) Appeal--A mechanism for an independent review of an adverse determination or a request for a review of an action or failure to act that may result in a fair hearing.

(3) Behavioral health emergency--A situation involving an individual who is behaving in a violent or self-destructive manner and in which preventive, de-escalation, or verbal techniques have been determined to be ineffective and it is immediately necessary to restrain or seclude the individual to prevent:

(A) imminent probable death or substantial bodily harm to the individual because the individual is attempting to commit suicide or inflict serious bodily harm; or

(B) imminent physical harm to others because of acts the individual commits.

(4) Case manager--A staff member of the comprehensive provider agency who provides mental health targeted case management services.

(5) CFP--Certified Family Partner. A person who meets the credentialing requirements in §353.1415(d) of this title (relating to Staff Member Credentialing).

(6) CFR--Code of Federal Regulations.

(7) Child or youth--An individual who is under age 21.

(8) Community-based--Mental health targeted case management services that are provided at a location other than the comprehensive provider agency's office.

(9) Community data--Additional information gathered during the uniform assessment.

(10) CSSP--Community services specialist. A staff member of a local mental health authority who has documented full-time experience in the provision of mental health targeted case management and mental health rehabilitative services prior to August 31, 2004. See definition in 25 TAC §412.303 (relating to Definitions).

(11) Comprehensive provider agency--An entity that provides or subcontracts for the delivery of the full array of mental health targeted case management and mental health rehabilitative services set forth in this subchapter, with the exception of §354.2715 of this subchapter (relating to Day Programs for Acute Needs).

(12) Crisis plan--A plan developed in advance of a crisis and in collaboration with the individual, LAR, caregiver, or family of the individual receiving services that identifies circumstances that determine a crisis that would jeopardize the individual's ability to remain in the community and the actions preferred and necessary to avert removal from the community.

(13) CSU--Crisis stabilization unit. A crisis stabilization unit licensed under Chapter 577 of the Texas Health and Safety Code and 25 TAC Chapter 134 (relating to Private Psychiatric Hospitals and Crisis Stabilization Units).

(14) Family Psychotherapy--Therapy that focuses on the dynamics of the family unit where the goal is to strengthen the family's problem solving and communication skills.

(15) Group Psychotherapy--Therapy that involves one or more therapists working with several clients at the same time.

(16) HHSC--The Texas Health and Human Services Commission, or its designee.

(17) IMD--Institution for mental diseases. Based on 42 CFR §435.1009, a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental illness, including medical attention, nursing care, and related services.

(18) Independent Living--A service within psychosocial rehabilitative services that assists an individual in acquiring the most immediate, fundamental functional skills needed to enable the individual to reside in the community and avoid more restrictive levels of treatment or reducing behaviors or symptoms that prevent successful functioning in the individual's environment of choice. Such services include training in symptom management, personal hygiene, nutrition, food preparation, exercise, money management, and community integration activities.

(19) Individual--A person seeking or receiving mental health targeted case management, mental health rehabilitative services, or both under this subchapter.

(20) Individual Psychotherapy--Therapy that focuses on a single client.

(21) Intensive case management--A level of mental health targeted case management that includes a focused effort to coordinate community resources, uses an evidence-based wraparound planning process to address a child's or youth's unmet needs across life domains, and assists a child or youth in gaining access to necessary care and services appropriate to the child's or youth's needs.

(22) Intensive case management plan--A written document that is part of the medical record for a child or youth receiving intensive case management and is developed by a case manager, in collaboration with the child or youth and the child's or youth's LAR or primary caregiver, that identifies services needed by the child or youth and sets forth a plan for how the child or youth may gain access to the identified services.

(23) In-vivo--The individual's natural environment (e.g., the individual's residence, work place, or school).

(24) LAR--Legally authorized representative. A person authorized by law to act on behalf of an individual with regard to a matter described in this subchapter, including a parent, guardian, or managing conservator of a minor, or the guardian of an adult.

(25) Licensed medical personnel--A staff member who is:

(A) a physician;

(B) a physician assistant;

(C) an advanced practice registered nurse;

(D) a registered nurse;

(E) a licensed vocational nurse; or

(F) a pharmacist.

(26) Life domains--Areas of life, including safety, health, emotional, psychological, social, educational, cultural, and legal.

(27) LPHA--Licensed Practitioner of the Healing Arts. A staff member who is:

(A) a physician;

(B) a licensed professional counselor;

(C) a licensed clinical social worker;

(D) a licensed psychologist;

(E) an advanced practice registered nurse;

(F) a physician assistant; or

(F) a licensed marriage and family therapist.

(28) Medication training and support services--Medication training and support services consist of education and guidance about medications and their possible side effects.

(29) Mental health rehabilitative services--Services that are individualized, age-appropriate, and provide training and instructional

guidance that restore an individual's functional deficits due to serious mental illness or serious emotional disturbance. The services are designed to improve or maintain the individual's ability to remain in the community as a fully integrated and functioning member of that community.

(30) Mental health targeted case management--Services furnished to assist individuals with severe mental illness and functional impairments or serious emotional disorders and functional impairments to gain access to needed medical, social, educational, and other services.

(31) On-site--Services that are provided at a location operated by a comprehensive provider agency.

(32) Peer provider--Staff with lived experience with a mental health condition who meet the credentialing requirements in §353.1415(c) of this title.

(33) Pharmacological management--In-depth management of psychopharmacological agents to treat an individual's mental health symptoms.

(34) Primary caregiver--A person 18 years of age or older who has:

(A) actual care, control, and possession of a child or youth; or

(B) assumed responsibility for providing shelter and care for an adult.

(35) Psychiatric diagnostic evaluation--An integrated biopsychosocial assessment, including history, mental status, and recommendations.

(36) Psychosocial rehabilitative services--Social, behavioral, and cognitive interventions provided by members of an adult's therapeutic team that build on strengths and focus on restoring the adult's ability to develop and maintain social relationships, occupational or educational achievements, and other independent living skills that are affected by a serious mental illness in adults. Psychosocial rehabilitative services may also address the impact of co-occurring disorders upon the adult's ability to reduce symptomology and increase daily functioning.

(37) QMHP-CS--Qualified Mental Health Professional-Community Services. Staff who meet the credentialing requirements in §353.1415(a) of this title.

(38) Recovery--A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

(39) Recovery or treatment plan (recovery/treatment plan)--A written plan that:

(A) is developed with the individual, the LAR if required, and a QMHP-CS or LPHA;

(B) is completed in conjunction with the uniform assessment;

(C) amended at any time based on an individual's needs;

(D) guides the recovery process and fosters resiliency;

(E) identifies the individual's changing strengths, capacities, goals, preferences, needs, and desired outcomes; and

(F) identifies services and supports to meet the individual's goals, preferences, needs and desired outcomes.

(40) Recovery or treatment planning (recovery/treatment planning)--A systematic process for engaging the individual, LAR, and the primary caregiver and others to develop goals and identify a course of action to respond to the individual's clinically assessed needs, including medical, social, educational, and other services needed by the individual.

(41) Referral and linkage--Activities that help link an individual with medical, social, educational, and other providers that are capable of providing needed services.

(42) Routine care services--Mental health services provided to an individual who is not in crisis.

(43) Service provider--An entity separate from the comprehensive provider agency which may also provide services to an individual outside of the services performed under this subchapter.

(44) Staff member--Comprehensive provider agency personnel, including a full-time or part-time employee, contractor, or intern, but excluding a volunteer.

(45) Strengths-based--The concept used in service delivery that identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of the individual, LAR, or primary caregiver, and family, their community, and other team members. The focus is on increasing functional strengths and assets rather than on the elimination of deficits.

(46) Therapeutic team--A group of staff members who work together in a coordinated manner for the purpose of providing comprehensive mental health services to an individual.

(47) UA--Uniform assessment. A required assessment that assists in determining the medical necessity of services. For adults, the UA includes the Adult Needs and Strengths Assessment (ANSA), community data, relevant rating scales, diagnostic information, and any other state-required assessment tools and procedures. For children or youth, the UA includes the Child and Adolescent Needs and Strengths (CANS) assessment, community data, relevant rating scales, diagnostic information, and any other state-required assessment tools and processes.

(48) Utilization management guidelines--Guidelines developed by HHSC that establish the type, amount, and duration of mental health targeted case management services and mental health rehabilitative services for each individual.

(49) Wraparound Planning Process--A strengths-based approach used in intensive case management to develop an intensive case management plan that addresses the child's or youth's unmet needs across life domains.

### **§354.2605. Fair Hearings and Appeal Processes.**

(a) A Medicaid eligible individual whose request for services is denied or is not acted upon with reasonable promptness, or whose services are terminated, suspended, or reduced, is entitled to an HHSC fair hearing per Chapter 357, Subchapter A, of this title (relating to Uniform Fair Hearing Rules).

(b) An individual receiving services through enrollment in a managed care organization may also appeal with the managed care organization per §353.415 of this title (relating to Member Complaint and Appeal Procedures).

**§354.2607. Assessment and Service Authorization.**

(a) Assessment and documentation. A QMHP-CS with appropriate supervision and training must perform a face to face assessment of the individual. The assessment must be documented and must include:

(1) the individual's identifying information;

(2) completion of the appropriate uniform assessment(s) and assessment guideline calculations;

(3) the individual's present status and relevant history, including education, employment, housing, legal, military, developmental, and current available social and support systems;

(4) the individual's co-occurring substance use, intellectual or developmental disability, or physical health condition, if any;

(5) the individual's relevant past and current medical and psychiatric information, which may include trauma history;

(6) information from the individual and LAR, if applicable, regarding the individual's strengths, needs, natural supports, community participation, responsiveness to previous treatment, as well as preferences for and objections to specific treatments;

(7) the need or desire of the individual for family member involvement or other identified natural supports in treatment and mental health community services, if the individual is an adult without an LAR,;

(8) the identification of the LAR's or family members' need for education and support services related to the individual's mental illness or emotional disturbance and the plan to facilitate the LAR's or family members' receipt of the needed education and support services;

(9) recommendations and conclusions regarding treatment needs; and

(10) date, signature, and credentials of the staff member completing the assessment.

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

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

(2) based on diagnostic criteria from the latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders;

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

(4) supported by and included in the uniform assessment.

(c) Provision of services. The comprehensive provider agency and staff members must implement procedures to ensure that each individual is provided mental health services based on:

(1) the assessment conducted under subsection (a) of this section;

(2) medical necessity as determined by an LPHA; and

(3) when available, physical health care needs as determined by a physician, physician assistant, or advanced practice registered nurse.

(d) Prerequisites to provision of services. With the exception of crisis intervention services provided under §354.2707 of this subchapter (relating to Crisis Intervention Services), before providing services to an individual under this subchapter a comprehensive provider agency must:

(1) if required by the managed care organization, submit authorization requests to the managed care organization with which the individual is enrolled for the type(s), amount, and duration of services to be provided to the individual in accordance with the uniform assessment and the utilization management guidelines; and

(2) in collaboration with the individual and his LAR, if applicable, develop a recovery/treatment plan for the individual that complies with the requirements of this subchapter.

### **§354.2609. Recovery/Treatment Planning, Recovery/Treatment Plan Review, and Discharge Summary.**

(a) Timeframe for recovery/treatment plan. A comprehensive provider agency must develop a written recovery/treatment plan:

(1) before the provision of mental health targeted case management or mental health rehabilitative services; and

(2) within 10 business days after the date the individual is eligible and has been authorized for routine care services.

(b) Credentials for completing recovery/treatment plan. A staff member credentialed as a QMHP-CS, at a minimum, is responsible for completing and signing the plan.

(c) Content of recovery/treatment plan (plan).

(1) The plan must reflect input from the individual and each of the disciplines of treatment to be provided to the individual based on the assessment. The plan must include:

(A) a description of the individual's presenting problem(s);

(B) a description of the individual's strengths;

(C) a description of the individual's needs arising from the mental illness or serious emotional disturbance;

(D) a description of the individual's co-occurring substance use disorder, intellectual or developmental disability, or physical health condition(s), if any;

(E) a description of the recovery goals and objectives based on the assessment, and expected outcomes of the treatment in accordance with paragraph (2) of this subsection;

(F) the expected date by which the recovery/treatment goals will be achieved; and

(G) a list of the type(s) of intervention(s) within each form of treatment that will be provided to the individual (e.g., psychosocial rehabilitation, medication services, supported employment), and for each type of service listed:

(i) a description of the strategies to be implemented by staff members in providing the service and achieving goals;

(ii) the frequency, number of units (e.g., 10 counseling sessions, two skills training sessions), and duration of each service to be provided (e.g., .5 hour, 1.5 hours); and

(iii) the credentials of the staff member responsible for providing the service.

(2) The goals and objectives with expected outcomes required by paragraph (1)(E) of this subsection must:

(A) specifically address the individual's unique needs, preferences, experiences, and cultural background;

(B) specifically address the individual's co-occurring substance use or physical health disorder, if any;

(C) be expressed in terms of overt, observable actions of the individual;

(D) be objective and measurable using quantifiable criteria; and

(E) reflect the individual's self-direction, autonomy, and desired outcomes.

(3) The plan must be developed in consultation with the individual, and LAR if applicable.

(4) The individual, and LAR if applicable, must be provided, in an understandable format as appropriate to meet the needs of each individual, a copy of the plan and each subsequent reviewed and revised plan.

(d) Review of recovery/treatment plan.

(1) A comprehensive provider agency must:

(A) review an individual's continued eligibility for services as specified in §354.2703 of this subchapter (relating to Continued Eligibility); and

(B) review an individual's plan prior to requesting an authorization for the continuation of services, including:

(i) reviewing the individual's plan in its entirety, considering input from the individual, the individual's LAR as applicable, and each member of the therapeutic team;

(ii) determining if the plan is adequately addressing the needs of the individual;

(iii) documenting progress on all goals and objectives; and

(iv) documenting any recommendation for continuing services, any change from current services, and any discontinuation of services.

(2) In addition to the required review under paragraph (1)(B) of this subsection, a comprehensive provider agency may review an individual's recovery/treatment plan:

(A) if clinically indicated; and

(B) at the request of the individual or the LAR, or the primary caregiver of a child or youth.

(3) Any time an individual's recovery/treatment plan is reviewed, the comprehensive provider agency must:

(A) meet with the individual face-to-face to solicit and consider input from the individual regarding a self-assessment of progress toward the recovery goals;

(B) solicit and consider the input from each member of the therapeutic team in assessing the individual's progress toward the recovery goals and objectives with expected outcomes;

(C) solicit and consider input from the LAR or primary caregiver, as applicable, regarding the level of satisfaction with the services provided; and

(D) document all the input described in subparagraphs (A) - (C) of this paragraph.

(e) Revisions to the recovery/treatment plan. If, after any review of the recovery/treatment plan, the individual or comprehensive provider agency determines that the plan does not adequately address the needs of the individual, the comprehensive provider agency, with input from the individual, must appropriately revise the content of the plan.

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

(1) a summary, based on input from each member of the therapeutic team, of all the services provided, the individual's response to treatment, and any other relevant information;

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

(3) the individual's most current diagnosis, based on diagnostic criteria from the latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

**§354.2611. Pharmacological Management, Psychiatric Diagnostic Evaluations, and Psychotherapy.**

(a) Service Array. A comprehensive provider agency must have the capability to deliver pharmacological management, psychiatric diagnostic evaluation, and psychotherapy, either directly or through subcontract(s).

(b) Pharmacological management. Pharmacological management is the in-depth management of psychopharmacological agents to treat a client's mental health symptoms. Pharmacological management is a physician service and cannot be provided by a non-physician or "incident to" a physician service, with the exception of advanced practice registered nurses and physician assistants whose scope of license in Texas permits them to prescribe under delegation of prescriptive authority. Supporting documentation for pharmacological management must include:

(1) complete diagnosis using diagnostic criteria from the latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders;

(2) current list of medications;

(3) current psychiatric symptoms and problems, to include presenting mental status;

(4) problems, reactions, and side effects, if any, to medications;

(5) any medication modifications made during the visit and the reasons for medication adjustments, including the discontinuation of a medication;

(6) desired therapeutic drug levels, if applicable, for medications requiring blood level monitoring;

(7) current laboratory values, if applicable, for medications requiring monitoring for potential side effects; and

(8) the individual's related treatment goals.

(c) Psychiatric diagnostic evaluation.

(1) Psychiatric diagnostic evaluations must be conducted by:

- (A) a psychiatrist;
- (B) a psychologist;
- (C) an advanced practice registered nurse;
- (D) a physician assistant;
- (E) a licensed clinical social worker;
- (F) a licensed professional counselor; or
- (G) a licensed marriage and family therapist.

(2) Documentation for a psychiatric diagnostic evaluation must include:

- (A) the individual's presenting problem(s);
- (B) the individual's prior diagnoses and any prior treatment;
- (C) other pertinent medical, social, and family history;
- (D) clinical observations and results of a mental status examination;
- (E) complete diagnosis using diagnostic criteria from the latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders;
- (F) expected long-term and short-term goals; and
- (G) recommendations.

(d) Psychotherapy. Psychotherapy services may include individual psychotherapy, group psychotherapy, or family psychotherapy. A comprehensive provider agency is required to use, and be able to demonstrate fidelity to, evidence-based psychotherapy modalities approved by HHSC.

**§354.2613. Criminal History Background Checks.**

A comprehensive provider agency must obtain a criminal history background check on each staff member and applicant to whom an offer of employment is made if the responsibilities of the position include personal contact with an individual receiving services, in order to ensure that individuals do not come in contact with and are not provided services by a staff member who has a conviction for any of the criminal offenses listed in Texas Health and Safety Code, §250.006, or for any criminal offense that the comprehensive provider agency has determined to be a contraindication to employment.

TITLE 1 ADMINISTRATION  
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION  
CHAPTER 354 MEDICAID HEALTH SERVICES  
SUBCHAPTER M MENTAL HEALTH TARGETED CASE MANAGEMENT AND  
MENTAL HEALTH REHABILITATION  
DIVISION 2 MENTAL HEALTH TARGETED CASE MANAGEMENT

**§354.2651. Eligible Individuals.**

(a) Mental health targeted case management is available to a child or youth who:

(1) is a resident of the State of Texas;

(2) is a recipient of the Texas Medicaid Program;

(3) has a serious emotional, behavioral, or mental disorder and:

(A) is at risk of disruption of a preferred living or child-care environment due to psychiatric symptoms; or

(B) is enrolled in a school system's special education program because of serious emotional disturbance;

(4) has a diagnosis or diagnoses of mental illness or serious emotional disturbance as defined in the latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, not including a single diagnosis of an intellectual or developmental disability or a substance use disorder; and

(5) who has been determined via the uniform assessment process as described in §354.2607 of this subchapter (relating to Assessment and Service Authorization) to have serious functional impairments and is in need of mental health targeted case management services.

(b) Mental health targeted case management is available to an adult who:

(1) is a resident of the State of Texas;

(2) is a recipient of the Texas Medicaid Program;

(3) has a diagnosis or diagnoses of mental illness as defined in the latest edition of the American Psychiatric Association's Diagnostic and Statistical

Manual of Mental Disorders, not including a single diagnosis of an intellectual or developmental disability, dementia, or a substance use disorder; and

(4) who has been determined via an assessment process based on §354.2607 of this subchapter to have serious functional impairments and is in need of mental health targeted case management services.

(c) An individual is not eligible for Medicaid-funded mental health targeted case management if the individual is:

(1) an inmate of a public institution, as defined in 42 CFR §435.1009;

(2) a resident of an intermediate care facility for individuals with an intellectual disability or related conditions as described in 42 CFR §440.150;

(3) a resident of an IMD;

(4) a patient of a general medical hospital; or

(5) receiving psychosocial rehabilitative services, a component of mental health rehabilitative services.

### **§354.2653. Continued Eligibility.**

Continued eligibility for mental health targeted case management services is based on:

(1) the eligibility criteria described in §354.2651 of this division (relating to Eligible Individuals);

(2) a reassessment by the comprehensive provider agency every:

(A) 90 days for children and youth; or

(B) 180 days for adults; and

(3) reauthorization of services by the managed care organization, as applicable.

### **§354.2655. Mental Health Targeted Case Management Services.**

(a) Mental health targeted case management services are provided to eligible individuals to assist them in gaining access to needed medical, social/behavioral, educational, and other services and supports that are appropriate to the individual's needs.

(b) Mental health targeted case management includes:

(1) development and periodic revision of a specific recovery/treatment plan per §354.2609 of this subchapter (relating to Recovery/Treatment Planning, Recovery/Treatment Plan Review, and Discharge Summary);

(2) making referrals and performing other related activities to help an individual obtain needed services and supports, including activities that help link an individual with:

(A) medical, social/behavioral, and educational providers; and

(B) other providers that provide needed services to address identified needs and achieve goals in the recovery/treatment plan;

(3) monitoring and follow up activities of service effectiveness, with the individual, family members, providers, or other entities or individuals, that occur regularly or at least annually to ensure the recovery/treatment plan is implemented and adequately addresses the individual's needs; and

(4) coordination with, and not duplication of, activities provided as part of institutional services and discharge planning activities that take place at inpatient facilities.

(c) Mental health targeted case management services must be provided, at minimum, by an individual credentialed as a QMHP-CS.

(d) A mental health targeted case manager must be assigned to an individual within two business days after receiving notification that the individual has been authorized to receive mental health targeted case management services.

(e) The assigned mental health targeted case manager must:

(1) meet face-to-face with the individual and the individual's LAR or primary caregiver within 7 calendar days after the case manager is assigned;

(2) assist the individual in identifying the individual's immediate needs and in determining access to community resources that may address those needs;

(3) identify the individual's strengths, service needs, and assistance required to address identified needs;

(4) identify the goals and actions required to meet the individual's identified needs;

(5) take the steps necessary to accomplish the goals required to meet the individual's identified needs by using referral, linking, advocacy, and monitoring;

(6) meet face-to-face with the individual at the individual's, the LAR's, or the primary caregiver's request, or document why the meeting did not occur;

(7) meet face-to-face with the LAR, with or without the individual present, to provide a service that assists the individual in gaining and coordinating access to necessary care and services;

(8) meet face-to-face with the individual and the LAR or primary caregiver upon notification of a clinically significant change in the individual's functioning, life status, or service needs, or document why the meeting did not occur; and

(9) if notified that the individual is in crisis, coordinate with the appropriate providers of emergency services to respond to the crisis.

(f) Intensive case management services, available only to children and youth, incorporate a wraparound approach to recovery/treatment planning and recovery/treatment plan implementation. The assigned mental health targeted case manager must:

(1) incorporate the wraparound planning process in developing a recovery/treatment plan that addresses the child's or youth's unmet needs across life domains and includes, in addition to the required elements listed in §354.2609 of this subchapter (relating to Recovery/Treatment Planning, Recovery/Treatment Plan Review, and Discharge Summary):

(A) a list of the child's or youth's natural strengths and supports;

(B) a crisis plan developed in collaboration with the LAR, caregiver, and family;

(C) a prioritized list of the child's or youth's unmet needs that includes a discussion of the priorities and needs expressed by the child or youth and the LAR or primary caregiver;

(D) a description of the objective and measurable outcomes for each of the unmet needs as well as a projected time frame for each outcome;

(E) a description of the actions the child or youth, the case manager, and other designated people must take to achieve those outcomes;

(F) a list of the necessary services and service providers and the availability of the services; and

(G) a statement of the maximum period of time between face-to-face contacts with the child or youth, and the LAR or primary caregiver, determined in accordance with the utilization management guidelines;

(2) develop and document an intensive case management plan based on the child's or youth's needs that may include information across life domains from relevant sources such as the child or youth, the LAR or primary caregiver, other agencies and organizations providing services to the child or youth, the child's or youth's medical record, and other sources identified by the child or youth, LAR, or primary caregiver;

(3) ensure services are delivered in clinically appropriate, client-centered, community-based settings;

(4) meet face-to-face with the child or youth and the LAR or primary caregiver:

(A) within seven calendar days after the case manager is assigned to the child or youth or document the reasons the meeting did not occur;

(B) within seven calendar days after discharge from an inpatient psychiatric setting or document the reasons the meeting did not occur; and

(C) according to the child's or youth's recovery/treatment plan or document the reasons the meeting did not occur;

(5) take necessary steps to assist the child or youth in gaining access to needed services and service providers, and document these activities, including:

(A) making referrals to potential service providers;

(B) initiating contact with potential service providers;

(C) arranging, facilitating linkages, and accompanying the child or youth to initial meetings and non-routine appointments;

(D) arranging transportation to ensure the child's or youth's attendance at appointments with services providers;

(E) advocating with service providers; and

(F) providing relevant information to service providers; and

(6) monitor the child's or youth's progress toward the outcomes set forth in the recovery/treatment plan, including:

(A) gathering information from the child or youth, current service providers, LAR, primary caregiver, and other resources;

(B) reviewing pertinent documentation, including the child's or youth's clinical records and assessments;

(C) ensuring that the recovery/treatment plan was implemented as agreed upon;

(D) ensuring that needed services were provided;

(E) determining whether progress toward the desired outcomes was made;

(F) identifying barriers to accessing services or to obtaining maximum benefit from services;

(G) advocating for the modification of services to address changes in the needs or status of the child or youth;

(H) identifying emerging unmet service needs;

(I) determining whether the recovery/treatment plan needs to be modified to address the child's or youth's unmet service needs more adequately; and

(J) revising the recovery/treatment plan as necessary to address the child's or youth's unmet service needs.

### **§354.2657. Documentation Requirements.**

(a) Mental health targeted case management services must be documented in the individual's medical record. Case managers are required to maintain a record of each individual receiving mental health targeted case management, including:

(1) the name of the individual;

(2) the name of the comprehensive provider agency and the name of the assigned case manager;

(3) the date, nature, content, and units of each service received and whether goals specified in the recovery/treatment plan have been achieved;

(4) whether the individual has declined services in the recovery/treatment plan;

(5) the need for, and occurrences of, coordination with other staff members;

(6) a timeline for obtaining needed services; and

(7) a timeline for reevaluation of the recovery/treatment plan.

(b) Service documentation. The case manager must document the following for each service provided:

(1) the event or behavior that occurs while providing the service or the reason for the specific encounter;

(2) the person, persons, or entity, including other staff members, with whom the encounter or contact occurred;

(3) a collateral contact that is directly related to identifying the needs and supports for helping the individual access services and managing the individual's care, including coordination with other staff members;

(4) the recovery/treatment plan goal(s) that was the focus of the service, including the progress or lack of progress in achieving recovery plan goal(s);

(5) the specific intervention provided;

(6) date the service was provided;

(7) the start and end time of the service;

(8) location where the service was provided, and whether it was a face-to-face or telephone contact; and

(9) signature of the case manager providing the service, including credentials.

(c) Crisis service documentation. In addition to the general documentation requirements described in subsection (b) of this section, a staff member must document the following for crisis intervention services:

(1) behavioral description of the presenting problem;

(2) lethality (e.g., suicide, violence);

(3) the individual's relevant substance use or abuse;

(4) the individual's relevant trauma, abuse, or neglect;

(5) all actions, including rehabilitative interventions and referrals to other agencies, used by the provider of crisis intervention services to address the problems presented;

(6) the response of the individual, and if appropriate, the response of the LAR or primary caregiver and family members;

(7) the signature of the staff member providing the service and a notation as to whether the staff member is an LPHA or a QMHP-CS;

(8) any pertinent event or behavior relating to the individual's treatment which occurs during the provision of the service;

(9) follow up activities, which may include referral to another provider;  
and

(10) the outcome of the individual's crisis.

(d) Refusing mental health targeted case management services. If the individual refuses mental health targeted case management services, the assigned case manager must:

(1) document the reason for the refusal in the individual's medical record;  
and

(2) request that the individual sign a waiver of case management services that is filed in the individual's medical record.

**§354.2659. Exclusions.**

(a) The following services are not covered as mental health targeted case management:

(1) case management activities that are an integral component of another covered Medicaid service;

(2) the provision of a medical, educational, social/behavioral, or another service to which an individual has been referred, including foster care services;

(3) performing an activity that does not directly assist an individual in gaining or coordinating access to needed services;

(4) providing medical or nursing services;

(5) performing pre-admission or intake activities;

(6) providing services to the LAR or primary caregiver of the individual outside of the services allowable under this subchapter;

(7) transporting the individual, LAR, or primary caregiver outside of what is allowable under this subchapter;

(8) monitoring the individual's general health status;

(9) performing outreach activities;

(10) performing quality oversight of a service provider;

(11) conducting utilization review or utilization management activities;

(12) conducting quality assurance activities; and

(13) authorizing services or authorizing the provision of services.

(b) The following activities are included in the mental health targeted case management rate and, therefore, Medicaid payment is not made separately for the following activities:

(1) documenting the provision of mental health targeted case management services;

(2) on-going assessment to determine the amount, duration, and type of mental health targeted case management for each individual;

(3) travel time required to provide mental health targeted case management services at a location not owned, operated or under arrangement with the comprehensive provider agency; and

(4) quality assurance activities that are specific to mental health targeted case management.

(c) Texas Medicaid does not reimburse for mental health targeted case management services provided before the establishment of a diagnosis of mental illness and the authorization of services.

TITLE 1 ADMINISTRATION  
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION  
CHAPTER 354 MEDICAID HEALTH SERVICES  
SUBCHAPTER M MENTAL HEALTH TARGETED CASE MANAGEMENT AND  
MENTAL HEALTH REHABILITATION  
DIVISION 3 MENTAL HEALTH REHABILITATION

**§354.2701. Eligible Individuals.**

(a) Mental health rehabilitation services are available to a child or youth who:

(1) is a resident of the State of Texas;

(2) is a recipient of the Texas Medicaid Program;

(3) has a serious emotional, behavioral, or mental disorder and:

(A) is at risk of disruption of a preferred living or child-care environment due to psychiatric symptoms; or

(B) is enrolled in a school system's special education program because of serious emotional disturbance;

(4) has a diagnosis or diagnoses of mental illness or serious emotional disturbance as defined in the latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, not including a single diagnosis of an intellectual or developmental disability or a substance use disorder; and

(5) who has been determined via the uniform assessment process as described in §354.2607 of this subchapter (relating to Assessment and Service Authorization) to have serious functional impairments and is in need of mental health rehabilitation services.

(b) Mental health rehabilitation services are available to an adult who:

(1) is a resident of the State of Texas;

(2) is a recipient of the Texas Medicaid Program;

(3) has a diagnosis or diagnoses of mental illness as defined in the latest edition of the American Psychiatric Association's Diagnostic and Statistical

Manual of Mental Disorders, not including a single diagnosis of an intellectual or developmental disability, dementia, or a substance use disorder; and

(4) who has been determined via an assessment process based on §354.2607 of this subchapter to have serious functional impairments and is in need of mental health rehabilitation services.

(c) An individual is not eligible for Medicaid-funded mental health rehabilitation services if the individual:

(1) is an inmate of a public institution, as defined in 42 CFR §435.1009;

(2) is a resident of an intermediate care facility for individuals with an intellectual disability or related conditions as described in 42 CFR §440.150;

(3) is a resident of an IMD;

(4) is a patient of a general medical hospital; or

(5) is a resident of a nursing facility who has not been identified through the Preadmission Screening and Resident Review (PASSR) process as needing specialized mental health services.

### **§354.2703. Continued Eligibility.**

(a) A QMHP-CS conducts an assessment, as described in §354.2607 of this subchapter (relating to Assessment and Service Authorization), to determine the individual's continued eligibility for mental health rehabilitative services, based on the eligibility requirements described in §354.2701 of this division (relating to Eligible Individuals).

(b) An adult is automatically eligible for continued services, regardless of whether his or her level of functioning has improved and regardless of requirements described in this section, if the individual has a diagnosis of:

(1) schizophrenia;

(2) bipolar disorder; or

(3) major depressive disorder with a level of functioning that qualified the individual initially.

(c) Unless automatically eligible under subsection (b) of this section, an adult is reassessed for continued eligibility for mental health rehabilitation:

(1) at least every 180 days; or

(2) more frequently if clinically indicated.

(d) A child or youth is reassessed for continued eligibility for mental health rehabilitation:

(1) at least every 90 days; or

(2) more frequently if clinically indicated.

### **§354.2705. Mental Health Rehabilitative Services.**

Mental health rehabilitative services are interventions that provide assistance to individuals in maintaining functioning and achieving rehabilitation goals as defined in the individual's recovery/treatment plan.

Mental health rehabilitative services include:

(1) crisis intervention services;

(2) medication training and support services;

(3) psychosocial rehabilitative services;

(4) skills training and development services; and

(5) day programs for acute needs.

### **§354.2707. Crisis Intervention Services.**

(a) Crisis intervention services are intensive, community-based, one-to-one services provided to an individual who requires services to control acute symptoms that place the individual at immediate risk of hospitalization, incarceration, or placement in a more restrictive treatment setting. The intervention:

(1) is in response to a crisis;

(2) seeks to reduce or manage symptoms of serious mental illness or serious emotional disturbance; and

(3) seeks to prevent admission of the individual to a more restrictive environment.

(b) Crisis intervention services include:

(1) an assessment of dangerousness of the individual to self or others;

(2) the coordination of emergency care services;

(3) behavior skills training to assist the individual in reducing distress and managing symptoms;

(4) problem-solving;

(5) reality orientation to help the individual identify and manage his or her symptoms of serious mental illness or serious emotional disturbance; and

(6) providing instruction, structure, and emotional support to the individual in adapting to and coping with immediate stressors.

(c) Crisis intervention services must be provided one-to-one.

(d) Crisis intervention services may be provided on-site or in-vivo.

(e) Crisis intervention services must be provided by a QMHP-CS, at a minimum.

(f) Crisis intervention services may be provided without a recovery/treatment plan, as described in §354.2609 of this subchapter (relating to Recovery/Treatment Planning, Recovery/Treatment Plan Review, and Discharge Summary).

(g) Crisis intervention services may not be provided to an individual who is currently admitted to a CSU.

### **§354.2709. Medication Training and Support Services.**

(a) Medication training and support services must assist an individual in:

(1) understanding the nature of his/her serious mental illness or serious emotional disturbance;

(2) understanding the concepts of recovery and resilience within the context of the serious mental illness or serious emotional disturbance;

(3) understanding the role of his/her prescribed medications in reducing symptoms and increasing or maintaining his/her functioning;

(4) identifying and managing his/her symptoms and potential side effects of his/her medication;

(5) learning the contraindications of his/her medication;

(6) understanding the overdose precautions of his/her medication; and

(7) learning self-administration of his/her medication.

(b) Medication training and support services may be provided to:

(1) an adult;

(2) a child or youth; or

(3) the LAR or primary caregiver of an adult, child, or youth.

(c) Medication training and support services may be provided individually or in a group, and on-site or in-vivo.

(d) Medication training and support services provided to an adult or an adult's LAR or primary caregiver must be provided by a:

(1) QMHP-CS;

(2) CSSP;

(3) peer provider; or

(4) licensed medical personnel.

(e) Medication training and support services provided to a child or youth or the child's or youth's LAR or primary caregiver must be provided by a:

(1) QMHP-CS;

(2) CSSP;

(3) CFP; or

(4) licensed medical personnel.

(f) Medication training and support services may not be provided to an individual who is currently admitted to a CSU.

**§354.2711. Psychosocial Rehabilitative Services.**

(a) Psychosocial rehabilitative services must include the following services, as determined necessary for each individual:

- (1) independent living;
- (2) coordination;
- (3) employment related;
- (4) housing related; and
- (5) medication related.

(b) Independent living services assist an individual in acquiring the most immediate, fundamental functional skills needed to enable the individual to reside in the community and avoid more restrictive levels of treatment, or assist an individual in reducing behaviors or symptoms that prevent successful functioning in the individual's environment of choice. Such services include training in symptom management, personal hygiene, nutrition, food preparation, exercise, money management, and community integration activities.

(c) Coordination services are training activities that assist an individual in improving the ability to gain and coordinate access to necessary care and services appropriate to the individual's needs. Coordination services include instruction and guidance in such areas as:

- (1) assessment--identifying strengths and areas of need across life domains;
- (2) recovery/treatment planning--prioritizing needs, establishing life and treatment goals, selecting interventions, and developing and revising recovery/treatment plans that include wellness, relapse prevention, and crisis plans;
- (3) access--identifying and initiating contact with potential service providers and support systems across all life domains, including advocacy groups;
- (4) coordination--setting appointments, arranging transportation, and facilitating communication between providers; and

(5) advocacy--

(A) asserting treatment needs, requesting special accommodations, and evaluating provider effectiveness and compliance with the agreed upon recovery/treatment plan; and

(B) requesting improvements and modifications to ensure maximum benefit from the services and supports.

(d) Employment related services provide supports and skills training that are not job-specific and focus on developing skills to reduce or manage the symptoms of serious mental illness that interfere with an individual's ability to make vocational choices or obtain or retain employment. Such services consist of:

(1) instruction in dress, grooming, socially and culturally appropriate behaviors, and etiquette necessary to obtain and retain employment;

(2) training in task focus, maintaining concentration, task completion, and planning and managing activities to achieve outcomes;

(3) instruction in obtaining appropriate clothing, arranging transportation, utilizing public transportation, accessing and utilizing available resources related to obtaining employment, and accessing employment-related programs and benefits;

(4) interventions or supports provided on or off the job site to reduce behaviors or symptoms of serious mental illness that interfere with job performance or that interfere with the development of skills that would enable the individual to obtain or retain employment; and

(5) interventions designed to develop natural supports on or off the job site to compensate for skill deficits that interfere with job performance.

(e) Housing related services develop an individual's strengths and abilities to manage the symptoms of the individual's serious mental illness that interfere with the individual's capacity to obtain or maintain independent, integrated housing. Such services consist of:

(1) skills training related to:

(A) home maintenance and cleanliness;

(B) problem-solving with the individual's landlord and neighbors, mortgage lender, or homeowners association; and

(C) maintaining appropriate interpersonal boundaries; and

(2) supportive contacts with the individual to reduce or manage the behaviors or symptoms related to the individual's serious mental illness that interfere with maintaining independent, integrated housing.

(f) Medication related services provide training regarding an individual's medication adherence. Such services consist of training in:

(1) the importance of the individual taking the medications as prescribed;

(2) the self-administration of the individual's medication;

(3) determining the effectiveness of the individual's medications;

(4) identifying side-effects of the individual's medications; and

(5) contraindications for medications prescribed.

(g) Conditions for the delivery of psychosocial rehabilitative services.

(1) Psychosocial rehabilitative services may be provided:

(A) only to adults who are not currently admitted to a CSU;

(B) individually or in a group;

(C) on-site or in-vivo; and

(D) only by a member of the individual's therapeutic team.

(2) The therapeutic team must be constituted and organized in a manner that ensures:

(A) the team includes a sufficient number of staff to adequately address the rehabilitative needs of individuals assigned to the team;

(B) team members are appropriately credentialed to provide the full array of component services;

(C) team members have regularly scheduled team meetings either in person or by teleconference; and

(D) every member of the team is knowledgeable of the needs and services available to the specific individuals assigned to the team.

(3) Independent living services, coordination services, employment-related services, and housing-related services must be provided by a:

(A) QMHP-CS;

(B) CSSP; or

(C) peer provider.

(4) Only licensed medical personnel may provide medication-related services.

(5) Crisis-related services must be provided by a QMHP-CS.

(h) An individual receiving psychosocial rehabilitation is not eligible to simultaneously receive either skills training and development or targeted case management services.

### **§354.2713. Skills Training and Development Services.**

(a) Skills training and development is training provided to an individual or the LAR or primary caregiver of an individual. The training:

(1) addresses serious mental illness or serious emotional disturbance and symptom-related problems that interfere with the individual's functioning;

(2) provides opportunities for the individual to acquire and improve skills needed to function in the community as appropriately and independently as possible; and

(3) facilitates the individual's community integration.

(b) Skills training and development services consist of:

(1) teaching an individual:

(A) skills for managing daily responsibilities, such as paying bills, attending school, and performing chores;

(B) communication skills, such as effective communication and recognizing or changing problematic communication styles;

(C) pro-social skills, such as replacing problematic behaviors with behaviors that are socially and culturally appropriate or developing interpersonal relationship skills necessary to function effectively with family, peer, teachers, or other people in the community;

(D) problem-solving skills;

(E) assertiveness skills, such as resisting peer pressure, replacing aggressive behaviors with assertive behaviors, and expressing one's own opinion in a manner that is socially appropriate;

(F) social skills and expanding the individual's social support network, such as selection of appropriate friends and healthy activities;

(G) stress reduction techniques, such as progressive muscle relaxation, deep breathing exercises, guided imagery, and selected visualization;

(H) anger management skills, such as identification of antecedents to anger, calming down, stopping and thinking before acting, handling criticism, and avoiding and disengaging from explosive situations;

(I) skills to manage the symptoms of serious mental illness or serious emotional disturbance and to recognize and modify unreasonable beliefs, thoughts and expectations;

(J) skills to identify and use community resources and informal supports;

(K) skills to identify and use acceptable leisure time activities; and

(L) independent living skills, such as money management, accessing and using transportation, grocery shopping, maintaining housing, maintaining a job, and decision making; and

(2) increasing the LAR's or primary caregiver's understanding of and ability to respond to the individual's needs identified in the assessment or documented in the recovery/treatment plan.

(c) Skills training and development services provided to an individual, LAR, or primary caregiver may be provided individually or in a group.

(d) Skills training and development services may be provided on-site or in-vivo.

(e) Skills training and development services provided to an adult or an adult's LAR or primary caregiver must be provided by a:

- (1) QMHP-CS;
- (2) CSSP; or
- (3) peer provider.

(f) Skills training and development services provided to a child or youth or the child's or youth's LAR or primary caregiver must be provided by a:

- (1) QMHP-CS;
- (2) CSSP; or
- (3) CFP.

(g) Skills training and development services may not be provided to an individual who is currently:

- (1) admitted to a CSU; or
- (2) receiving psychosocial rehabilitation.

**§354.2715. Day Programs for Acute Needs.**

(a) Day programs for acute needs provide short term, intensive treatment to an individual who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting. Day programs for acute needs:

- (1) are provided in a highly structured and safe environment with constant supervision;
- (2) ensure an opportunity for frequent interaction between an individual and staff members;
- (3) include services that are goal oriented and focus on:
  - (A) reality orientation;
  - (B) symptom reduction and management;
  - (C) appropriate social behavior;

- (D) improving peer interactions;
- (E) improving stress tolerance; and
- (F) the development of coping skills; and

(4) consist of the following component services:

- (A) psychiatric nursing services;
- (B) pharmacological instruction;
- (C) symptom management training; and
- (D) functional skills training.

(b) Components of day programs for acute needs.

(1) Psychiatric nursing services must consist of:

- (A) a nursing assessment;
- (B) the coordination of medical activities (e.g., referrals to specialists and scheduling medical laboratory tests);
- (C) the administration of medication;
- (D) laboratory specimen collections and screenings;
- (E) emergency medical interventions as ordered by a physician; and
- (F) other nursing services.

(2) Pharmacological instruction is training to an individual that addresses medication issues related to the crisis precipitating the provision of day programs for acute needs. Such training must include:

- (A) the role of the individual's medications in stabilizing acute psychiatric symptoms or preventing admission to a more restrictive setting;
- (B) the identification of substances that reduce the effectiveness of the individual's medications;
- (C) appropriate interventions to reduce side effects of the medications;  
and

(D) the self-administration of the individual's medication.

(3) Symptom management training assists an individual in recognizing and reducing psychiatric symptoms and must include training the individual on:

(A) the identification of thoughts, feelings, or behaviors that indicate the onset of acute psychiatric symptoms;

(B) developing coping strategies to address the symptoms;

(C) ways to avoid symptomatic episodes;

(D) identification of external circumstances that trigger the onset of acute psychiatric symptoms; and

(E) relapse prevention strategies.

(4) Functional skills training assists an individual in acquiring the skills needed to continue to reside in the community and avoid more restrictive levels of treatment and must include training the individual on:

(A) personal hygiene;

(B) nutrition;

(C) food preparation;

(D) money management;

(E) socially and culturally appropriate behavior; and

(F) accessing and participating in community activities.

(c) Conditions.

(1) Day programs for acute needs:

(A) may only be provided to adults;

(B) may be provided in a setting with any number of individuals; and

(C) may be provided:

(i) on-site; or

(ii) in a short-term, crisis resolution oriented residential treatment setting that is not:

(I) a general medical hospital;

(II) a psychiatric hospital; or

(III) an IMD.

(2) Except as provided by paragraphs (4) and (5) of this subsection, services in a day program for acute needs must be provided by a:

(A) QMHP-CS;

(B) CSSP; or

(C) peer provider.

(3) Day programs for acute needs must, at all times:

(A) have a sufficient number of staff members to ensure safety and program adequacy;

(B) have one registered nurse at the day program's location for every 16 individuals;

(C) have one physician available by phone within a 15 minute timeframe; and

(D) have at least two staff members at the day program's location who are QMHP-CSs, CSSPs, or certified peer providers, with:

(i) additional QMHP-CSs, CSSPs, or certified peer providers at the day program's location sufficient to maintain a ratio of one staff member to every four individuals; and

(ii) one additional QMHP-CS who is not assigned full-time to another day program and who is physically available within 30 minutes of notification additional staff is needed.

(4) Psychiatric nursing services, as described in subsection (b)(1) of this section, must be provided by a registered nurse at the day program's location.

(5) Pharmacological instruction, as described in subsection (b)(2) of this section, must be provided by licensed medical personnel at the day program's location.

**§354.2717. Exclusions.**

(a) Mental health rehabilitative services do not include:

(1) job task-specific vocational services;

(2) educational services;

(3) room and board residential costs;

(4) services that are an integral and inseparable part of another Medicaid-reimbursable service, including targeted case management services, residential rehabilitative behavioral health services, institutional, and waiver services;

(5) services that are covered elsewhere in the state Medicaid plan;

(6) respite services; or

(7) family support services.

(b) Texas Medicaid does not reimburse for mental health rehabilitative services provided before the establishment of a diagnosis of mental illness and the authorization of services.