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The Medicaid Rehabilitative Services ("Rehab") Option

*by John O'Brien
Human Services Research Institute*

Medicaid is the single largest source of funding for publicly funded mental health services, and every state uses Medicaid dollars to underwrite mental health services. Medicaid funding can play an especially critical role in meeting the needs of children with serious emotional disturbances and adults with serious mental illnesses in the community.

States obtain federal dollars for community mental health services for individuals who require intensive, extended services primarily through three optional Medicaid coverage categories:

- Targeted Case Management Option,
- Clinic Services Option, and
- Rehabilitative Services Option ("Rehab Option").

The Medicaid "Rehab Option" can contribute enormously to promoting recovery and resiliency as a central aim of a state's mental health service delivery system. Services covered under the "Rehab Option" provide a more flexible benefit than other services generally used for mental health services (e.g. clinic option)¹. These services can be provided in other locations in the community, including in the person's home or other living arrangement. Moreover, these services may be furnished by a wider range of individuals, including qualified community paraprofessional workers and peer specialists (persons who have themselves experienced a mental illness) when rendered under the supervision of a

licensed mental health professional. Most important, rehabilitation services may extend beyond the clinical treatment of a person's mental illness to include helping the person to acquire the skills that are essential for everyday functioning (e.g. symptom management, daily living skills, etc). All state Medicaid programs have added the Rehab Option to cover mental health services.

This paper provides information regarding recent state activities and trends in developing and revising the Rehab Option for mental health services. This paper highlights issues related to service coverage, agency and practitioner requirements, rates and coding, and management of services. Finally, it offers steps that states and other interested parties should consider when "updating" their Rehab Option.

Issue #1: Coverage

States have some flexibility regarding the mental health services that can be covered under the Rehab Option. Initially states were using the Rehab Option as an alternative to providing traditional behavioral health services (e.g. medication management, counseling, and day programs) in a clinic-based setting. However, the continued efforts by states to implement the Community Support Program initiative for adult consumers and the Children's System of Care initiative began to change service coverage dramatically. In the late 1980s and early 1990s some states were adding community support, skill building, behavior management, and treatment foster care as covered services under the Rehab Option. During the 1990s, states also added crisis services (District of Columbia, Hawaii, Maine, Arizona), residential supports



(West Virginia, Massachusetts, Georgia), and group skill building (Florida, Louisiana, Georgia), especially for adults participating in programs of psychosocial rehabilitation.

Over the past five years, states have begun to review their coverage under the Rehab Option in an effort to “update” services that reflect information on promising or evidence-based practices. A brief review of approved state plan amendments indicates that states are adding new services such as:



- **Assertive Community Treatment (ACT):** More than 8 states have included ACT in their Medicaid program. The definitions and requirements for this service are consistent with standards established by the National Mental Health Association and the Substance Abuse and Mental Health Services Administration draft toolkit². These states include Delaware, District of Columbia, Florida, Georgia, Hawaii, Maine, New Mexico (pending) and North Carolina.
- **Integrated Dual Disorders Treatment:** More recent definitions have defined a specific component for individuals with co-occurring disorders using an IDDT approach (Louisiana, Hawaii)³.
- **Peer Support:** Several states (Georgia and South Carolina) have added peer supports or services provided in peer centers to their Medicaid program using the Rehab Option. These services provide structured activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills.
- **Focused Therapies:** States are beginning to define the specific treatment modalities that will be reimbursed under the Rehab Option. States are specifying trauma counseling, cognitive behavioral therapy, and functional family therapy in their Rehab Option or description of therapy or counseling services in their provider manual. States that have explicitly included specific treatment modalities are Louisiana, South Carolina and Hawaii.
- **Community Supports:** More than ten states have included this “rehabilitation coordination” service in the Rehab Option. Community support activities include: assistance with identifying and coordinating services and supports identified in an individual’s service plan; supporting an individual and family in crisis situations; providing individual interventions to develop or enhance interpersonal and community coping skills; and facilitating adaptation to home, school, and work environments.

This service also seeks to develop and enhance an individual’s ability to make informed and independent choices. States that have community supports included in their state Medicaid plan include: Arkansas, District of Columbia, Georgia, Louisiana, Maine, Missouri, Ohio, North Carolina (pending), Texas and Wisconsin.

- **Illness Management:** States such as New Hampshire were the pioneers with their Mental Illness Management Service (MIMS) supporting individuals to develop skills to manage symptoms of their own illness and to develop their self care skills so they can live as independently as possible.

The Centers for Medicare and Medicaid services have clear policies regarding services/activities that are not covered by the Medicaid program under the Rehab Option⁴. These services and activities are described below.

Restrictions on Medicaid Coverage: What can the Rehab Option not cover?

Room and board: Although treatment and support services in residential programs are covered in some states, room and board are not.

Education: Federal rules specifically exclude education from Medicaid reimbursement and academic teaching cannot be a Medicaid covered service.

Vocational services: Medicaid does not cover specific programs that provide training or education regarding a trade.

There are a few “gray areas” regarding some of these exclusions. For instance, several states have described their skill building or community support activities to include supports that assist an individual to obtain or maintain employment. Counseling activities that support an individual’s ability to pursue an educational or employment goal may be covered elements of rehabilitation services.

Issue #2: Agency and Practitioner Requirements

One of the major tenets of the Medicaid program is that Medicaid recipients have freedom to choose among any qualified, willing provider able to furnish needed services⁵. There are no specific federal requirements that define a qualified and willing provider of rehabilitation services. It is the state Medicaid agency that is responsible for determining who is willing and qualified. A primary concern of the Medicaid agency is ensuring that provider qualifications are related to the description of the services to be covered and the capacity of providers to deliver these services.

In many states, these considerations result in provider qualifications that are agency-based, in addition to identifying criteria related to individual practitioners. Rehabilitation services are usually delivered through behavioral health agencies that state mental health authorities rely on to provide most of the rehabilitation services for people with the most intense mental health services needs. States have found that agencies—collections of specialty skilled practitioners working together within an administrative, financial, and clinical infrastructure—are often best suited to meet the needs of many children with serious mental disorders and adults with serious mental illnesses. Individual and small group practitioners on their own tend to lack the capacity to provide consistent 24-hour crisis response, for example, or to transition consumers to different levels of care while maintaining sufficient clinical and supportive “connectedness” to the person being served. Moreover, many of the most effective rehabilitation services are “team-based,” and the agency provides the framework necessary to support and coordinate the team’s efforts.

How Do States Decide Who Is a Willing & Qualified Provider?

Approaches include:

- Accredite agencies according to the standards of a national organization such as JCAHO, CARF, or COA⁶
- Tie certification to state licensing requirements.
- Require “specialty” certification for certain services.
- Define which providers qualify as Licensed Practitioners of the Healing Arts (LPHAs).
- Establish required curricula or competencies for new positions, such as “mental health technician” or “peer specialist.”

States employ various approaches when defining who is a willing and qualified provider for rehabilitation services. Some states (Georgia, Louisiana) require agencies to obtain *accreditation* from a national organization such as Joint Commission on Accreditation of Health Care Organizations (JCAHO), Joint Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA). These organizations require accredited facilities to follow various requirements regarding assessment, service planning, medication management, and treatment, as well as performance improvement, human resources, and information management. The length of time between initial and ongoing accreditation can vary from six months to approximately three years.



Some states tie certification to *state licensing requirements*. For instance, New Mexico allows only licensed mental health centers to provide psychosocial rehabilitation services. Louisiana requires agencies that provide adult skill building to have an adult day care license specific to their Mental Health Rehabilitation Program. Other states have certification requirements that parallel national accrediting bodies but generally have fewer requirements than these national organizations.

Some states require “*specialty*” certification for some services covered under their Rehab Option. For instance, agencies offering Assertive Community Treatment or Multi-Systemic Therapy (MST) are required to meet specific service standards in addition to accreditation or state certification. For instance, states require that the ACT team must meet specific staff credentials and maintain low caseloads (one staff to ten ACT participants). Agencies that provide MST must agree to participate in specific training and supervision activities established by the University of South Carolina. Agencies that offer Functional Family Therapy (FFT) must ensure that staff receive the appropriate initial and ongoing training to provide this service.

The Center for Medicare and Medicaid Services (CMS) requires that mental health services delivered under the Rehab Option be medically necessary and recommended by a physician or other *licensed practitioner of the healing arts* (LPHA)⁷. Currently, no federal LPHA definition exists. CMS allows states to define credentials for LPHAs and grants them flexibility in outlining the process for recommending services. The following mental health practitioners are most likely to be defined as LPHAs:

- Psychiatrists,
- Psychologists,
- Licensed clinical social workers,
- Registered nurses, and
- Advanced practice nurses.

CMS also gives states flexibility in defining the practitioners who deliver services approved by an LPHA. States allow either the LPHA or an individual “under the direction” of an LPHA to render services. Ultimately, each state is responsible for developing practitioner qualifications and for designing a credentialing process to ensure that practitioners meet these qualifications.

States often develop practitioner qualifications for authorizing and providing Medicaid Rehab Option services based on existing state laws, rules, or standards. For instance, most jurisdictions have practice acts that are governed by various licensing boards. These practice acts specify who can administer medication and provide individual, group, and family counseling. For non-licensed individuals, states have developed various nomenclature to define these practitioners. For instance several states have created a “mental health practitioner” or “mental health technician” definition to cover individuals who work under the supervision of an LPHA and have either a college degree in a human service-related field or a high school degree with several years of direct mental health service experience.

More states are focusing on ensuring competencies rather than having specific education requirements for their non-licensed practitioners. Several states have established specific orientation and ongoing training requirements for their mental health professionals or technicians. Crisis management, recovery and resiliency, wellness and illness management, and identification of natural supports and community resources are “required classes” in these states’ orientation and training requirements. Several states are also looking at national certification processes for their non-licensed professionals. Georgia, Hawaii, and Louisiana, for instance, require some staff members that provide psychosocial rehabilitation to be certified by the US Psychosocial Rehabilitation Association as a Certified Psychiatric Rehabilitation Professional (CPRP). Individuals seeking the CPRP sit for a written exam whose domains focus on interpersonal and professional competencies, community resources, assessment, planning and outcomes, interventions, and diversity⁸.

Over the past several years, the role of peer delivered services has grown exponentially under the Medicaid Rehab Option. States are allowing (and in some instances requiring) organizations to employ consumers for delivering services covered under their Rehab Option. These individuals, often referred to as “peer specialists,” are playing a valuable role in the mental health workforce. Although consumer-run services are not new, they were rarely covered under the Medicaid program. Since 1999, Georgia and a handful of other states have included peer services and peer specialists in their Medicaid Rehab Option. Each state credentials its peer specialists differently. For instance, Georgia and South Carolina have specific criteria for who can apply to participate in the certification process. If individuals meet the criteria, they must pass a written and oral examination. In addition, both states require the certified peer

specialist to be supervised by a qualified mental health professional. Several more states have developed training programs for peer specialists, coaches, and mentors including organizations in: Arizona, Kansas, Massachusetts, Colorado, New Jersey, Washington, West Virginia, Hawaii, New York, Pennsylvania, and Virginia⁹.

Issue #3: Rates and Coding

Each state must describe their rate-setting methodology in Medicaid state plan amendments. Most states use a fee-for-service methodology for reimbursing agencies for rehabilitation services. Under the fee-for-service approach, a provider is paid a predetermined amount for each unit of service provided and, generally, providers are reimbursed after the service has been provided. Some states (Louisiana and New York) are using a case rate for purchasing mental health services under the Medicaid Rehab Option.

Less exciting, but equally important, is the manner in which states code services. Codes define the unit of service provided by the agency. Prior to 2003 states had wide discretion in defining the unit of services. By using “local” codes states could purchase services in 15 minute, daily, or monthly increments. Some states used local codes for case rates, especially for intensive home based services for children. With the implementation of the Health Insurance Portability and Accountability Act of 1997, states had to use consistent “national” codes with specific units¹⁰. This affected various states’ codes and reimbursement practices. For instance states can no longer purchase ACT using a monthly payment (only 15 minute and daily units are allowable). MST can only be purchased using a 15-minute unit rather than a monthly unit or case rate. Child-serving agencies and advocates argue that such changes are focusing more on the unit of service than the intended outcome of the six to eight week intervention.

While HIPAA-compliant standardized codes often include specific time increments/units to identify how long a service was provided, the HIPAA-compliant electronic format nevertheless allows considerable flexibility for providers and individual payers such as Medicaid to identify and reimburse for services based on different/varying time units/increments. For example, a provider providing one month of ACT can use the ACT daily (base) code and indicate that the quantity of services is X30. Providers and/or payers, including Medicaid, who feel that the current HIPAA compliant national codes are simply not workable are encouraged to send a request to CMS for a new national code.

Issue #4: Managing Rehab Option Services

States have employed several strategies to ensure appropriate oversight for mental health services covered under the Medicaid Rehab Option.

Typical strategies for managing Rehab Option services focus on:

- Defining the eligible target population through screening and assessment,
- Specifying the amount and duration of services, and
- Determining who remains in the provider network (as described in the previous section).



States have traditionally focused their Medicaid Rehab Option programs on individuals with significant mental health disorders—generally adults with serious mental illness (SMI) and children with serious emotional and behavioral disorders (SEBD). Prior to receiving services a screening or assessment is performed to determine if they meet the criteria for SMI or SEBD. These screening and assessment instruments and protocols vary across states. Some states use a combination of diagnosis, functional level and duration of disability to determine eligibility for rehabilitation services. States use a variety of normed instruments to determine the level of functioning including the Global Assessment Scale, Child and Adolescent Functional Assessment Scale, Level of Care Utilization System (LOCUS) and the Child and Adolescent LOCUS.

States are beginning to define thresholds for the amount of service an individual may receive during a specific period and identify the “recommended” duration for the service. For instance, most states limit the number of assessments that can be provided to an individual annually (e.g. one or two complete assessments). Other states may limit the number of units of individual, group or family counseling an individual may receive annually. Yet others limit the duration of the service based on evidence-based or recommended practice. For instance MST and other intensive interventions for children and families are generally limited to five to seven months duration. The thresholds that states set for these services do have some flexibility. For instance, most states have developed utilization management processes (either internal staff or through a utilization management contractor) that review the needs of the individuals and allow additional units or duration based on pre-defined medical necessity criteria.

Follow Up: Steps Interested Parties Can Take

Potential changes in the Medicaid program at the federal level provide a great opportunity for states to review the coverage under the Medicaid Rehab Option and propose changes that are consistent with promising and evidence-based practices and can provide potential cost offsets to other services. Since revenue maximization opportunities under Medicaid may have a limited future, any changes a state proposes should look to reform, rather than to simply refinance, services. States should use any Rehab Option changes as an opportunity to move from traditional services that may have limited efficacy (e.g. targeted case management, day treatment, and general counseling) to services that produce outcomes and may be more time limited.

Some Critical Steps toward Change:

- Obtain stakeholder input
- Communicate a clear rationale for changes
- Consult with other states that have made similar changes
- Develop detailed service descriptions
- Review current agency and provider requirements carefully before modifying or adding new ones
- Communicate with and educate stakeholders about the proposed reforms

Prior to making changes, states should develop a stakeholder process for obtaining input regarding the larger reform. Obtaining solid input on the front end will prevent time needed on the back end justifying the changes. States should develop a clear rationale for these changes and a brief description that communicates the intent of the reform. Policymakers should also make sure that consumers and families are well represented and should be prepared to provide examples from other states to inform the stakeholder process.

If the state mental health authority is championing the reform, link the state’s Medicaid staff with Medicaid representatives from other states early in the process. Although the program staff at the state mental health authority can offer information regarding these services, peer interaction across state Medicaid agencies can provide valuable information regarding state plan amendments, rate setting, and network management.

Once new and revised services have been identified, detailed service descriptions for rules and provider manuals should be

developed. These descriptions can be used as a training tool for providers and information for consumers regarding the service. Recent service descriptions developed by states include information disseminated by various national organizations and universities (e.g. SAMHSA, Case Western Reserve University, Dartmouth Research Center, etc.). Detailed service descriptions can also provide a foundation for provider certification, monitoring and program audits. States generally include as part of their service descriptions a detailed list of billable activities, provider and practitioner requirements, admission and discharge criteria, and any additional documentation requirements. Good examples of service descriptions can be found in provider manuals in various states including: Florida, Georgia, Hawaii, South Carolina, and Illinois.

States that are considering using national accreditation as foundation for their agency qualifications should evaluate the purpose, value, and cost of the accreditation process. Some states require national accreditation and have many additional state requirements for providers to become certified. Other states accept or “deem” providers that are accredited by a national organization and have only a few additional state-specific requirements. The reform provides states with the opportunity to right-size antiquated regulations regarding Medicaid and mental health services. States sometimes just add the new requirements and do not take time to assess whether previous requirements are outdated or conflict with new requirements being developed. A critical review of these requirements can be tedious but is necessary. One last suggestion regarding certification requirements is to only add new requirements that are value-added and can be monitored.

States should also use the reform to review current practitioner requirements. The mental health workforce has changed significantly over the past fifteen years. There are fewer licensed professionals, especially licensed professionals that have the interest and competencies to provide some of the newer serv-

ices. Provider organizations have suggested making changes in states’ practice acts and licensing boards to broaden who can be a LPHA. It may not be prudent or politically feasible to make significant changes to your state practice acts as this can sometimes take years.



The same holds true for non-licensed practitioners. Some states continue to focus their attention on assuring quality by requiring degreed individuals to provide services. Other states have recognized the need to develop competency-based orientation and training. Some states have started discussions

on developing state specific credentialing processes through local colleges and universities for their community support, case management, and direct service staff.

The final two areas of focus relate to communications. System reform, especially related to Medicaid services, makes many stakeholders anxious. Reform entails changes to the number and credentials of staff, reimbursement process, and infrastructure. New services mean changes to provider’s management information systems and medical records. States that are making reforms need to develop a good communication plan. This communication plan can be as simple as a monthly newsletter and a targeted presentation to various stakeholder groups (regional provider groups, consumer and family groups, etc). In addition, some states have developed frequently asked questions (FAQs) that are updated and disseminated. States have also developed designated websites for their Medicaid Rehabilitation programs (several are identified in the footnotes). Finally, states should have a well-defined training plan that provides broad and/or detailed information regarding the proposed system reform. States should plan this training to allow enough time for stakeholders to digest the proposed reform and plan for the necessary program and infrastructure changes. In addition, some states continue training soon after implementation as the reform is more real and raises more specific and detailed questions.

About the Author

John O’Brien is a Senior Associate for the Technical Assistance Collaborative, Inc. Mr. O’Brien has worked with numerous states, providing organizational, human resource, policy, regulatory, and management expertise for publicly funded health, behavioral health and human services entities

in both public and private sectors. Mr. O’Brien has assisted states by identifying priority services, populations and coordinating programmatic needs with other state and federal funding streams.

¹ Services can be furnished outside a clinic when they are provided to homeless individuals

² Assertive Community Treatment Implementation Resource Kit, federal Department of Health and Human Services, Substance Abuse and Mental Health Administration, Center for Mental Health Services 2002

³ Integrated Dual Disorders Treatment Implementation Resources Kit, federal Department of Health and Human Services, Substance Abuse and Mental Health Administration, Center for Mental Health Services 2002

⁴ HCFA (CMS) Informational Memorandum (1992) Rehabilitation Services for the Mentally Ill

⁵ Title 42 Code of Federal Regulations, Chapter IV, Part 431, SubPart B, Section 431.51

⁶ Joint Commission on Accreditation of Healthcare Organizations, Commission on Accreditation of Rehabilitation Facilities, and Council on Accreditation

⁷ Title 42 Code of Federal Regulations, Chapter IV, Part 440, SubPart A, Section 440.130

⁸ US PRA Psychiatric Rehabilitation Program Certification, <http://www.uspra.org/certification/taking/study.html>

⁹ Peer to Peer Resource Center, Chicago, Illinois, <http://www.peersupport.org>

¹⁰ Public Law 104-191, Section 1173(c) (1), August 21, 1996, S

Sample Medicaid Manuals for Rehabilitative Services

District of Columbia

<http://dmh.dc.gov/dmh> (click on Mental Health Rehabilitative Services)

Florida

<http://floridamedicaid.acs-inc.com> (click provider support, then provider handbook (right column) and then click Community Behavioral Health Services (left side of page))

Georgia

http://mhddad.dhr.georgia.gov/DHR-MHDDAD/DHR-MHDDAD_CommonFiles/FY04ProviderManualrev1.pdf
(search Medicaid Manual from this site)

Louisiana

<http://www.mhrsla.org>

Rhode Island

http://www.rules.state.ri.us/rules/released/pdf/MHRH/MHRH_2368.pdf

South Carolina

http://www.dhhs.state.sc.us/ServiceProviders/CMH+Manual.htm#wbc_purpose=Basic

<http://www.dhhs.state.sc.us/internet/pdf/manuals/cmh/cmh%20SECTION%20%20Policies%20and%20procedures.pdf>

(Search “mental health” to view mental health handbook)

Wisconsin

http://dhfs.wisconsin.gov/medicaid6/handbooks/parth_d5/pdfs/all_handbook.pdf

ILRU Community Living Partnership

In September 2001 the Centers for Medicare and Medicaid Services (CMS) began funding Real Choice Systems Change projects as a result of the President's New Freedom Initiative. The initiative included funding to provide technical assistance to the agencies and organizations that received these grants, and ILRU, a program of The Institute for Rehabilitation and Research, was one of the initial organizations to be named a technical assistance provider. ILRU continues to provide assistance to projects funded in 2001 and 2002 and most recently received funding to provide technical assistance to all 51 grantees funded in 2004. TA is provided in partnership with Boston College Graduate School of Social Work; Family Voices, Inc.; Human Services Research Institute; Institute for Disability Access; The MEDSTAT Group, Inc.; National Association of State Units on Aging; CHANCE, Institute

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For More Information

Sharon Finney, Information and Communications Specialist, sfinney@ilru.org

ILRU Community Living Partnership:
National State-to-State Technical Assistance Center
Independent Living Research Utilization
2323 South Shepherd, Suite 1000, Houston, Texas 77019
(713) 520-0232 ext. 129 (voice), (713) 520-5136 (TTY), (713) 520-5785 (fax)
<http://www.hcbs.org>

Richard Petty, Project Director, richard.petty@bcm.tmc.edu
Darrell Jones, Program Coordinator, djones@bcm.tmc.edu

