USING MEDICAID TO SUPPORT WORKING AGE ADULTS WITH SERIOUS MENTAL ILLNESSES IN THE COMMUNITY: A HANDBOOK. DETAILED DISCUSSION OF MEDICAID MENTAL HEALTH COVERAGES

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This section describes in detail federal policies that apply to the principal coverage categories through which community mental health services are furnished to working age adults with serious mental illnesses. It includes information on applicable federal law, regulations, and other CMS guidance concerning each coverage category. State examples are also provided.

As a general matter, a full-featured, comprehensive approach to employing Medicaid funding in support of working-age adults in the community could include: (a) a robust rehabilitative services benefit; (b) targeted case management services; (c) ready access to prescribed drugs associated with the treatment of mental illnesses; (d) inpatient hospital services as necessary; and, (e) personal assistance services to address dimensions of community living that are outside the scope of the rehabilitative services benefit. The linchpin of a full-featured Medicaid mental health services strategy is the rehabilitative services option.

Clinic vs. Rehab Option: Differences

The main Medicaid coverages that states employ to furnish community mental health services are (a) clinic services (often referred to as the clinic option and (b) rehabilitative services (the rehab option). Each is described in more detail below. Here, these two coverages are compared and contrasted. While either option can serve as a vehicle for securing Medicaid funding for mental health treatment, there are important differences between the coverages, as summarized in the insert below. It is worth noting that services which can be provided under the clinic option also may be furnished under the rehab option but not necessarily vice versa.

One of the main differences between the options is the location of services. Except for services furnished to homeless individuals, clinic services must be furnished on-site at the clinic. Under the rehab option, services may be furnished to individuals in their own home, a community living arrangement and other community locations as well as at fixed mental health program sites or locations. It is for this reason that the rehab option is regarded as more congruent with the principles of Community Support Services (CSS) and recovery.

Clinic v. Rehab Option[13]	
Clinic Option	**Rehabilitative Services Option**
Medical model	Recovery model
Stabilization	Active treatment and participation
Clinic based	Community based
Licensed and higher degreed professionals	Professionals, mental health technicians, and peer specialists
Organized clinics/outpatient programs	Organizations that provide one or more covered services

Also, the clinic option requires a high level of direct physician (e.g., psychiatrist) involvement in the provision of services, either by direct service provision or close supervision of staff-furnished services. Under the rehab option, licensed medical and mental health professionals play important roles (through the development and monitoring of individual program plans and the provision of services reserved to them under state law), but they need not always be directly

involved in day-to-day service delivery, which may be carried out by a variety of qualified personnel, including Qualified Mental Health Professionals (QMHPs), appropri-ately qualified community workers, and peer specialists. Under the rehab option, a state can draw from a larger provider pool, thereby improv-ing consumer choice and overall system capabilities.

Finally, the clinic option is more or less confined to the provision of a relatively narrow array of psychiatric services and, thereby, is often portrayed as a medical model. In contrast, the rehabilitative services option spans a broader range of services and supports, including psychosocial rehabilitation and other key components often associated with recovery.

Federal law does not dictate that a state must choose between the clinic and rehabilitative services options. The two can and do operate side-by-side in many states. Many states reserve the provision of rehabilitative services for individuals with serious mental illnesses while making clinic services more broadly available to Medicaid beneficiaries whose mental health treatment needs can be addressed on an outpatient basis. Alternatively, some states (e.g., Georgia) have elected to unify their coverage of mental health services under the rehab option.

Outpatient Mental Health Services

In the past, many states used either the optional clinic coverage or the mandatory outpatient hospital coverage, or both, as their main vehicle(s) to qualify outpatient mental health services for Medicaid payment. Many states retain the clinic option, but several have dropped it in favor of the more comprehensive and flexible rehabilitative services option.[14] The clinic option is a broad Medicaid coverage. It is not reserved solely for mental health services. Other health care services may be furnished under the clinic option as well, including ambulatory services, surgical care, and substance abuse treatment.

Clinic Services
Social Security Act: §1905(a)(9) "clinic services [are those] furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a phys-ician, including such services furnished outside the clinic by clinic personnel to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address."

The primary distinction between the mandatory outpatient hospital coverage[15] and the optional clin-ic coverage[16] relates to the nature of a provider entity. Outpatient hospital services are operated as an adjunct to an inpatient hospital. A typical outpatient service is partial hospitalization. Clinics, on the other hand, are freestanding entities. States commonly employ the clinic option to provide outpatient mental health services, often through their network of community mental health centers and/or other similar organizations.

CMS has issued guidance (in the *State Medicaid Manual* -- included in Appendix A) concerning the provision of outpatient psychiatric services that applies equally to services furnished under the out-patient hospital coverage and the clinic option coverage. This guidance clarifies that

- Psychiatric services rendered to Medicaid beneficiaries must be closely related to the persons psychiatric condition;
- Admission for services must be based on an intake evaluation that evaluates the recipient's mental condition and, based on the patient's diagnosis, determines whether treatment in the outpatient program would be appropriate. Moreover, the assessment should include a certification by the evaluation team that the program is appropriate to meet the recipient's treatment needs;
- Services must be furnished as specified in an individual plan of care (POC). This consists of a written, individualized plan to improve the patient's condition to the point where the patient's continued participation in the program (beyond occasional maintenance visits) is no longer necessary. The POC contains a written description of the treatment objectives for that patient. The plan also should describe: (a) the treatment regimen; (b) projected service delivery schedule; (c) the personnel who will furnish services; and (d) when reevaluations will be conducted to update the POC;
- The POC must be reviewed no less frequently than every 90 days by an evaluation team; and,
- Any services furnished to an individual that depart from the treatment plan (e.g., emergency services) must be thoroughly documented when billed.

This CMS guidance makes it clear that outpatient psychiatric services are limited to the provision of treatment for the persons psychiatric disorder rather than to support broader rehabilitative purposes.

Treatment services provided under the clinic option (e.g., therapeutic services) must be performed directly or supervised by qualified professionals, and federal rules require that ultimate responsibility for services provided lies with a licensed physician. Virginia, for example, requires that services be rendered or supervised by (a) licensed physicians who have completed three years of post-graduate residency training in psychiatry; or (b) licensed clinical psychologists, clinical social workers, licensed professional counselors and clinical nurses with a psychiatric specialty. Unlicensed personnel may furnish services but must be supervised by qualified professionals.

Virginias coverage of mental health clinic services illustrates how this coverage is often fashioned.[17] (Virginia also covers an array of community rehabilitative services for persons with serious mental illnesses.) In particular:

- Clinic services are available for persons with a psychiatric diagnosis who exhibit deficits in four areas that result in functional limitations;[18]
- The services that may be furnished include: (a) individual psychotherapy; (b) group psychotherapy; (c) pharmacologic management; (d) family therapy (provided that it is not furnished to groups of families); and, (e) testing and diagnosis. Services must be spelled out in a plan of care that is signed by a qualified professional, and the plan of care must be reviewed no less frequently than every 90 days or every sixth session, whichever time frame is shorter;
- Specifically excluded from coverage is the teaching of life-related skills because they are not considered psychotherapy;
- Virginia limits outpatient mental health services to 26 visits per year and services must be pre-authorized.

Virginias mental health clinic services coverage is roughly similar to mental health services offered under commercial health insurance plans. Parallel requirements attach to services provided by freestanding mental health practitioners (e.g., psychiatrists) who are not associated with a clinic. Virginias coverage of clinic services is a basic mental health benefit. The states rehab option is designed to serve individuals who require more intensive services. Outpatient mental health/ psychiatric services are frequently needed to treat individuals with serious mental illnesses. The main drawback to using the clinic option to provide them is the limited scope of services that may be furnished, and the inability to provide them in a wide range of home and community settings.

Rehabilitative Services

The coverage of rehabilitative services is the most important Medicaid option for working-age adults with serious mental illnesses. This coverage (§1905(a)(13) of the Social Security Act; 42 CFR 440.130(d)) permits a state to offer a wide range of services throughout the community. In many states, this coverage is reserved for and underwrites community support services for individuals with serious mental illnesses who require especially intensive supports to aid their recovery. Mental health rehabilitative services generally are not employed in support of individuals whose needs can be met through the provision of basic counseling and psychotherapy services.

Rehabilitative Services
Social Security Act: §1905(a)(13) "Other diagnostic, screening, preventive, and rehab-ilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level."

A full-featured, comprehensive coverage of rehabilitative services for individuals with serious mental illnesses will include:

- Diagnosis and assessment
- Individual and group clinic outpatient mental health services
- Crisis services
- Family psychosocial education
- Peer support[19]
- Life skills training and support across a variety of community living dimensions
- Assertive Community Treatment with the capability to step down yet maintain intensive support as needed
- Medication education and management
- Community residential services and supports
- Illness and disability management
- Supported employment

In Chapter 5, more information is provided concerning many of these key components of comprehensive coverage. This array of rehabilitative services should be complemented by other Medicaid services: i.e., inpatient hospital as needed, case management/service coordination, substance abuse treatment, and access to prescribed drugs used in the treatment of mental illnesses (as well as medication management). Providing a comprehensive array of mental health rehabilitative services equips a system with wide-ranging capabilities that can be tailored to meet the specific needs of each individual. Individualized assessment and planning identify the specific rehabilitative services (along with other Medicaid and non-Medicaid supports) that will best address the needs of each person.

The Medicaid statute does not limit the coverage of rehabilitative services solely to mental health services. States offer other types of rehabilitative services in their Medicaid programs, including substance abuse treatment and physical rehabilitation services (e.g., occupational therapy and physical therapy.) However, the coverage of mental health services is among the most common uses of the rehabilitative services coverage. Today, nearly every state employs the rehabilitative services option to underwrite services and supports for individuals with mental illnesses. However, states vary in the scope of services that they offer under the rehab option.

The statutory and parallel regulatory provisions regarding rehabilitative services are brief. They have the following practical meanings:

- A rehabilitative service must involve the treatment or remediation of a condition that results in an individuals loss of functioning and, therefore, the service must be restorative or remedial. Federal policy distinguishes between rehabilitative and habilitative services. Habilitative services typically are furnished to individuals with intellectual or cognitive disabilities (e.g., mental retardation). Persons who have experienced a brain injury may also benefit from habilitation. Habilitative services are designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills. Habilitation services are not restorative or remedial because they are intended to aid individuals to gain new skills rather than restore previous functioning levels. Habilitation may not be covered as a rehabili-tative service.
- In the case of rehabilitative services for persons with serious mental illnesses, licensed practitioners of the healing arts (LPHAs) include psychiatrists, psychologists, licensed clinical social workers, registered nurses and advance practice nurses. Federal law allows LPHAs to recommend services. This recommend clause is generally interpreted by states to involve activities such as: (a) evaluation and diagnosis; (b) development and/or approval of a persons service plan; and, (c) ongoing review to determine the continued need for services.[20] It is important to note that neither the statute nor the regulations mandate that a psychiatrist or psychologist directly furnish or oversee the day-to-day provision of a rehabilitative service. This contrasts with the clinic option where a qualified professional (e.g., a psychiatrist or other licensed practitioner) must furnish the service directly or closely supervise its provision by unlicensed personnel, and a licensed physician retains ultimate clinical responsibility.
- The statute specifically provides that rehabilitative services may be furnished in a variety of community locations, including an individuals home. Unlike the clinic option, the provision of rehabilitative services is not tethered to a clinic site. This is one reason why the rehabilitative services option is so well suited to implementing the community support services concept, where the emphasis is on bringing services to individuals in their homes and elsewhere in the community. For example, in the provision of crisis services, under the rehabilitative services option, a crisis team may be dispatched to assist a

person in his or her living arrangement and continue to support the person until the crisis has abated. Under the clinic option, a team may be dispatched to assist the person but the person must be transported to the clinic for ongoing services.

To date, CMS has not published additional guidance in the form of a State Medicaid Manual transmittal concerning the coverage of mental health rehabilitative services. However, it has issued other guidance.

In 1992, the Director of the HCFA Medicaid Bureau (now CMS) issued an information memorandum to Regional Administers concerning services for persons with mental illnesses that could be included under the optional rehabilitation benefit. (This letter is included in Appendix A).

The main points made in this memorandum include the following.

- In deciding whether a service could be offered under this coverage, states were advised that while it is not always possible to determine whether a specific service is rehabilitative by scrutinizing the service itself, it is more meaningful to consider the goal of the treatment. Services necessary for the treatment of mental illness may be coverable as rehabilitative services.
- Examples of services that could potentially be covered as rehabilitative services were provided, including:
    - **Basic Skills Training** -- the restoration of those basic skills necessary to independently function in the community, including food planning and preparation, maintenance of living environment, community awareness and mobility skills.
    - **Social Skills** -- Redevelopment of those skills necessary to enable and maintain independent living in the community, including communication and socialization skills and techniques.
    - **Counseling and Therapy** -- Services directed toward the elimination of psychosocial barriers that impede the development or modification of skills necessary for independent functioning in the community.
- The memorandum cautioned that services unrelated to the treatment of mental illnesses fall outside the scope of rehabilitative services. For example, the provision of personal assistance services to assist a person in an activity of daily living may not be covered as a rehabilitative service. Such services must be covered elsewhere in the state plan as personal care services. This guidance means that a states coverage of rehabilitative services cannot mix treatment with other non-treatment or unrelated services. This does not mean that such services cannot be provided to individuals but, in order to do so, they must be covered through alternative means. The memorandum distinguished between providing assistance (such as meal preparation) for the individual (personal assistance) as opposed to teaching meal preparation skills to the person (rehabilitation).
- States were advised that job training, vocational and educational services may not be provided as rehabilitative services. This exclusion arises from the long-standing federal policy prohibition against Medicaid funding for purely vocational services. However, this prohibition does not preclude the provision of services that might assist individuals to function in the work place, provided that the services furnished are not directly associated with specific job performance.
- The memorandum noted that case management-type services could be covered as rehabilitative services so long as they were confined to managing Medicaid covered services (e.g., coordinating the provision of several rehabilitative services). However, where case management involves assisting individuals to obtain non-Medicaid services (e.g., housing), it cannot be covered as a rehabilitative service (although it could be covered as targeted case management services -- see the discussion of service coordination/ case management below). For this reason, states commonly cover targeted case management services side-by-side with rehabilitative services.
- The memorandum also pointed out that rehabilitative services must be furnished exclusively for the benefit of the individual with the mental illness. While such services could include consultation and training of others who are important in the persons life (e.g., spouse and/or other family members), the memorandum cautioned that services could not include the treatment of these other individuals except to the extent that they also qualify for rehabilitative services.
- Additionally, the memorandum cautioned that a state may not arbitrarily limit the providers of rehabilitative services (e.g., only permit community mental health centers to provide services) except when the state has an approved freedom of choice waiver. A state may specify reasonable provider qualification standards that it deems appropriate.

Although more than a decade old, this memorandum is the last official broad federal policy guidance issued concerning rehabilitative services coverage of mental health services. It remains in effect and continues to reflect fundamental CMS policy concerning the coverage of mental health services as rehabilitative services.

There are several facets of the coverage of rehabilitative services that warrant additional discussion. In particular:

- There is no federally prescribed array of mental health rehabilitative services that a state may offer. It is up to each state to fashion its own array. The specific mental health rehabilitative services that states cover vary considerably. Some states have confined their coverage to just a few services; others have crafted broader arrays. For example, in the past, Minnesota limited its coverage of mental health rehabilitative services solely to day treatment. Recently, the state expanded its coverage to include other elements of community support services that were previously funded exclusively with state dollars. Decisions concerning which services to cover, obviously, should reflect the states own policy goals and objectives with respect to supporting individuals with serious mental illness-es.
- Similarly, there are no federally prescribed definitions of the services that a state may offer as rehabilitative services. Each state may craft its own definitions to reflect its goals and objectives. While some services (e.g., psychosocial rehabilitation) are commonly covered by states under the rehabilitative services coverage, CMS has not prescribed the scope of these services or issued definitions for them. States are free to propose to cover new types of services, so long as the proposed service fits within the statutory parameters of rehabilitative services. CMS has avoided issuing prescriptive guidance that would have the effect of narrowing a states latitude to craft a coverage that comports with statutory provisions.
- Federal policy is also silent concerning the a-mount, duration and scope of mental health rehabilitative services. In other words, it does not dictate that such services be time limited or dictate that their use be capped or otherwise limited. A state may impose its own limits on the provision of such services, as long as these limits comply with the requirement that a service be sufficient in amount, duration and scope to reasonably achieve its purpose.
- Like other Medicaid services, the provision of rehabilitative services revolves around a medical necessity determination. States have latitude in establishing their own medical necessity criteria for rehabilitative services. Some states have relatively broad, general criteria. Others employ more sophisticated, sometimes two-tiered approaches to determine who may receive rehabilitative services. For example, Nevada requires that, in order to receive mental health rehabilitative services, individuals must meet level of care criteria based on the extent of their functional and other limitations.

Once individuals meet level of care criteria, the authorization of specific rehabilitative services hinges on whether the person meets the service eligibility criteria associated with each service. Another way states define medical necessity is by using step down criteria. This applies when individuals who require intensive supports later step down to a less intensive service level when their condition improves.

- As with other Medicaid services, a state may employ prior authorization and other utilization management methods in order to ensure that mental health rehabilitative services are being employed appropriately. These managed care-like methods may be applied in fee-for-service delivery systems and it is increasingly common practice for states to contract with private entities to conduct such utilization management activities. For example, utilization management is a central feature in the operation of Georgias mental health rehabilitative services. It also is employed in other states, for example, Montana and Nebraska.

Fundamentally, the rehabilitative services coverage option gives states considerable flexibility in aligning Medicaid-funded mental health services with system goals in supporting working age adults with serious mental illnesses. Among the states, there is considerable variety in the services offered under this coverage option; this variety is evidence of the flexibility of the coverage. There are no major federal policy obstacles to states employing the rehabilitative services coverage as a vehicle for promoting recovery or underwriting evidence-based practices.

This coverage option -- like any other -- has its limitations. It does not include services that are not rehabilitative in nature. But, it may be used to combine services that have similar elements or goals (e.g., individual and group therapies, peer supports, medication management). Like any other Medicaid coverage, payment for services is subject to generic Medicaid requirements, including documentation and fee-for-service billing.

The following two pages illustrate how Georgia and Minnesota have crafted their rehabilitative services coverage.

Case Management/Service Coordination

Federal Medicaid law permits a state to obtain federal financial participation in the cost of two distinct types of case management services. One type is targeted case management which is used to assist beneficiaries to access both Medicaid *and* non-Medicaid services, as well as to coordinate and monitor service provision. Targeted case management is a separately coverable service under a states Medicaid plan.

The other type can be termed services case management, since it involves the internal coordination of the delivery of Medicaid health care services to meet an individuals needs. Care management activities may also be conducted during the course of furnishing a covered service. For example, ACT features close coordination of a skilled, multi-disciplinary team in support of an individual. Such coordination is reimbursable as part of the provision of ACT. Similarly, the coordination by a mental health professional of mental health rehabilitative services is reimburs-able as a rehabilitative service since it is integral to the provision of such services.

Targeted case management is distinguished from services case management mainly in its scope and focus (assisting individuals to obtain and access a wide variety of services). CMS guidance concerning Medicaid case management services is spelled out in the *State Medicaid Manual* (included in Appendix A). The Manual describes the scope and purpose of targeted case management and also the circumstances when case management may be furnished as a component service under another coverage category. The Manual also discusses claiming case management costs as an administrative expense. In mental health, this is not a common practice.

Georgias Coverage of Mental Health Rehabilitative Services

Until 2001, Georgia relied on a very limited rehabilitative services option to obtain federal Medicaid funding for community mental health services. In order to bolster funding for such services as well as adopt a recovery framework across its community mental health service system, Georgia enhanced its coverage. Georgia's rehabilitative services coverage is comprehensive. It spans mental health services for persons of all ages and includes substance abuse services (which may be furnished to individuals who have a mental illness as well as those who do not). The coverage allows for the provision of services to individuals who have serious mental illnesses (or, in the case of children, a severe emotional disturbance) as well as individuals who need less intensive mental health services. A copy of Georgia's plan - including its service definitions may be found in Appendix B.

The following services may be furnished to adults with mental illnesses.[21]

- Diagnostic/functional assessment
- Clinic-based crisis management
- Out-of-clinic crisis management
- Crisis residential services
- Peer support (described in more detail in Chapter 5)
- Individual outpatient services (in a clinic or a community setting)
- Family outpatient services
- Group outpatient services (in a clinic or a community setting)
- Medication administration
- Ambulatory detoxification
- Physician assessment
- Nursing assessment and care
- Psychiatric intensive day treatment (provides for the stabilization of psychiatric impairments with time-limited, intensive, clinical service by a multi-disciplinary team in a clinic or facility-based setting)
- Psychosocial rehabilitation (as a step-down from intensive day treatment)
- Psychosocial day support
- Substance abuse intensive outpatient services
- Residential rehabilitative services (in 24-hour supervised facilities with 16 or fewer beds at three levels of intensity)
- Assertive community treatment
- Community support services (as a step-down from ACT)

Some of the foregoing services (e.g., ACT and psychosocial rehabilitation) are used exclusively for adults with severe and persistent mental illnesses. Others (e.g., individual outpatient therapy) may be furnished regardless of the severity of the person's mental illness and, thereby, constitute the state's basic Medicaid mental health benefit. Georgia's coverage includes the services (e.g., therapy) that states typically offer under the clinic option as a basic mental health benefit. However, because these services are furnished under the rehabilitative services option, their provision is not necessarily limited to clinic sites and they may be provided by mental health professionals other than psychiatrists.

Georgia also fashioned its provider qualifications so that some services may only be furnished by and through "comprehensive community mental health centers" that have the capacity to offer wide-ranging services; other services (e.g., peer support) may be furnished by other mental health providers. Georgia has also provided for step-downs in its plan. ACT is furnished to individuals who require especially intensive services; when ACT is no longer required, a person may receive community support. This use of step-downs assures that necessary services can be furnished in a cost-effective manner to individuals once they no longer require such intensive services. If a person's situation changes and more intensive services are once again necessary, ACT can be reinstated.

Georgia mandates the authorization of all rehabilitative services and employs APS Healthcare as its external review organization to conduct authorization and utilization review/management on its behalf. The state's *Medicaid Community Mental Health Center Program Manual* provides extensive information about the services that Georgia offers under the rehabilitative services option, including provider requirements and utilization management guidelines.[22]

Georgia's rehabilitative services coverage is an example of a state's pulling together all its community mental health services together under a single, unified Medicaid coverage that features a broad array of services and relies on service eligibility criteria, pre-authorization, and utilization management to ensure that such services are appropriate and cost-effective.

Minnesota's Coverage of Mental Health Rehabilitative Services[23]

Until recently, Minnesota confined its community mental health rehabilitative services coverage to day treatment for adults. Like some other states, Minnesota funded community support services for individuals with serious and persistent mental illnesses principally through state-funded grants to its network of county mental health organizations. In 2001, the Minnesota legislature authorized the expansion of Medicaid services to cover a broader array of rehabilitative services in order to increase the resources available to support people in the community. This was the first step in a multi-year strategy to expand and enhance community services so that they would be more flexible and less site-based. It was estimated that approximately 15,000 Minnesotans would receive expanded services and an additional 5,000 individuals would be able to receive services for the first time as a result of this change. Under the rehab option, somewhat broader eligibility criteria are employed than the state's definition of serious and persistent mental illnesses. Minnesota structured this expansion so that its added costs would be borne by state rather than county-funds. This freed up state grant funds to serve individuals not eligible for Medicaid who needed the same types of services, thus avoiding the emergence of a two-tiered system.

Under its amended 2001 rehabilitative services coverage option (in addition to day treatment and the state's general purpose outpatient mental health services coverage), Minnesota added the following services for individuals age 18 and older who have a "substantial disability and functional impairment" in three or more areas:[24]

- Adult rehabilitative mental health services that "enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, and independent and community living skills." These services "instruct, assist, and support the [individual] in areas such as: interpersonal communication skills, community resource utilization and integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, and transition to community living skills." Three service sub-categories are included: (a) basic living and social skills; (b) community intervention to "alleviate or reduce a recipient's barriers to community integration or independent living or minimize the risk of hospitalization or other more restrictive living arrangement;" and, (c) medication education services (as opposed to medication management) to instruct the person, family and/or significant others in the correct procedures for maintaining a prescription drug regimen.
- Crisis response services, including: (a) crisis assessment; (b) mobile crisis Intervention; and, (c) crisis stabilization services, provided in a range of settings including the person's own home, the family's home, or a residential setting.

Provision of these services must be based on a diagnostic and functional assessment of the individual and furnished under an Individual Treatment Plan (ITP) that serves as the basis for the provision of specific services. The ITP must be updated at least every six months. Provider agency staff must qualify as mental health professionals, mental health practitioners, or mental health rehabilitation workers. In Minnesota, basic mental health benefits are commonly included as managed health care benefits furnished by health plans. Rehabilitative benefits, however, are provided on a fee-for-service basis, although Minnesota is studying their potential integration into managed health plans.

These rehabilitative services may be furnished by either county-operated or non-county operated mental health entities certified by the state. Previously, Minnesota relied exclusively on county-operated entities to serve people with serious and persistent mental illnesses. Regardless of type, each certified entity must demonstrate the capacity to deliver the full array of rehabilitative mental health services and meet legislatively established standards concerning staff, program responsiveness to individual needs, coordination with other providers and quality assurance.

In 2003, the Legislature approved the second stage of the state's planned expansion of rehabilitative services to include community residential services and Assertive Community Treatment. It also modified county matching requirements to require increased county funding when a person is institutionalized. The aim of this change is to provide incentives to counties to employ non-institutional settings.

Targeted Case Management

Until 1986, the only practical avenue available for a state to secure Medicaid funding for freestanding case management services was through the HCBS waiver program. In 1986, Congress -- by enacting §1915(g) of the Social Security Act -- gave states the option to cover what were termed targeted case management services under their Medicaid plans.[25]

Targeted Case Management

Social Security Act: §1915(g):
(1) A State may provide, as medical assistance, case management services under the plan without regard to the requirements of section 1902(a)(1) [statewideness] and section 1902(a)(10)(B) [comp-arability]. The provision of case management ser-vices under this subsection shall not restrict the choice of the individual to receive medical assistance in violation of section 1902(a)(23) . The State may limit the case managers available with respect to case management services for eligible individuals with developmental disabilities or with chronic mental illness in order to ensure that the case managers for such individuals are capable of ensuring that such individuals receive needed services.
(2) For purposes of this subsection, the term "case management services" means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.

The expressed statutory purpose of targeted case management is to assist Medicaid recipients in gaining access to needed medical, social, educational and other services. This option is unique among Medicaid state plan coverages because it is not subject to the comparability requirement that services must be available to all beneficiaries. A state may limit its coverage of targeted case management services to a *specified group of Medicaid recipients* (hence the term targeted). These groups may be defined by condition or diagnosis (e.g., individuals with developmental disabilities) or their situation (e.g., persons who are homeless). A state may also offer these services on a less-than-statewide basis. Targeted case management is the sole Medicaid service that is exempt from the statutory comparability and statewideness requirements without a states having to obtain a federal waiver.

States are free to define the groups of Medicaid beneficiaries to whom they will provide targeted case management services and there is no limit on the number of groups that may be served under distinct coverages of targeted case management. For example, a state may have a distinct coverage for Medicaid beneficiaries with mental illnesses, and another for individuals with AIDS or HIV-related disorders. It is not uncommon for states to have multiple targeted case management coverages. A state may define a target population broadly (e.g., all Medicaid-eligible individuals with a mental illness) or more narrowly (e.g., Medicaid-eligible individuals with serious and persistent mental illnesses). As with other state plan services, once a state establishes its target population, case management services must be furnished to all beneficiaries who require them. A state may not limit the number of eligible individuals who may receive these services.

States have the option of limiting the entities that may furnish targeted case management services to individuals with developmental disabilities or mental illnesses. This provision permits a state to link these services to its single point of entry system, so that states can maintain a unified approach to service delivery. For example, Minnesota limits the providers of targeted case management services to its county human services agencies; however, they are authorized to contract with other qualified providers.

The services a state offers under targeted case management can be described as planning, linking, and monitoring direct services and supports obtained from various sources (the Medicaid program itself, other public programs, and private sources) -- making their scope potentially very broad. As cited by CMS, services and supports that case managers may assist a person to obtain include food stamps, energy assistance, emergency housing, and legal services. As noted above, this type of assistance may not be furnished under the rehabilitative services option.

Permissible targeted case management activities also may include facilitating service/support planning (including assessment), and monitoring the delivery of direct services and supports to ensure they meet the persons needs. In the mental health arena, targeted case management activities frequently include:

- Arranging for necessary assessments;
- Facilitating and participating in the development of individual treatment plans;
- Assisting individuals to obtain the mental health services in their plan and other public services (income assistance, housing, employment) that will further the achievement of personal goals;
- Monitoring the provision of services and individuals well-being, including identifying and resolving emerging problems;
- Serving as a point of contact in crisis and emergency situations and arranging the re-sponse to such situations; and,
- Advocating on behalf of individuals.

South Dakotas coverage of targeted case management services on behalf persons with serious mental illnesses spans many of these activities.

Targeted case management activities may be conducted face-to-face with the individual (e.g., visiting the person to conduct an interview), over the telephone with the person, and/or on a collateral contact basis (e.g., arranging for an appointment for the person with a local housing program or contacting providers who serve the person to obtain current information about her/his progress). Case manager activities must be specific to the individual beneficiary in order to qualify for Medicaid payment. As with other Medicaid services, individuals have the choice of accepting or rejecting targeted case management services.

Example: South Dakota

South Dakota furnishes targeted case management (TCM) services to adults age 18 and older who are severely and persistently mentally ill (as defined by the state.) The services that may be furnished to individuals in this target population include:

- Identification and follow-up, including assistance in obtaining needed services and entitlements, informing the person of his or her right to mental health treatment, and follow-up with persons who decline treatment or cannot obtain needed services;
- Coordination of needs assessments;
- Participation in treatment planning to ensure coordination of medical/mental health and support services;
- Development of an individualized case management service plan;
- Service mobilization, linkage and monitoring, including assistance, follow-through on referrals, and advocacy;

South Dakota limits the providers of TCM to employees of "comprehensive mental health facilities" that furnish a full range of community mental health services, and stipulates that TCM services be conducted by a qualified mental health professional (QMHP), as defined by the state. Case managers must be QMHPs or have a combination of education credentials, and/or experience in serving individuals with mental illnesses. In addition, case managers must participate in a training program developed and conducted by the South Dakota Division of Mental Health to ensure that they have the necessary skills and expertise.

Although a wide range of activities on behalf of beneficiaries may be included within the scope of targeted case management (at state discretion), some cannot. In particular:

- **Activities related to the authorization and approval of Medicaid services**. Targeted case management may not be employed as part of a prior authorization/utilization management system, or to direct beneficiaries to specific service providers. The statute expressly prohibits targeted case management activities that would have the effect of abridging a beneficiarys free choice of Medicaid provider. Prior authorization functions are eligible for federal payment as administrative expenses; if a states aim is to direct beneficiaries to a designated network of providers, then it must seek a 1915 (b) freedom of choice waiver.
- **Activities related to making basic Medicaid eligibility determinations**. Such activities are eligible for federal payment as administrative expenses.
- **Activities that constitute direct services to the consumer**. For example, the activity of transporting an individual to and from a doctors appointment is outside the scope of targeted case management. The persons case manager may certainly transport the individual to a physicians appointment. Although the costs involved cannot be claimed as case management (because the service is direct), they may be reimbursed as a transportation service under the Medicaid state plan or as an administrative expense. There is not a bright line drawn in federal policy between targeted case management and direct services. Planning, linking and monitoring, however, describe the essential features of targeted case management. States may not claim

federal funds for targeted case management activities that clearly fall under other coverage categories (e.g., driving a Medicaid beneficiary to a doctors appointment, which can be covered under transportation or personal assistance).

- **Activities that overlap or duplicate similar services that a person receives through other means**. For example, home health agencies are required to develop care plans for the individuals they serve. Targeted case management services cannot include development of these care plans. But they may include activities to ensure that the care plans are carried out and meet the consumers needs.

Targeted case management services may not be provided to individuals who reside in Medicaid-funded institutional settings (e.g., a nursing facility or an ICF/MR) except that they are reimbursable when furnished -- for up to 180 days in advance of discharge -- in order to facilitate a persons return to the community. This restriction on targeted case management services arises because: (a) federal regulations concerning Medicaid institutional services require that facilities themselves provide care coordination services to residents, and (b) Medicaid prohibits duplicate payments for the same service. The exception to this policy was specifically spelled out by CMS in 2000 as part of its initiatives to facilitate the community placement of institutionalized persons.[26]

Targeted case management services are not eligible for federal financial participation when furnished to individuals served in an IMD (because no services furnished to such persons may be claimed while the person is in an IMD). However, as in the case of other institutional settings such as hospitals, such services are eligible for federal financial participation when furnished up to 180 days prior to the discharge of a Medicaid beneficiary from an IMD. In this scenario, federal financial participation may only be claimed once the discharge has taken place. Targeted case management services may be furnished to Medicaid beneficiaries who are homeless or reside in homeless shelters. They may also be furnished to residents of community residential living arrangements that are not IMDs.

Because successfully supporting working age adults with serious mental illnesses in the community often involves not only addressing their treatment needs but also assisting them in other areas (e.g., finding affordable housing or securing employment), the coverage of targeted case management services is a means to support linkages to other services, as well as to monitor the well-being of individuals and assist them to address problems that they might encounter in community living.

Services Case Management

Services case management is an integral part of other services in a states rehabilitative services coverage, albeit not as a separate, distinct coverage. It is typically delivered in conjunction with service/treatment planning, periodic review of treatment plans, coordination and referral, monitoring, and/or advocacy. Again, it is important to keep in mind that, while these types of case management activities are eligible for federal financial participation since they are integral to the delivery of many services, their scope is limited to the management and coordination of activities and benefits covered as rehabilitative services. When the aim is to obtain or coordinate with other community resources, including non-Medicaid services, federal financial participation is only available under the targeted case management option.

Prescribed Drugs

Medications frequently play an important role in addressing mental illnesses. When individuals have appropriate medications, they are less likely to require other costly services. While prescribed drugs are an optional Medicaid benefit, they are covered by all states because they play such a critical role in contemporary health care, including mental health.[27]

Medicare Coverage of Prescribed Drugs

In 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act (P.L. 108-173). This legislation provides for Medicare coverage of prescribed drugs, starting January 1, 2006. The law also shifts the coverage of prescribed drugs for Medicare/Medicaid dual eligibles from Medicaid to Medicare, also effective in 2006. Once the law takes effect, states may no longer claim federal financial par-ticipation in the costs of furnishing prescribed drugs to dual eligibles. Dual eligibles must obtain their medica-tions through Medicare "Part D" plans.[28]

This change has substantial potential ramifications for dual eligibles. Within federal parameters, each Part D plan may establish its own coverage policies. It remains to be seen whether Part D plans will offer more or less extensive coverage of medications (in comparison to Medicaid coverages) that are critical for persons with serious mental illnesses.

While Medicaid coverage of prescribed drugs is optional, there are important statutory requirements that states must observe in choosing to provide this benefit. Congress enacted provisions in 1990 specifically intended to ensure access to necessary medications by Medicaid beneficiaries, including a requirement that states include in their formularies all prescribed drugs produced by manufacturers that sign rebate agreements. Congress also allowed states to exercise some control over prescribed drug formularies through implementation of prior approval/prior authorizations processes and generic substitutions. How-ever, states may not keep a completely closed formulary. Medicaid beneficiaries must be permitted to obtain necessary medications.

In 1998, the Centers for Medicare and Medicaid Services sent a letter to state Medicaid Directors urging states to update their formularies to include the new atypical antipsychotics because they have fewer side effects, thereby increasing treatment compliance. Mental health advocacy organizations (e.g., NAMI and NMHA) have adopted policy positions urging states to maintain open access to these new medications.

There is clinical evidence that individuals with certain mental illnesses do not respond to some medications but will respond to others. As a consequence, an open formulary approach that permits trials using various medications is important for finding the right drug for a person. Additionally, the use of some types of medications must be accompanied by periodic testing. Medicaid payment for such testing is available through the mandatory laboratory and x-ray services benefit. Services such as medication education and medication management may be covered under either the rehabilitative services or clinic services options. Chapter 5 discusses effective practices that combine medication and other treatments.

In recent years, state Medicaid expenditures for all prescribed drugs have risen. State expenditures for medications related to the treatment of mental illness have also climbed rapidly during this period. In response to upwardly spiraling pre-scribed drug spending, states have resorted to a variety of cost containment and utilization manage-ment measures, including caps on the number of drugs that a beneficiary may receive, prior approval processes, fail-first policies,[29] dosage and refill limits, the imposition of co-payments, the use of preferred drug lists and formularies, and mandatory substitution of generic for brand-name drugs when available.[30] Because some of these strategies can be problematic, many states grant exceptions from them. For example, when states employ preferred drugs lists and formularies, non-listed medications remain available, although they may require prior authorization or approval. While states may establish prior authorization and other utilization management processes, their effect cannot be to deny medically necessary medications to beneficiaries. Additional strategies that states are employing (i.e., medication algorithms) are discussed in Chapter 5.

While a number of these strategies have been somewhat effective in containing prescribed drug costs, they can have the unintentional adverse effect of driving up health care costs through increased emergency room utilization. An October 2003 Bazelon Center survey of changes to state prescribed psychiatric drug policies indicates that many states are utilizing a variety of cost containment strategies whose impact is not yet fully known.[31]

Given the rapidly changing landscape of state prescribed drug policies, it is difficult to pin down the exact effects they have had on access to and the availability of critical medications for individuals with serious mental illnesses. In a few states, some classes of individuals have been exempted from prior authorization or other pharmaceutical restrictions. For example, Colorados generic substitution rule exempts medications used to treat mental illnesses with biological bases. New Mexico is implementing a preferred drug list that exempts atypical and typical antipsychotics for individuals with serious mental illnesses.

The Medicaid program provides access to critical medications for individuals with mental illnesses. In general, states may not refuse to reimburse for medications except for non-indicated uses or when an equally efficacious, but lower cost substitute is available. Many states have adopted the sound policy of providing unrestricted access to more efficacious second-generation antipsychotic medi-cations with favorable safety and side effect profiles, even though these medications can be substantially more costly than conventional antipsychotics.

Inpatient Hospital Services

A central goal of community mental health services is preventing institutionalization or hospitalization. The provision of effective rehabilitative and other services can help to avoid hospitalization. For example, ACT is designed specifically with this aim in mind. In many cases, states have structured their managed behavioral health plans to create financial incentives to reduce hospitalization. However, under some circumstances, individuals may need to be treated in a hospital setting.

Medicaid payment is not available for the services furnished to individuals age 22 to 64 in IMDs, but is available for inpatient hospital services furnished to individuals who are admitted to general hospitals as a result of a psychiatric condition, including the psychiatric units of such hospitals, as long as they are not classifiable as IMDs. The coverage of psychiatric inpatient hospitalization falls under the mandatory Medicaid inpatient hospital benefit rather than as a distinct coverage category. States have the option of covering inpatient psychiatric services for children and youth under age 22 as a distinct coverage category.[32]

As with other hospital services, states can manage the utilization of inpatient hospital services through prior approval processes, including requiring admission approval. In addition, it is common for states to limit length of stay and/or restrict how many times an individual may be admitted. A state may also require continued stay review. In general, states require that individuals be discharged once they have stabilized. In most instances, state policies concerning inpatient psychiatric hospitali-zation more or less parallel their policies for other types of hospitalization.

Personal Care/Assistance

Personal care services include the performance of daily tasks that individuals without disabilities can perform on their own but individuals with disabilities cannot as a result of functional impairments. Daily tasks include activities of daily living (ADLs) such as bathing, dressing, eating, toileting, and transferring from a bed to a chair, and instrumental activities of daily living (IADLs) such as cooking, grocery shopping, and medication management. Personal assistance may also include supervision and oversight.

Personal Care/Assistance
Social Security Act: §1905(a)(24) Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, [ICF/MR], or [IMD] that are (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or other location

Since the mid-1970s, states have had the option to offer personal care services under the Medicaid state plan, making these services one of the longest standing Medicaid home and community benefits. This option was first established administratively under the Secretarys authority to add coverages over and above those spelled out in §1905 of the Social Security Act, if such services would further the Acts purposes.[33] In 1993, Congress formally added personal care to the list of services spelled out in the Medicaid statute.

When the option for states to offer personal care was created, it had a decidedly medical orientation. The services had to be prescribed by a physician, supervised by a registered nurse, and delivered in accordance with a care plan. Moreover, they could be provided only in the persons place of residence. Generally, the personal care services that a state offered included assisting individuals with ADLs. Other forms of assistance, such as laundry and housekeeping were offered on a limited basis, i.e., only when they were incidental to ADL assistance.

Starting in the late 1980s, some states sought to broaden the scope of personal care services, providing them outside the individuals home in order to enable beneficiaries to participate in community life. In 1993, Congress not only formally incorporated personal care services into federal Medicaid law but also authorized their provision outside the individuals home. Congress went a step further in 1994, allowing states to: (1) use means other than nurse supervision to oversee the provision of personal care services, and (2) establish means other than physician prescription for authorizing such services. In November 1997, CMS issued new regulations concerning optional Medicaid state plan personal care services to reflect these statutory changes.

Personal care/assistance services are most commonly provided to individuals with physical disabilities. Federal Medicaid policy concerning personal care/assistance services does not forbid their provision to persons with serious mental illnesses, but states do not usually provide them. Some individuals with serious mental illnesses have difficulty performing certain types of activities of daily living and may benefit from the provision of personal care/assistance. When such assistance is needed, it cannot be covered under the rehabilitative services option. Under that option, individuals may be taught -- if needed -- basic life skills so that they are able to be more independent. However, performing or assisting the individual to perform essential life tasks falls outside the boundary of rehabilitative services.

In January 1999, CMS released a State Medicaid Manual Transmittal (included in Appendix A) that significantly revised and updated the Agencys guidelines concerning the coverage of personal care services. This guidance made it clear that personal care services may span the provision of assistance not only with ADLs but also with instrumental activities of daily living (IADLs), such as personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management.

The guidance further clarified that, for persons with cognitive impairments (including persons with mental illnesses as well as persons who have Alzheimers disease or other dementias), personal care may include cueing along with supervision to ensure the individual performs the task properly. In other words, a person might be able to physically perform a task but has limitations in actually performing the task because of his/her mental condition. The guidance also explicitly recognized consumer direction of personal care services.

A little more than one-half of the states offer personal care/assistance under their Medicaid state plans. In recent years, states have tended to employ the Medicaid HCBS waiver program rather than Medicaid state plan coverage of personal assistance to expand the availability of personal assistance for individuals of all ages with various disabilities. Personal assistance is a common feature of HCBS waiver programs. Individuals with mental illnesses are not precluded from participating in HCBS waiver programs. However, they can only receive waiver services if they meet the states institutional eligibility criteria for hospital, nursing facility, or ICF/MR services.

Relatively few states furnish personal care/assist-ance routinely to support significant numbers of individuals with mental illnesses. Like other Medicaid services, a state may not discriminate on the basis of disability when it offers a service under the state plan. Consequently, a state may not deny personal care/assistance services to individuals who have mental illnesses but otherwise meet the states criteria for such services. At the same time, a state may not reserve personal care/assistance solely for such individuals. Personal care/assistance services cannot be targeted by specific type of disability.

Often, there are impediments to obtaining personal care/assistance for people with serious mental illnesses. Despite the changes in federal policy during the 1990s that permitted states to de-medicalize these services, some states have not changed their policies. Also, in many states, the threshold service eligibility criteria for personal care/assistance continue to focus on difficulties in performing activities of daily living, giving lesser weight to IADL needs. Additionally, some states continue to circumscribe the scope of personal care/assistance services by limiting it to the provision of services in the individuals living arrangement. Finally, securing personal care services on behalf of individuals with mental illnesses requires coordination between systems of care because personal care services are managed through different networks and programs than those that provide mental health services.

West Virginia's Personal Assistance State Plan Amendment

In 2002, West Virginia amended its Medicaid state plan coverage of personal assistance to provide that such services could be (a) furnished outside the beneficiary's home and (b) used in support of individuals to obtain and retain competitive employment. In particular, West Virginia's coverage specifies that

> *Personal care services are available to assist an individual with a disability (as defined by SSI) to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs) in the individual's home. Personal care services are provided in the recipients' residence. Personal care services in the form of assistance with ADLs and IADLs are also available outside the home to eligible disabled individuals who require assistance to obtain and retain competitive employment of at least 40 hours a month. Assistance outside the home may be provided as necessary to assist the individual to and from work, at the work site, and in locations for obtaining employment such as employment agencies, human resources offices, accommodations preparation appointments, and job interview sites.*

In a few states, personal care funding has been used to partly underwrite the costs of community residences, including residences that support individuals with mental illnesses. Personal care funding was employed extensively by Michigan in the late 1980s as a means of financing community residential services for persons with mental illnesses and developmental disabilities. Michigans approach recognized that many of the supports that people receive in residential settings included personal care and that Medicaid funding could be employed to pay for a portion of the costs of operating such residences. In some states, personal care funding pays for some of the costs of operating domiciliary-type residential settings where individuals with mental illnesses may reside. However, in many instances, these settings do not furnish mental health services and supports for such individuals.

Recently, a few states have started to use personal assistance services to support the employment of individuals with disabilities. This development has been spurred on by the passage of the federal Ticket to Work and Work Incentives Improvement Act, Medicaid buy-in eligibility options (as discussed in Chapter 3), and CMS Medicaid Infrastructure Grants, which include a requirement for states to assess and strengthen personal assistance services to support people with disabilities who work.

At least three states -- California, West Virginia[34] and Utah -- have augmented their existing Medicaid state plan coverage of personal assistance services specifically to support people with disabilities who work, including individuals with serious mental illnesses.[35] In each instance, the state plan amend-ments take advantage of the 1993 amendments that allow for the provision of personal assistance outside the persons home to include the provision of employment-related personal assistance.

In 2003, California amended its Medicaid state plan to give individuals the option of receiving personal care services in the workplace to the same extent they are provided in the home.[36] Utah has recently added innovative employment-related personal care coverage, which is discussed in more detail in Chapter 5.

Personal care/assistance potentially offers an avenue for underwriting non-treatment supports for individuals with serious mental illnesses, including those that support employment. Not all states offer personal care and, in some that do, individuals may not qualify for services based on the states eligibility criteria, or there may be other barriers to obtaining these services.