Leveraging Medicaid

A Guide to Using Medicaid Financing in Supportive Housing

July 2008

Corporation for Supportive Housing
Technical Assistance Collaborative, Inc.

Dear Reader:

We hope you enjoy ***Leveraging Medicaid: A Guide to Using Medicaid Financing in Supportive Housing***. The Guide provides an overview of the various Medicaid strategies that can be used to serve individuals who live in permanent supportive housing. This Guide is intended for many audiences. We want to provide federal policy-makers additional guidance about how services and supports for individuals in supportive housing can be incorporated into a CMS regulation, policy transmittal or other documents. It is also intended to provide more clarity to state policy-makers about which services are eligible for Federal Financial Participation (FFP) and under what conditions. We also want the Guide to be available to the Centers for Medicare and Medicaid Services as it evaluates requests from states for these services and supports. In addition, we hope the Guide will give counties, service providers and advocates some tools with which to approach State Medicaid programs seeking collaboration and the best use of funds.

The Medicaid program is not static. Policies and programs are changed frequently to meet the needs of the populations served by the program, create flexibility to states in delivering the benefit, or reflect the intent of the federal administration to address costs, access and/or quality. We are in a particularly active period of Medicaid policy change as we publish this Guide, with the proposed Targeted Case Management and Rehabilitation Option rule changes under consideration (and presently under a Congressional moratorium). There has been debate among stakeholders about the potential impact of some of these pending rule changes, and the future is uncertain. In recent months new rules have also been proposed for some other Medicaid benefits, including Home and Community Based Services. Even though these impending changes may make the immediate course somewhat less clear, it is important that policy makers and providers consider the strategies described in this Guide to effectively plan and implement programs when utilization of Medicaid financing is under consideration. The information in this guide will be updated in the future to reflect changes to the program. The Corporation for Supportive Housing and the Technical Assistance Collaborative will continue to revise this Guide or provide supplemental information as significant changes are made to the Medicaid program that impacts the availability of services and supports to individuals in supportive housing.

We hope you will find this Guide useful. We wish you great success in your efforts to change the lives of people who live in supportive housing!

Corporation for Supportive Housing

Technical Assistance Collaborative, Inc.

About CSH

The Corporation for Supportive Housing (CSH) is a national non-profit organization and Community Development Financial Institution that helps communities create permanent housing with services to prevent and end homelessness. Founded in 1991, CSH advances its mission by providing advocacy, expertise, leadership, and financial resources to make it easier to create and operate supportive housing. CSH seeks to help create an expanded supply of supportive housing for people, including single adults, families with children, and young adults, who have extremely low-incomes, who have disabling conditions, and/or face other significant challenges that place them at on-going risk of homelessness. For information regarding CSH's current office locations, please see www.csh.org/contactus.

About TAC

The Technical Assistance Collaborative, Inc. (TAC) is a national non-profit organization that works to achieve positive outcomes on behalf of people with disabilities, people who are homeless, and people with other special needs by providing state-of-the-art information, capacity building, and technical expertise to organizations and policymakers in the areas of mental health, substance abuse, human services, and affordable housing. TAC was founded in 1992 and is based in Boston, Massachusetts. TAC staff members are multi-disciplinary professionals with extensive public and non-profit sector experience in the fields of affordable housing, human services, homelessness, and health care. In addition to in-house staff, TAC's unique collaborative model includes the capacity of a nation-wide network of partner organizations and consultants who specialize in areas such as public mental health financing and service delivery, organizational development and management, and permanent supportive housing. For more information, please see www.tacinc.org.

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SECTION 1
Purpose of This Guide

Medicaid plays a critical role in financing services and supports for many individuals needing permanent supportive housing (PSH). However, because of the complexity of the Medicaid program, supportive housing providers and local and state government agencies are not always able to access these resources systematically. Adding to the complexity, recent federal legislation and regulations continue to change the program. The Deficit Reduction Act of 2005, the regulations regarding rehabilitative services and pending policies regarding the use of targeted case management provide opportunities and challenges to state and local agencies. Some of these changes provide the state Medicaid program with additional flexibility in defining a benefit package for certain populations. In other instances, the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees the Medicaid program, is clarifying the intent and scope of various Medicaid services.

This paper provides an overview of how these strategies may affect the use of Medicaid to finance services and supports for individuals in PSH. Specifically the purpose of this guide is to:

- Define a service taxonomy that could serve as a basic benefit package for individuals in permanent supportive housing.
- Provide policy-makers additional guidance about how the coverage of these services could be incorporated into a CMS regulation, policy transmittal or other documents.
- Assist CMS in its efforts to evaluate request from states for services and supports.
- Give states more clarity about which services are eligible for Federal Financial Participation (FFP) and under what conditions; this will make it easier for states to:
    - Amend the state Medicaid plan, or modify procedures for implementation of current state plan to add services or redefine existing services;
    - Modify plan or administrative provisions that may limit the locations where covered services can be delivered, provider qualifications, etc.; and
    - Apply for waivers when needed.
- Give States a standardized way to talk about, compare, set quality standards and pay for services and/or contract with Medicaid managed care organizations using Medicaid and other sources of funding that may be available for a range of health services.
- Give Counties, service providers and advocates a tool with which to approach State Medicaid programs seeking funding and collaboration.

This paper provides a basic overview of the Medicaid program and critical regulations that govern current Medicaid State Plans and certain Waiver programs. The paper sets forth a proposed taxonomy for individuals who need permanent supportive housing and identifies which services could be covered under certain Medicaid programs.

The paper also identifies the various strategies that policymakers may consider to cover and obtain reimbursement for these services. For each strategy, this paper provides:

- Possible populations and services that could be covered by these programs.
- Advantages and challenges presented to states for each strategy.
- Recent example of how a state used the strategy to finance services.

The final section suggests specific steps that a state may want to consider to seek coverage for various Medicaid services for individuals needing permanent supportive housing.

SECTION 2
Overview of the Medicaid Program

Overview of Medicaid

The Medicaid Program is the third largest source of health insurance in the United States. As the largest program in the federal "safety net" of public assistance programs, Medicaid provides essential medical and medically related services to some of the most vulnerable populations in society. The Medicaid program covers 59 million people,[1] including many of those who need services and supports to live in supportive housing.

In general, Medicaid eligibility is based on a combination of financial and categorical eligibility requirements. Medicaid is a means-tested program. Beneficiaries must be low-income and meet certain resource standards. Each state determines income thresholds and resource standards for their Medicaid program following federal guidelines. These thresholds and standards can vary by state and may differ for each Medicaid-eligible population group within a state (e.g., children, adults, elders, and individuals with disabilities).

Some individuals needing permanent supportive housing may not be eligible for Medicaid. In general Medicaid covers pregnant women, women with children and adults who are disabled. Eligibility for the latter group of individuals is closely tied to their eligibility for the federal Supplemental Security Income (SSI) Program due to their disability. Applying for SSI can be very complicated and time consuming, and individuals with a severe mental illness often are not able to get through the process without significant assistance. In addition, the changes to Social Security in 1994 determined that an individual with a primary diagnosis of substance abuse was not eligible for SSI.

Major Regulations

Title XIX of the Social Security Act sets forth many regulations that apply to nearly every aspect of the Medicaid program. Understanding these regulations is essential to understanding the responsibilities single state agencies have, as well as the range of options state decision makers have in expanding or controlling Medicaid. The critical regulations of the Medicaid program include:

- ***Statewideness***—In practical terms, the statewideness requirement is the federal government's method of assuring that the services and processes under a state's Medicaid program are made available for Medicaid recipients throughout the state.

[1] Key Medicare and Medicaid Statistics, Henry J Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured

- ***Equal Access***—The purpose of the equal access provision is to ensure adequate access and quality of care delivered by non-institutional providers, and to tie these outcomes, at least in part, to the reimbursement methodology selected by a state.
- ***Free Choice of Providers***—Medicaid recipients must have the ability to choose among qualified providers for covered services from any willing provider who undertakes to provide such services.
- ***Amount, Duration and Scope***—The Medicaid State plan must specify the amount, duration, and scope of each service that it provides for Medicaid recipients. Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.
- ***Comparability***—Once an individual qualifies for Medicaid, the benefit offered must be comparable to that offered to other Medicaid recipients in the same eligibility group.
- ***Relations with Other Agencies***—The State Medicaid Plan must provide for a written agreement (or formal written intra-agency arrangement) between the Medicaid agency and the applicable state agencies responsible for licensing or certifying a particular type of provider.
- ***Institution for Mental Diseases ("IMD") Exclusion***—IMDs are defined as "a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing and related services." Essentially, this provision states that there is no federal reimbursement available under Medicaid for any services provided to individuals aged 22 to 64 residing in IMDs. The IMD exclusion has led states to develop community-based systems of care for people with mental health needs.
- ***Medical Necessity***—Medicaid services are always subject to medical necessity. Medically necessary or medical necessity means that any covered services furnished must meet various conditions established by the federal government. They must be:
    - Necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
    - Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
    - Consistent with generally accepted medical standards as determined by the Medicaid program, and not experimental or investigational;
    - Reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
    - Furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

Proposed federal provisions in the proposed rehabilitation option regulations will require that services must be identified in an individual's service plan in order to be considered medically necessary.

State/Federal Responsibilities

The states and the federal government jointly finance the Medicaid program. Medicaid is an entitlement program. The number of people participating in the program and services provided determines federal spending levels. Federal funding for Medicaid comes from general revenues. Some states rely upon a combination of state and local funding sources to provide the required matching funds. The federal financial participation ("FFP") is the amount that the federal government matches for each state dollar spent on the program. The federal matching rate (FMAP) varies from state to state and year to year because it is based on the average per capita income in each state. States with lower per capita incomes relative to the national average receive a higher federal matching rate. Currently the FMAP in states ranges from 50 percent to 76 percent for states.

Federal Medicaid regulations require each state to designate a "single state agency" responsible for the Medicaid program. The single state agency is designated to administer or supervise the administration of the State Medicaid Plan, and make rules and regulations in implementing the plan. The single state agency serves as the primary point of contact with the federal government agency; provides or oversees the provision of Medicaid eligibility determination and processes; oversees policies, rules, and operations carried out by Medicaid; and monitors and oversees the Medicaid budget.

Overview of State Plan and Waiver Process

The relationship between the U.S. Department of Health and Human Services and each state participating in the Medicaid program is established through its State Medicaid Plan. The State Medicaid Plan is a comprehensive written statement maintained by the single state agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity to all federal requirements. The State Medicaid Plan contains all information necessary for the Centers for Medicare and Medicaid Services (CMS) – within the Department of Health and Human Services – to determine whether the plan can be approved to serve as a basis for federal financial. Significant changes to a state's Medicaid program require the single state agency to submit a State Medicaid Plan Amendment for CMS approval.

The State Medicaid Plan, which serves as the contract between a state and CMS, is actually a technical document that includes a description of groups eligible for Medicaid, services provided, how providers are reimbursed, and other program requirements. Many of the details governing the administration of the State Medicaid Plan are not included in the State Medicaid Plan itself, however, but are found in state statutes, regulations, Memoranda of Agreement among state agencies; state-level provider licensure and certification requirements.

In some cases, a state may request *waivers* of some of these requirements discussed above. The Social Security Act authorizes multiple waiver and demonstration authorities to allow states flexibility in operating Medicaid programs. The State Medicaid agency must submit to CMS for review and approval a waiver. Initially most waivers are approved for a three-year period, and waivers are renewed for five-year intervals.

In order to implement a waiver (including a Home and Community Based Services (HCBS) waiver, discussed later in this guide), a state must submit an initial waiver application to CMS. The application describes the proposed waiver's design and must include sufficient information to permit CMS (acting on behalf of the Secretary of Health and Human Services) to determine that the waiver meets applicable statutory and regulatory requirements, including health and safety assurances specified in federal regulations.

Continuation of a waiver beyond its initial three-year approval period requires that the state submit a five-year waiver renewal application and a determination by CMS that, while the waiver has been in effect, the state has satisfactorily met the waiver assurances and other Federal requirements, including the submission of mandatory annual waiver reports. Each subsequent waiver renewal also requires the submission of a renewal application and a CMS determination that the state has continued to meet Federal requirements. The approved waiver application specifies the operational features of the waiver. A state must implement the waiver as specified in the approved application. If the state wants to change the waiver while it is in effect, it must submit an amendment to CMS for its review and approval. All requests for new waivers, waiver renewals and amendments must be submitted by the state Medicaid agency. There is no limit on the number of waivers that a state may operate.

In its application and each year during the period that the waiver is in operation, the state must demonstrate that the waiver is *cost neutral*. In particular, the average per participant expenditures for the waiver and non-waiver Medicaid services must be no more costly than the average per person costs of furnishing institutional (and other Medicaid state plan) services to persons who require the same level of care.

How has Medicaid Been Used for Supportive Housing?

There are a variety of supports and services that are covered under various Medicaid programs for the individuals who need supportive housing. Services and supports covered under Medicaid often include:

- Coordinating, brokering and referring individuals to services and supports through case management.
- Directly providing services and supports to help consumers locate and maintain housing, including building the skills needed to reduce problems related to symptoms of mental illness and substance use disorders and to function in independent housing.

- Offering meaningful and effective opportunities to develop or redevelop the skills necessary to maintain their housing (e.g., money management, illness management).
- Supporting individuals during crisis when they may be most at risk of losing their housing and other benefits.
- Offering supports for individuals to develop the necessary skills for employment. These skills focus on assisting the individual to be punctual, develop appropriate relationships with co-workers and management and dress appropriately for their job.
- Several Medicaid programs offer great flexibility as to where these services and supports can be delivered, including an individual's home, work or other natural environment.
- Managing illness/addiction symptoms that could interfere with obtaining and maintaining housing.

The next section describes in more detail the taxonomy of services that are often needed by individuals in permanent supportive housing and the strategies state and jurisdictions have used to cover these services under the Medicaid program.

SECTION 3
Taxonomy of Services for Individuals in Supportive Housing

Taxonomy

In order for permanent supportive housing to work successfully there must be three elements: housing production, rent subsidies, and services and supports. Services and supports must promote integration, independent functioning and housing retention. Supportive services vary depending on who lives in the housing. Most permanent supportive housing providers offer some type of case management and housing support, but may also offer more intensive services such as mental health services, substance abuse services, vocational/employment services, etc. These services may be offered onsite or at a community-based agency. Supportive services can play a vital role in diverting people from emergency rooms, crisis care settings, long-term psychiatric care, nursing facilities, and in some cases the juvenile justice and criminal justice systems.

For individuals with a mental illness and for individuals with a substance abuse disorder, services must promote recovery and rehabilitation. The services and supports must be based on a recovery model that encourages self-determination by individuals and their families. Supportive services are the "supports" in permanent supportive housing. Without them, the housing is the same as any other subsidized housing.

There are a wide variety of services and supports that are needed by individuals in permanent supportive housing. Most of these services and supports fall into the following categories:

- ***Health and Medical Services***—Including routine medical care, medication management, health and wellness education, nutritional counseling, home health aides and personal care services.
- ***Mental Health Services***—Including screening, assessments, counseling, psychiatric services, clubhouses, peer services, and assertive community treatment.
- ***Substance Abuse Services***—Including relapse prevention, counseling, intensive outpatient services, medication assisted treatment, detoxification, residential services and formal and informal (AA/NA) recovery support services.
- ***Educational Services***—Including GED preparation, literacy services and college preparedness.
- ***Vocational Services***—Including vocational and career assessment, job readiness training and supported employment.
- ***Independent Living Services***—Financial management services, entitlement assistance, training in cooking and meal preparation, and mediation training.

- ***General Supportive Services***—Including services such as case management, community support, meals, peer support, crisis intervention, transportation, recreational and social opportunities.

A more detailed taxonomy is provided in Attachment A.

Which Services Does Medicaid Cover?

Service coverage for health, mental health, substance abuse and supportive services varies significantly across state Medicaid programs. However, each state Medicaid program must cover "Mandatory Services" identified in the federal statute. These service categories include:

- Inpatient hospital services
- Outpatient hospital services
- Prenatal care
- Vaccines for children
- Physician services
- Nursing facility services for persons aged 21 or older
- Family planning services and supplies
- Rural health clinic services
- Home health care for persons eligible for skilled-nursing services
- Laboratory and x-ray services
- Pediatric and family nurse practitioner services
- Nurse-midwife services
- Federally qualified health-center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21

In addition to covering the mandated services, states have the discretion to cover additional services – i.e., "Optional Services." States may choose among thirty-plus Optional Services to include in their Medicaid programs. Following are the most common of the currently approved optional Medicaid services categories:

- Diagnostic services
- Clinic services
- Intermediate care facilities for the mentally retarded (ICFs/MR)

- Prescribed drugs and prosthetic devices
- Optometrist services and eyeglasses
- Nursing facility services for children under age 21
- Transportation services
- Targeted Case Management
- Rehabilitation and physical therapy services
- Home and community-based care to certain persons with chronic impairments

Within each of these service categories, states can further define the specific services and interventions that can be covered. For instance outpatient hospital services can include various medical services including: initial health assessments or screenings, medication evaluation and administration. Rehabilitation services can include physical, occupational and speech therapy as well as mental health and addiction recovery services. It should be noted that tenancy supports are not a specific service definition within Medicaid, but tenancy supports in general can be provided under several of the Medicaid service categories (e.g. skill building, community supports).

Medicaid generally does not cover room and board or job-specific vocational services. Supported employment services are generally available to individuals enrolled in a Medicaid Home and Community Based Waiver or a new State Plan Option included in the 2005 Deficit Reduction Act. Some states have covered skill building activities that assist the individual to become work ready and to obtain and maintain employment. However these activities must not be duplicative of similar activities funded under the federal Vocational Rehabilitation Act.

As indicated previously, Medicaid does not cover services for adults with mental illness between the ages of 18 and 64 when provided in an Institution for Mental Disease (IMD). Specifically, the IMD exclusion precludes Medicaid reimbursement, and any federal matching dollars, for services received by individuals in facilities that meet the IMD criteria. A facility meets the IMD criteria when they are:

- More than sixteen beds.
- Specializing in the treatment of persons with mental illnesses or addictive disorders.
- Licensed or accredited as a psychiatric facility.

Medicaid does not cover vocational or educational services. These services are viewed as the purview of other federal agencies and funding sources (e.g. Vocational Rehabilitation, Department of Education).

Medicaid Coverage Strategies

The state plan serves as the basis for a state's specific Medicaid coverage. The state plan identifies the scope of services that will be available to individuals who are Medicaid eligible. This coverage may be dependent on several factors. For instance, certain services may only be available to certain groups (e.g. EPSDT is only available to children[2]). States may choose whether or not to cover various optional services. Most state Medicaid agencies have designed managed care programs (mostly for medical and primary care) that limit the amount, scope and duration of services as well as limit an individual's choice of providers.

Many of the medical and general health services that an individual in permanent supportive housing may need are "mandatory services" [3]and therefore are covered by a state's Medicaid program. Therefore inpatient and routine outpatient care as well as family planning are always a covered benefit in a state's Medicaid program. However, other medical services including prescription drugs, vision and dental services, nursing and personal care services are optional services.

Other services (e.g. mental health, substance abuse, independent living and other supportive services) that are critical in sustaining individuals in PSH are most often optional services. These services are generally covered through the following Medicaid strategies:

The ***Medicaid Rehabilitation Option*** (the "Rehab Option") offers rehabilitative services that a state Medicaid program may add to its state Medicaid plan. Rehabilitative services are defined in 42 CFR §440.130 as "any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level." States typically utilize the Rehab Option to cover services rendered by physicians, physical therapists ("PT"), occupational therapists ("OT"), speech/language pathologists, psychologists, and licensed clinical social workers ("LCSW"), to name a few, to be provided in community-based, non-institutional settings including the person's natural environment (e.g., home or school).

Targeted Case Management assists individuals eligible for Medicaid in gaining access to necessary care and services appropriate to the needs of an individual. Case management services are referred to as targeted case management (TCM) services when the services are provided only to a defined "targeted" group of people, and therefore are not furnished in accordance with Medicaid statewideness or comparability requirements. This flexibility enables states to target case management services to specific individuals or to

[2] While EPSDT may be a reimbursement strategy for some services for children and transition-aged youth who live in supportive housing, a discussion of EPSDT is beyond the scope of this guide.
[3] In this context, "mandatory" refers to services that states are required to cover in their Medicaid program. This use of the term "mandatory" in this context does not mean that participation in these services by tenants is required.

individuals who reside in specified areas. While case management services have not been further defined in regulations, activities commonly understood to be allowable under TCM include: 1) assessment of the eligible individual to determine service needs, 2) development of a specific care plan, 3) referral and related activities to help the individual obtain needed services, and 4) monitoring and follow up.

In addition, many states have developed ***Home and Community Based Services (HCBS)*** Waivers to cover many of the support services that are needed by individuals in PSH including case management, services to transition an individual from an institution, general goods and services, transportation, personal care and peer supports. These Waivers are often termed 1915c Waivers referring to the provision in the Social Security Act that established this program. Historically, most of these HCBS Waivers have focused on individuals who were older and individuals with developmental disabilities. States have employed the HCBS waiver program extensively to promote the cost-effective delivery of long-term services to many Medicaid beneficiary target population groups. The cost of furnishing community services has been demonstrated to be considerably lower than institutional services. In addition, the program is very flexible. States have wide-ranging latitude in selecting the populations to which they will furnish services and in the services that they offer through their programs. States also may opt to have more generous eligibility rules for individuals to qualify for HCBS services. For instance, in most states individuals with incomes up to 300 percent of the federal poverty level can qualify for these services. The 1915c program has generally not be afforded to adults with mental health or addictive disorders. In most instances the majority of their institutional costs were incurred in an IMD, which is not reimbursed by Medicaid. Therefore, it is difficult, if not impossible to demonstrate cost neutrality under a 1915c for these individuals.

Another strategy that states may use to cover home and community-based services in ***Section 6086 of the Deficit Reduction Act*** (DRA), P.L. 109-171. Section 6086 gives states the ability to provide home and community-based services to elderly individuals and people with disabilities without requiring a HCBS waiver or demonstrating cost neutrality. Section 6086 established a new provision in the Social Security Act, 1915i, for state to offer these home and community-based services.

The strategy a state employs to cover a service under the Medicaid program may vary. For instance, some of the functions of case managers can be covered by any of these strategies. Service coordination and brokering can be covered under TCM and 1915c and 1915i. Skill building services and supportive counseling provided by case managers may be a Rehab Option covered service. Attachment B provides an overview of how these different strategies are used to cover the services set forth in Attachment A.

From a consumer's perspective, these strategies are not mutually exclusive. States may use several of these strategies to cover services that are needed by individuals in PSH. For example, an individual may be participating in a 1915c Waiver and receiving targeted case management and rehabilitative services. States can mix and match these strategies to achieve optimal service coverage.

Each of these strategies is discussed in more detail in the following sections. For each strategy, this report describes the populations generally covered by the strategy, the specific services and interventions that a state may choose to cover, advantages and disadvantages of each approach, and a relevant example of the strategy.

MEDICAID REHABILITATIVE SERVICES

The Medicaid "Rehab Option" has traditionally been used to cover many services and supports especially for individuals with mental illness and/or addictive disorders. All state Medicaid programs have added the Rehab Option to cover mental health. Many states have included this option to cover substance abuse services. It should be noted that CMS has recently developed proposed regulations regarding the "Rehab Option" that will have a significant effect on service coverage, treatment planning and reimbursement of these services. These draft regulations can be found at http://www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2261P.pdf Pages 6 through 41 of the document provides a description of the background and proposed changes for these regulations.

Populations Covered

CMS has not established eligibility criteria for the rehab option. Each state develops specific criteria for an individual to receive any service covered in their "rehab option" or specific criteria for each covered service. For instance, Louisiana requires an individual to meet certain criteria (e.g. diagnosis, functional level and history of mental illness) to receive any or all of the seven services in the Mental Health Rehabilitation Program. Georgia has specific eligibility criteria for each service. The criterion for receiving individual counseling is different than the criteria for assertive community treatment or community support.

Many individuals who need or live in PSH have co-occurring mental health and substance abuse need. These individuals can benefit from integrated treatment and other services and supports that address disability and functional impairments resulting from both disorders. Some states have separate coverage in the "rehab option" for individuals with mental health or addictive disorders. Other states have designed their "rehab option" to cover individuals with an identified behavioral health disorder that includes mental illness and addictive diseases.

Generally, individuals with a diagnosis of mental retardation or a pervasive developmental disorder are not eligible for services under the rehabilitation option. Services for these individuals are often seen as habilitation versus rehabilitation. Habilitation often assumes that the individual is learning or acquiring a new skill whereas rehabilitation assumes that the individual is relearning a skill that was lost or minimized due to their disability. In addition, recipients that have an organic brain disorder (dementia or delirium) or other psychiatric or neurological conditions that prohibit communications may not be eligible for these services.

Description of the Service

Many critical services and supports needed by Medicaid recipients with significant physical, mental health and substance abuse needs can be covered under the Rehabilitative Services program. Over the past decade many states have used the rehabilitation option to finance various services that support individuals with mental illnesses and addictive disorders to function more independently in the community.

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[4] initiative for adult consumers and the Children's System of Care[5] initiative began to change service coverage dramatically. In the late 1980s and early 1990s some states were adding community support, skill building, and behavior management as covered services under the Rehab Option. During the 1990s, states also added crisis services, residential supports, and group skill building, 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:

- ***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.
- ***Community Supports*** — More than ten states have included this "active case management" 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.
- ***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.

[4] The Community Support Programs foster integrated systems of community services and rehabilitation, identify the best and most cost-efficient ways to help people who have serious mental illnesses, and help States and communities put consumer-driven methods into practice.

[5] The SAMHSA System of Care approach is a community-based, family-focused service delivery systems providing a comprehensive spectrum of mental health and other service supports, and enabling children with mental health needs to remain within their homes and communities.

- ***Assertive Community Treatment (ACT)*** — Several states have included ACT in their Medicaid program. A few states have modeled their definitions and requirements for this service consistent with standards established by the National Mental Health Association and the Substance Abuse and Mental Health Services Administration draft toolkit.[6]

Sample service definitions that are currently used by other states in their "Rehab Option" are included in Attachment C.

Over the past several years, the role of peer delivered services has grown exponentially under the Medicaid Rehab Option. Several states 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.

States are allowing (and in some instances requiring) organizations to employ consumers for delivering other services covered under their Rehab Option. These individuals, often referred to as "**peer specialists**," are playing a valuable role in the mental health workforce. These peer specialist provide such services as community support and crisis intervention.

Advantages/Challenges

Many states have used their "Rehab Option" to cover a variety of services and supports that could be used for individuals in PSH. There are several advantages in deploying this option. For instance:

- Services covered under the "Rehab Option" provide a more flexible benefit than either Targeted Case Management or services provided in outpatient clinics.
- These services can be provided in other locations in the community, including in the person's home or other living arrangement if the state plan provides for this.
- 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). This is in contrast to other Medicaid services that require licensed or practitioners with specific credentials to provide a service.

States have experienced several challenges with the "Rehab Option." These challenges include:

- There may be a lack of clarity regarding the covered service interventions. A state's service definition may be too broad and the intervention may be seen as "maintenance" rather than rehabilitative. In some instances the federal

[6] 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

government has disallowed Medicaid reimbursement for recreational and social programs that were not focused on rehabilitation. In these instances, states were required to pay-back significant amounts of the FFP.

- States may not have the match needed to continue to cover current services or offer new services. In some instances, states experienced a significant increase in the expenditures for "rehab option" services. This required additional general revenue funds for state match. In most instances new state match dollars were not available. Therefore states use existing general revenue funds. The unintended consequence is that less general revenue funds are available for services not covered by Medicaid or for individuals that were indigent and did not qualify for Medicaid.
- Interventions covered under the "rehab option" may require more workforce development than medical or case management services. As states continue to finance evidence-based practices through the rehab option, initial and ongoing workforce development will require significant resources.

Relevant Example

The state of Georgia has used the "rehab option" to develop a broad array of community-based services for individuals who need mental health and/or addiction services. Over the past eight years, the state has submitted state plan amendments to add new services that reflect current evidence-based or promising practices as well as eliminate services that had little therapeutic or rehabilitative value. For instance, the state no longer covered day treatment programs and focused on developing structured psychosocial rehabilitation programs and developing more flexible groups based on a consumer's needs and preferences. In addition, Georgia was the first state to cover peer services. They also implemented a statewide community support program that allowed flexible supports and services to individuals when and where they lived. Over the past year, CMS has asked the state to revise its rehabilitation program. They specifically raised concerns about services provided in various residential settings (paying for services provided in an IMD and rates that may have included room and board). Georgia's proposed changes to their rehabilitation option is presented in Attachment D.

MEDICAID TARGETED CASE MANAGEMENT

Targeted Case Management (TCM) is an activity that assists individuals eligible for Medicaid in gaining access to necessary care and services appropriate to the needs of an individual. Case management services are referred to as targeted case management services when the services are provided only to a defined or "targeted" group of people versus every Medicaid recipient. The state can also be prescriptive as to who can provide targeted case management services. This flexibility enables states to target case management services to specific individuals or to individuals who reside in specified geographic areas. The purpose of targeted case management is to assist Medicaid recipients in gaining access to needed medical, social, educational and other medically necessary services. Targeted case management programs are authorized under Section 1915 (g) of the Social Security Act.

The overall impact of a targeted case management program can result in improved quality of life and functioning for an individual. A common parallel in the medical arena is disease management. If you are managing the care of an individual with multiple health issues like diabetes, obesity and coronary artery disease, it is important that the person's treating professionals are communicating with each other, appointments are kept, medication taken, medication monitored, and so forth. The net effort of providing these supports is improved the health, quality of life and ultimately to lower the cost to health care and the cost to the individual. Targeted case management when provided correctly provides supports until the person or the person's natural support system is strong enough.

The Deficit Reduction Act of 2005 makes certain changes to the Targeted Case Management program. Specifically the DRA redefines the Medicaid TCM benefit, and restricts the ability of states to use Medicaid TCM services when case management is also reimbursable by another federally-funded program. In addition, the DRA caps the federal matching rate of TCM to 50%. Currently the federal share of TCM is matched at a state's FMAP rate that varies from 50% in one state to nearly 80% in another state.

Populations Covered

Targeted case management involves the provision of services to a particular population such as seniors, adult parole, children in foster care, or persons with disabilities including individuals with an addictive disorder. States can define the group or groups that can receive targeted case management as long as they are otherwise eligible for Medicaid. States often use targeted case management for individuals that have significant medical or mental health conditions, HIV/AIDS, developmental disabilities, or other conditions that require them to be treated by multiple health care providers.

Description of Services

Targeted Case Management (TCM) is the provision of case management, defined as services that assist eligible individuals in gaining access to needed medical, social, educational and other services. The DRA of 2005 clarified that the following activities would be covered under TCM:

- Assessment of an eligible individual to determine service needs by taking a client history, identifying an individual's needs and completing related documentation, and if needed, gathering information from other sources.
- Development of a specific care plan based on the information collected through an assessment that specifies the goals and actions to address the individual's needs.
- Referral and related activities to help an individual obtain needed services.
- Monitoring and follow-up.

Medicaid will not reimburse for targeted case management services under certain conditions. For instance, Medicaid will not reimburse targeted case management for transporting recipients. Medicaid will generally not reimburse targeted case management

services provided by more than one case manager to the same recipient.

In 2007, CMS developed new regulations for Targeted Case Management. These rules are still under review. The regulations include a lengthy definition of what constitutes case management under Medicaid. It is a restatement of previous federal policy. The major changes are:

- Strict limitations on when child welfare agencies, juvenile justice and other agencies may bill for case management or targeted case management.
- Limitations on when schools may bill for case management, which will deny reimbursement for case management for any child in school until the child has a special education program that includes case management as a necessary service.
- Requirements that no individual have more than one case manager, even when the person has a combination of impairments (such as mental illness and HIV/AIDS, or mental retardation and a severe medical condition).
- Restrictions on payment methodology and units of service for case management that require fee-for-service payment only and payment for 15-minute units of service.

Advantages

- TCM provides assistance to Medicaid eligible individuals in gaining access to "medical, social, education, and other services" whether or not the services are covered under Medicaid. This is particularly important for individuals who are in permanent supportive housing who can use this benefit for case management services to access and retain housing and non-Medicaid supports (e.g. employment, child care).
- Under TCM, states have the ability to define who is a qualified case manager and require specialized experience and/or expertise appropriate to meeting the needs of the target group.
- Defining a target population allows the state some predictability in the number of individuals that might access the services.

Challenges

- Targeted case management is not always seen as a recovery-oriented approach. Case managers may perform functions on behalf of the individual rather than assisting the individual to learn the skills to access services and supports.
- Medicaid will not reimburse targeted case management services for the provision of hands-on, direct therapeutic medical or clinical services (e.g., providing psychotherapy or skill building services); however these might be reimbursable as rehabilitation services.

- The Targeted Case Management program continues to receive great scrutiny from CMS. Therefore Medicaid authorities and other state policy-makers may be reluctant to pursue this option.

Recent State Example

Florida is a good example of a state's Targeted Case Management program. Services are offered to several different "targeted" populations including children, adolescents and adults. Services may be provided by an individual or as a team when short term intensive case management is needed. The primary goal of targeted case management is to optimize the functioning of recipients who have complex needs by coordinating the provision of quality treatment and supportive services in the most efficient and effective manner.

To receive targeted case management services in Florida a recipient must be an adult (18 and over) with serious mental illness. To receive TCM services an individual's mental illness must be "certified" by the Florida Administration for Health Care Administration (AHCA) To be certified to receive TCM services, an individual must have a disability that requires advocacy for and coordination of services to maintain or improve level of functioning. The disability must last for a minimum of one year. In addition, the individual must require services to assist in attaining self-sufficiency and satisfaction in the living, learning, work, and social environments of choice and lack a natural support system with the ability to access needed medical, social, educational, and other services. Institutional admissions, crisis admissions and inability to live independently are factors considered in making the decision to provide case management. The intensive case management criteria, for example, include 2 or more hospital or 3 or more admissions to crisis stabilization services in the past 36 months.

HOME AND COMMUNITY-BASED SERVICES—1915C WAIVERS

Prior to the enactment of §1915(c), the Medicaid program provided for little in the way of coverage for long-term services and supports in non-institutional settings. The §1915(c) was enacted to enable states to address the needs of individuals who would otherwise receive costly institutional or nursing home care by furnishing cost-effective services to assist them to remain in their homes and communities. Services and supports that can assist individuals with certain disabilities to obtain and maintain supportive housing can be accessed through a Home and Community-Based Services Waivers (HCBS). States offer home and community services to individuals who otherwise qualify for services furnished in a nursing facility, intermediate care facility for the mentally retarded or a hospital. Individuals who meet the level of care requirements for these Medicaid institutional settings may instead be offered home and community services when a state operates an HCBS waiver program. Individuals must affirmatively elect to receive home and community services in lieu of institutional services.

A critical component of the 1915c program is the ability for Waiver participants to direct their own care. Participant direction of waiver services means that the individual has the authority to exercise decision making authority over some or all of her/his waiver

services and accepts the responsibility for taking a direct role in managing them. Participant direction is an alternative to provider management of services wherein a service provider has the responsibility for managing all aspects of service delivery in accordance with the participant-centered service plan. Participant direction promotes personal choice and control over the delivery of waiver services, including who provides services and how they are delivered. For example, the participant may be afforded the opportunity and be supported to recruit, hire, and supervise individuals who furnish daily supports. When a waiver service is provider-managed, a provider selected by the participant carries out these responsibilities.

The 1915c Waiver authority may be a promising approach to state to consider for individuals in permanent supportive housing ***if*** these individuals have a history of using nursing home or chronic hospital care or would otherwise be eligible for care in those settings. This may include elderly adults who are homeless with complex chronic health problems or people with HIV/AIDS or other serious medical conditions (in addition to / complicated by mental health or substance use problems) who would otherwise qualify for nursing home or hospital care.

Eligibility/Populations Covered

Federal regulations permit HCBS waiver programs to serve the elderly, persons with physical disabilities, developmental disabilities, mental retardation or mental illness. States may also target 1915(c) waiver programs by specific illness or condition, such as technology-dependent children or individuals with AIDS. States can make home and community-based waiver services available to individuals who would otherwise qualify for Medicaid only if they were in an institutional setting. Montana's Behavioral Health Waiver for Adults with Severe Disabling Mental Illness (SDMI Waiver) established the following eligibility criteria for their Waiver participants:

- "Severe disabling mental illness" means with respect to a person who is 18 or more years of age that the person meets the requirements of (a) or (b) or (c).
    a) has been involuntarily hospitalized for at least 30 consecutive days because of a mental disorder at Montana State Hospital at least once; or
    b) has specific DSM-IV diagnosis of (i) schizophrenic disorder (295); (ii) other psychotic disorder (iii) mood disorder (iv) amnesic disorder (v) disorder due to a general medical condition; or (vi) pervasive developmental disorder not otherwise specified when not accompanied by mental retardation; (vii) anxiety disorder; or
    c) has a DSM-IV diagnosis of personality disorder that causes the person to be unable to work competitively on a full-time basis or to be unable to maintain a residence without assistance and support by family or a public agency for a period of at least 6 months (or for an obviously predictable period over 6 months); and
    d) has ongoing functioning difficulties because of the mental illness for a period of at least 6 months (or for an obviously predictable period over 6 months), as indicated by at least two of the following:

(i) medical professional with prescriptive authority has determined that medication is necessary to control the symptoms of mental illness;

(ii) the person is unable to work in a full-time competitive situation because of mental illness;

(iii) the person has been determined to be disabled due to mental illness by the Social Security Administration;

(iv) the person maintains a living arrangement only with the ongoing supervision , is homeless, or is at risk of homelessness due to mental illness; or

(iv) the person has had or will predictably have repeated episodes of decompensation. An episode of decompensation includes:

- increased symptoms of psychosis;
- self-injury;
- suicidal or homicidal intent; or
- psychiatric hospitalization.

If states are considering a 1915c strategy for similar populations, some of this eligibility criterion may be apropos.

Services Covered

The Act specifically lists seven services that may be provided in HCBS waiver programs: case management, homemaker/home health aide services, personal care services, adult day health, habilitation, and non-medical respite care. Other services, requested by the State because they are needed by waiver participants to avoid being placed in a medical facility (such as non-medical transportation, in-home support services, special communication services, minor home modifications, and adult day care) may also be provided, subject to Centers for Medicare and Medicaid Services (CMS) approval. The law further permits day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness. Examples of supports offered under the HCBS waivers are:

- ***Personal Care Assistance*** is a service that assists a recipient with eating and meal preparation, dressing, bathing, personal hygiene, and activities of daily living. The services may also include vacuuming and bed making when these activities are essential to the health and welfare of the beneficiary and when there is no one else to perform them.
- ***Homemaker Services*** are those household activities such as meal preparation, laundry, vacuuming and routine household cleaning provided by a trained homemaker, when the person who usually handles these tasks is unable to perform them. The intent of this service is to ensure that the beneficiary's home environment remains safe, clean and sanitary.

- ***Companion Services*** consist of supervision and socialization activities and may assist the beneficiary with such tasks as meal preparation, laundry and shopping. This service may also include light housekeeping tasks. Other examples of companion services include going to the library, getting a library card, shopping for groceries, or going to an animal shelter to learn about animals.
- ***Chore Services*** are provided to maintain the recipient's apartment? and property as a clean, sanitary and safe environment. These services include heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, replacing broken windows or moving heavy furniture to make the home safer.
- ***Residential Habilitation Services*** provide specific training activities that assist the beneficiary to acquire, maintain or improve skills related to activities of daily living. The service focuses on personal hygiene skills such as bathing and oral hygiene; homemaking skills such as food preparation, vacuuming and laundry; and on social and adaptive skills that enable the beneficiary to reside in the community.
- ***Support Coordination*** is the service of advocating, identifying, developing, coordinating and accessing supports and services on behalf of a beneficiary, or assisting the beneficiary or family to access supports and services on their own. These services may be provided through waiver and other Medicaid State Plan services, as well as needed medical, social, educational, other appropriate services, and community resources regardless of the funding source through which access is gained. The waiver support coordinator is responsible for assessing a beneficiary's needs, preferences and future goals (outcomes). From that information, the waiver support coordinator assists the beneficiary in developing a support plan and cost plan.
- ***Supported employment*** services provide training and assistance in a variety of activities to support beneficiaries in sustaining paid employment. The supported employment provider assists with the acquisition, retention or improvement of skills related to accessing and maintaining such employment. With the assistance of the supported employment provider, the beneficiary is assisted in securing employment according to their desired outcomes, including the type of work environment, activities, hours of work, level of pay and supports needed. Supported employment is conducted in a variety of settings, to include work sites in which individuals without disabilities are employed.

A state is barred from claiming the costs of "room and board" (e.g., housing and other routine living expenses) furnished to waiver participants. Such expenses must be met from the beneficiary's own resources (e.g., SSI payments) or other funds. In addition, all services provided through a waiver program must be spelled out in a "plan of care." The plan of care must identify other services and supports (paid and unpaid) that are integral to supporting the person in the community. In proposing to operate a waiver program, a state specifies the number of individuals it plans to serve. A state is not obligated to furnish services to additional persons once it reaches its self-imposed enrollment cap.

However, there are no federal limits on how many individuals a state may serve in a waiver program.

Advantages

Only a few states have used a Waiver to cover services and supports that could be used for individuals in PSH (with the exception of individuals with developmental disabilities or HIV/AIDS). States see several advantages in deploying this option. For instance:

- States can cover services that are not included in the state Medicaid program. This includes respite, supported employment, transitional services (including security deposits, initial payments for utilities), and non-medical transportation.
- Self-directing care can be very effective for individuals in permanent supportive housing. Self directed care can result in increased satisfaction and decreased cost when: (a) people directed their own services, and (b) control over the nature, extent, and duration of services was shifted from professional provider organizations to the individuals and/or their families.
- The Waiver provides states with more predictability as to the costs for services and supports. The requirement regarding budget neutrality "caps" how much a state can expend on its HCBS program. It allows states to cap the costs of the program in aggregate rather than capping the costs of each individual participating in the program.

Challenges

- The Waiver sets a limit on the number of individuals that can participate in the program. Individuals that need and are eligible for Waiver services in excess of the state's cap often are placed on a waiting list and receive no or poorer service substitutions.
- States may see Waivers as administratively burdensome. There are additional reporting requirements for states. In addition, states are held to higher quality standards for services provided under the Waiver.
- States have not pursued this option since it is difficult, if not impossible to demonstrate cost neutrality under a 1915c for these individuals due to the IMD regulations.

Relevant Example

In 2007, Montana Department of Public Health and Human Services, Addictive and Mental Disorders Division received approval from CMS for its Behavioral Health Waiver for Adults with Severe Disabling Mental Illness (SDMI Waiver). The SDMI Waiver is designed to provide a consumer with SDMI a choice of receiving long-term care services in a community setting as an alternative to receiving long-term care services in a nursing home setting. The consumer must meet nursing home level of care and reside in an area of the state where the SDMI Waiver is available. The objective of the SDMI Waiver is rehabilitation and recovery, while encouraging the consumer to accept personal

responsibility for services and desired outcomes. The SDMI Waiver will serve 105 individuals per year.

The package of services to be included in the SDMI waiver are: Case Management, Chore, Homemaker, Personal Assistance (and Specially Trained Attendant Care), Adult Day Health, Residential Habilitation, Day Habilitation, Prevocational Services, Supported Employment, Respite, Psychosocial Rehabilitation, Adult Residential Care, Chemical Dependency Counseling, Dietitian/Nutrition/Meals, Habilitation Aide, Personal Emergency Response Systems, Private Duty Nursing (and Registered Nurse Supervision), Specialized Medical Equipment and Supplies, Supported Living, Non-Medical Transportation, Occupational Therapy, Illness Management and Recovery, and Wellness Recovery Action Plan. The specific service definitions are included in their Waiver application at: http://www.dphhs.mt.gov/amdd/services/hscswaiver/waiver applicationsig.pdf.

DEFICIT REDUCTION ACT—1915I

The Deficit Reduction Act (DRA), P.L. 109-171, was passed by Congress and signed by the President on February 8, 2006. The law creates new options for states under the Medicaid program that allow states greater flexibility to furnish community-based services. Section 6086 gives states the ability to provide home and community-based services to elderly individuals and people with disabilities without requiring a waiver or demonstrating cost neutrality.

Section 6086 gives states the option to offer home and community-based services (HCBS) to elderly individuals and people with disabilities with incomes up to 150% of the federal poverty level without requiring a waiver or demonstrating cost neutrality. A state need only amend its Medicaid plan to provide any of the services now covered under HCBS waivers. Section 6086 expands services to populations not previously eligible for HCBS waivers, especially to adults from ages 22 through 64 who have a mental disorder. This section does not require cost-neutrality between the new community services and a covered Medicaid institutional service. This new program is referred to as 1915i State Plan Amendment (SPA). At the time this Guide was being written, only Iowa has an approved 1915i SPA. This Waiver provides case management and habilitation services for adults with serious mental illness.

Section 6086 allows states to limit the number of people served and to maintain waiting lists. States electing this option may also chose to provide the services in limited areas without having to meet Medicaid's state-wideness requirement. States that select this option can then cover (for people it selects as eligible) a range of community services that includes supported employment, respite care, family support and other community services. Services permitted under this option, however, must be services that could have been covered through the HCBS waiver authority. In addition, states may use stricter level-of-care eligibility criteria for individuals it chooses to cover under this SPA. CMS also requires several other key provisions under the 1915i SPA, including:

- The State must establish needs-based criteria for determining an individual's

eligibility for HCBS services.

- Each State must develop an independent assessment process that: determines a necessary level of services and supports to be provided, consistent with an individual's physical and mental capacity; prevents the provision of unnecessary or inappropriate care; and establishes an individualized care plan for the individual.
- The State must include services that are specifically authorized or otherwise included in §1915(c) of the Social Security Act.
- The State may, but is not required to project the number of individuals to be provided home and community-based services.

Participation by an individual in a 1915i program does not preclude the delivery of other Medicaid services that are covered under a state's Medicaid plan. For instance, health and medical services, outpatient mental health and substance abuse treatment, medication administration may be provided to these individuals if they are or continue to be medically necessary.

Possible Populations

Section 6044 of the DRA will allow states to tailor home- and community-based services to the needs of a particular population. Recently approved and proposed 1915i have focused on individuals who have significant mental health and/or addiction service needs. Several states that have developed or are considering a 1915i are developing target population criteria for individuals with serious and persistent mental illness and or addictive disorders. These criteria include individuals who:

- Have undergone or are currently undergoing psychiatric or addiction treatment more intensive than outpatient care, more than once in a lifetime (e.g., emergency services, alternative home care, medical detoxification, intensive outpatient services, partial hospitalization or inpatient hospitalization).
- Have a history of psychiatric and/or substance abuse disorder resulting in at least one episode of continuous, professional supportive care other than hospitalization.
- Demonstrate a need for assistance by some of the following criteria on a continuing or intermittent basis for a specific length of time (e.g. at least two years):
    - Is unemployed, or employed in a sheltered setting, or has markedly limited skills and a poor work history;
    - Shows severe inability to establish or maintain a personal social support system;
    - Requires help in basic living skills such as self-care, money management, housekeeping, cooking, or medication management;
    - Exhibits inappropriate social behavior that results in demand for intervention.

Using these criteria a state could construct a screening and assessment process to identify those individuals that would participate in their 1915i program.

CMS has recently drafted proposed rules that would amend the Medicaid regulations to define and describe home and community-based State plan services implementing new Section 1915(i). These proposed rules can be found at [Federal Register: April 4, 2008 (Volume 73, Number 66)][Proposed Rules] [Page 18675-18700].These can be found from the Federal Register Online via GPO Access [wais.access.gpo.gov.

Services

States that develop a 1915i for a specific population can offer a range of community services that includes supported employment, personal care, psychosocial rehabilitative and other community services. Services permitted under this option, however, must be services that could have been covered through the HCBS waiver authority. A potential taxonomy that states may consider for 1915i services and supports for individuals with serious and persistent mental illness and or addictive disorders could include:

- Community Support consisting of rehabilitative or habilitative services and supports necessary to assist the person in achieving rehabilitative and recovery goals. The service activities of Community Support consist of a variety of interventions: identification and intervention to address barriers that impede the development of skills necessary for independent functioning in the community; participation in the development of the consumer's service plan, and one-on-one interventions with the consumer to develop interpersonal and community coping skills, including adaptation to home, school and work environments; symptom monitoring and self management of symptoms. The focus of the interventions comprising Community Supports include, minimizing the negative effects of psychiatric symptoms and addiction that interfere with the consumer's daily living, financial management, and personal development; developing strategies and supportive interventions for avoiding out-of-home placements for adults; assisting consumers to increase social support skills that ameliorate life stresses resulting from the consumer's disability and coordinating rehabilitative services in the service plan.
- Peer and Recovery Support Services are provided to support the recovery of individuals with mental illnesses and/or addictive disorders. Services are directed toward achievement of specific goals as defined by the individual and specified in an individual's service plan. Services are multi-faceted and include: advocacy; crisis management support; skills training and coordination and linkage with other necessary services and resources. Peer support services are delivered by trained self-identified individuals with mental illness or an addictive disorder. Services are person-centered with a recovery focus. Services are provided one-to-one, in groups, with team members in community settings, or the individual's natural environment.
- Supported employment services consisting of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their

disabilities, need supports, to perform in a regular work setting. Supported employment may include assisting the participant to locate a job or develop a job on behalf of the participant. Supported employment is conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by participants, including management of symptoms and developing and sustaining relationships with co-workers and management.

- Personal Care Services that consist of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.
- Assertive Community Treatment for consumers discharged from a hospital after multiple or extended stays, or who present various challenges to engage in treatment. ACT includes a comprehensive and integrated set of interventions provided in non-office settings, 24-hours/seven days a week. Service interventions offered through ACT include, as medically necessary: medication administration and monitoring; self-medication training and support; 24/7 intervention; symptom assessment, management and individual supportive therapy; substance abuse training and counseling; psychosocial rehabilitation and skill development; personal, social and interpersonal skill training; consultation, and psycho-educational support for individuals and their families.

Advantages

The HCBS option has some advantages not available under a waiver.

- Unlike the option, waivers are generally limited to three or five years, requiring states to ask for renewals. With the HCBS option, once a state plan has been approved, any changes to it must be reviewed and approved by CMS. However, once a state has received approval from CMS, no further permission to offer the benefit is required.
- The 1915i does not limit beneficiaries who need home-based services to those who would need institutional care without them. Under the option, States can now provide home- and community-based care to those who may not yet be at risk for immediate institutionalization and for people with severe mental illness (for whom care at an IMD would not be a Medicaid cost).
- States can cover services that are not included in the state Medicaid program but are statutory services, meaning the services specifically contained in §1915(c) of the Act and 42 CFR §440.180. This includes respite, supported employment, and personal care. However, a state cannot cover some other services that would be allowed under the 1915c authority (e.g. transitional services).
- States can also choose to offer 1915i services in select areas of the state versus other state plan services that have to be available statewide.

The challenges presented by a 1915i include:

- The HCBS option does have some limitations that a waiver does not. The option is limited to individuals whose incomes do not exceed 150 percent of the Federal poverty level (FPL), whereas waivers 1915c can include individuals whose incomes are as high as 300 percent of SSI income.
- States may not waive comparability (i.e. a state must provide comparable services to all eligible individuals and may not limit services based on diagnosis, type of illness or condition).
- Similar to the 1915c, States may see this option as administratively burdensome. For example, there are additional reporting requirements for states (but not as many as the 1915c). In addition, states are held to higher quality standards for services provided under this option and other management issues are emerging as states begin consideration of this option.

Relevant Example

Iowa is the first state to receive federal approval for a HCBS state plan amendment (approved in early April, 2007). Iowa did not limit service availability geographically—services will be available statewide. However, Iowa has set enrollment caps and there will be a waiting list for the HCBS. The state plans to serve 3,700 people in the first year, with the number of participants increasing to nearly 4,500 in the fifth year.

Financial eligibility is connected to existing Iowa Medicaid eligibility rules, and individuals who are covered by Medicaid as medically needy will be eligible. The needs-based criteria limit services to those with a history of mental illness. In addition, the functional eligibility criteria are more restrictive than eligibility criteria states generally use for rehabilitation services. Iowa did not elect to employ a participant-directed service model. The Iowa 1915i requires the service plan to be developed by the participant and his/her interdisciplinary team. This team consists of the participant, a legal representative if applicable, the case manager and anyone else, including providers, the participant would like to have involved. The interdisciplinary team then develops a service plan based on the participant's strengths, needs, and goals. Individuals participating in Iowa's 1915i will be offered case management and habilitation. Habilitation services are divided in four components:

- Home-based habilitation
- Day habilitation
- Prevocational habilitation
- Supported employment habilitation

Home-based habilitation assists with skills related to living in the community, day habilitation offers support with socialization and adaptive skills and takes place in a non-residential setting, prevocational habilitation helps prepare individuals for employment,

and supported employment habilitation provides assistance in the work setting to help individuals maintain a job.

SECTION 4
Charting Your Course

States may pursue numerous strategies for developing a Medicaid reimbursable benefit package for individuals who need permanent supportive housing. The strategies discussed in this paper offer the most promise for Medicaid-reimbursable services and supports needed by these individuals. It should be noted that these strategies are not mutually exclusive. For instance, many states cover both some case management functions under Targeted Case Management and other treatment and recovery services under the Rehabilitation Option. There are several steps that state policy-makers can take to determine how to best mix and match its Medicaid strategies to optimize service coverage. Each of these steps are described below in more detail.

Step 1: Clearly Define the Proposed Population

This step is really the foundation to any Medicaid proposal for enhancing service coverage. It will be necessary to define the proposed population succinctly. Once defined, the characteristics of this population will drive the service taxonomy and both will drive the Medicaid strategy. For instance, homeless seniors with disabling medical conditions or homeless adults with multiple chronic health conditions may suggest that a state pursue a 1915c for these individuals since they may be at significant risk for admission to a chronic care hospital or a nursing facility. Individuals with complex co-occurring disorders, especially individuals with significant mental health and substance abuse treatment needs may benefit from services provided under the Rehab Option.

Therefore it may be helpful for states to consider the three "Ds": diagnosis, disability and duration when defining their target population.

Often an individual's diagnosis group will affect the strategy that a state Medicaid agency will consider for individuals in permanent supportive housing. For instance, individuals with a diagnosis of mental retardation, developmental disabilities, HIV/AIDs or traumatic brain injured may be viewed as ideal candidates for a 1915c Home and Community Based Waiver and/or Targeted Case Management. As previously indicated, the 1915c strategy allows states to develop and tailor a service package that is not covered under the mandatory and optional services. The same is true for TCM since this state plan option allows states to specifically target individuals with certain diagnosis. For individuals with significant behavioral health needs, state may consider using the Rehab Option given CMS focus on covering recovery-oriented services in its proposed rules regarding this state plan service.

In addition to, or in lieu of, diagnosis to describe the proposed population, it may be beneficial to define their "disability." This would include defining the functional characteristics of the intended population. This could include characteristics used by some states: basic living skills (e.g. self-care, money management, medication

management), extensive use of inpatient hospitalization or crisis services, and functional assessment scores. In some instances the functional criteria may be the eligibility criteria to get all services (e.g. 1915i services or for a states Medicaid Rehabilitation Option program) or can be applied to a specific service. For instance, some states apply specific functional criteria for more intensive services (e.g. Assertive Community Treatment) rather than all services covered in a state MRO.

Duration may also be included in the description of the target population and will impact the strategy that the state may use to rethink its service coverage. For many individuals in permanent supportive housing, the general premise is that occupancy and supportive services are not time limited. States need to be cautious projecting Medicaid reimbursement to sustain the ongoing supportive services in PSH. Tenants may lose Medicaid eligibility or they may meet the established medical necessity criteria episodically.

For populations that may need continuous home and community-based services for long periods of time (several years or indefinitely) the 1915i or 1915c may be a more suitable Medicaid strategy. Populations that may need treatment and support services for a shorter period of time (several months to a few years) may indicate the use of rehabilitative services or intensive case management offered under TCM.

The reader should do an analysis of what populations are not being well served by the services that are now covered in their state's Medicaid program. They should undertake a thorough analysis of the state's Medicaid eligibility criteria and any program or service specific criteria that has been established that limits an individual's ability to benefit from current or new services. Readers will need to make the business case for making changes to the target population for services covered under the various Medicaid programs (e.g. rehabilitation option, targeted case management)—especially those individuals who are particualry vulnerable and/or for whom costs of current services are high. State policymakers may be persuaded to make changes to the criteria used to define eligibility for services if a business case can be made. For example, individuals who are currently receiving high cost services in hospital emergency rooms, crisis treatment facilities, or inpatient hospital settings, may be more effectively served if they are eligible for community support Medicaid services that could be linked to housing. Any new criteria for describing the target population for Medicaid services will need to be clearly defined. Some possible criteria could include:

- Having a mental illness, including serious mental (Axis I or Axis II) illness, depression, PTSD, etc.
- Having a substance use disorders including substance dependence and substance use problems that interfere with health / appropriate utilization of health services
- Having a chronic and/or life-threatening diseases that require ongoing management of symptoms, medications, health care, and changes in lifestyle or risk-related behaviors (e.g. HIV/AIDS, hepatitis, diabetes, heart disease, hypertension, emphysema, asthma, cancer).

- Having a developmental disabilities or substantial cognitive impairment resulting from brain injury.

In addition, the criteria could include additional conditions that may succinctly define the target population for existing or new services. This could include some of the following conditions:

- Individuals with co-occurring disorders (2 or more of the conditions listed above).
- Moderate to severe symptoms or functional impairments due to one or more of the conditions listed above.
- 2 or more hospitalizations, or 4 or more emergency room visits in past 18 months.
- Homeless or at high risk of homelessness due to residential instability.
- History of inadequate follow-through with elements of a Treatment Plan related to risk factors (including lack of follow through taking medications or keeping appointments for outpatient care, following a crisis plan, or maintaining housing.
- Consistent or intermittent non-adherence to prescribed medication or other prescribed treatment for serious health conditions, resulting in significantly increased risk of avoidable hospitalization, emergency room visits, serious health consequences, or death.
- Legal issues (conditional release; parole or probation).
- Individual needs assistance with daily living skills including coordination to gain access to necessary rehabilitative and medical services.
- Self harm or threats of harm to others within the last year.
- Involvement in child welfare system (as a parent or as a child) within the past 24 months.

In addition to defining the target population, it may also be helpful to consider strategies for Medicaid eligibility for individuals that may need permanent supportive housing. Initially, a state may want to perform an analysis of how many individuals that could benefit from permanent supportive housing would be Medicaid eligible before defining the target population, developing service descriptions or specific Medicaid state plan changes. If the Medicaid penetration of individuals in PSH were low, this may be due to state plan coverage or other issues (e.g. potentially eligible individuals didn't apply for benefits). If the analysis indicated the latter, the state may want to consider an approach that would help supportive housing providers maximize the number of people who are enrolled in SSI/Medicaid. Since SSI and Medicaid eligibility are intrinsically connected, becoming eligible for SSI is the stepping stone to becoming eligible for Medicaid. The SSI/SSDI Outreach, Access and Recovery (SOAR) technical assistance project has several strategies that can improve access to SSI/SSDI benefits for individuals in PSH. The SOAR website is http://www.prainc.com/SOAR.

Step 2: Identify the Service Coverage

Once the population has been defined, the next step is to identify the services that would be needed by the population. The taxonomy provided in Attachment A provides a good framework for the services needed by individuals who need PSH. Policymakers are encouraged to consider the whole continuum of services and supports that are needed by this population and not just those services that may be covered under Medicaid. Far too often, advocacy organizations and policymakers will focus on developing a taxonomy that is driven by potential reimbursement rather than a "fearless" inventory of services needed by a particular population.

The next step is to determine which service could be covered under the state's Medicaid program. The matrix in Attachment B provides guidance and a crosswalk to policymakers regarding which services may be a covered Medicaid service. In addition, it provides some guidance regarding the strategies a state may consider for enhancing its coverage to include these services (e.g. TCM, Rehab Option, 1915 c or 1915i)..

The final step is to define the covered services. This is more "art" than science. There is some consistency across state's states service definitions. However, a review of the service description contained in state's 1915c Waivers, TCM and MRO Medicaid plans demonstrate the adage "if you see one state's plan (or Waiver), you have seen one state's plan." Many of these definitions were developed years (or decades) ago and may need to be re-examined for the population and the evidence-based and promising practices that have emerged in health and behavioral healthcare. In the future, some services currently covered under the "Rehab Option" may no longer be. The proposed "Rehab Option" rules will require CMS to review current state plans to determine if they are consistent with the federal intent for the program.

When reviewing or developing new service definitions, policymakers should answer the following questions:

- What is the intent, purpose, features, use and expected outcomes of the service?
- What are the programmatic requirements? This may include:
    - Types of allowable interventions (e.g., face-to-face, collateral and phone contact);
    - Services are mostly delivered in the community versus the clinic or facility;
    - Operating hours (i.e., operating a certain number of hours/week, weekends, evenings); and
    - Minimum contacts (week/month).
- What are the required or allowable staff credentials for delivery and supervision of each service, staff ratios, schedules, and training requirements? States would rely heavily on their practice act regulations that specify the credentials of individuals that can provide primary care and behavioral health services.

- Will there be annual (or other period of time) service limits (if any)?

It should be noted that CMS has developed some standardized definitions for 1915c services. The §1915(c) Home and Community-Based Waiver Application (Version 3.4), Appendix C has service description for most Waiver services. Many of these definitions could also be used for states that are interested in pursuing 1915i. The following link contains information on the 1915c Waiver and definitions http://www.hcbs.org.

Recent service descriptions developed by states include information disseminated by SAMHSA and 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 North Carolina, and Illinois. Attachment C provides information to access these descriptions.

Step 3: Understanding Your State's Current Coverage (Populations and Services)

The next step is to determine whether the proposed population and service coverage are included in your state's current Medicaid state plan. Unfortunately, there is no one website that has each state's Medicaid plan. In addition, these state plans are voluminous and confusing. Continuous changes and amendment to a state plan sometime can make it difficult for the average individual to read and track. CMS does have information regarding (or links to) most states 1915c programs. The CMS website for Waiver information is http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp.

Perhaps the best description of a state's coverage for mandatory and state plan services is your State Medicaid Agency's website. In most instances, the Medicaid agency has a provider manual that is specific to each category of covered service. For instance, there is a section or separate manual for targeted case management, rehabilitative services, outpatient hospital and physician services. These manuals often describe the Medicaid covered services in more detail than the state plan language. Policymakers are encouraged to review the proposed services against those services described in the Medicaid state plan or provider manual. In some instances, there may be several "grey" areas regarding coverage—where current services may seem to cover services proposed in your taxonomy. In these instances, it is best to discuss this service with state Medicaid staff who are familiar with and manage the Medicaid program.

Financing and Resources that Can Support Your Strategies

The next step is to determine the cost of you proposed strategy. Cost-effectiveness and cost-offset information can be persuasive to Medicaid authorities when discussing new

coverage. In addition, policymakers will also have to address various risks for enhancing coverage. For instance, new coverage creates additional financial exposure for the state. As previously indicated, states will need to identify the state match for new services. They will also have to identify audit and program integrity strategies that will need to be deployed to ensure that providers keep what they bill. Recent audits by the federal Office of the Inspector General (OIG) have required that states "pay back" FFP when the OIG determined that medical records did not supported the payments reported to CMS.

Regardless of which strategy a state pursues, they will still need to determine the cost of any Medicaid program strategies that increases or changes population or service coverage. Depending on the proposed strategy, CMS will require the state Medicaid agency to provide multi-year cost projections (e.g. three to five years). . These cost projections often take into account the number of individuals served, number of service units provided and the reimbursement rate for each service.

Recently, CMS has provided states more guidance regarding rate setting for various support services—often requesting the state to develop statewide rates for each service by practitioner or practitioner type (e.g. licensed clinician, bachelor-degreed staff and paraprofessionals or peer specialists). In addition, CMS is requesting that states develop rates for 15-minute increments for most services covered under their "rehab option." This is presenting various challenges to states that cover rehabilitative services provided by a team of individuals (mobile crisis and Assertive Community Treatment) and services that were previously reimbursed on an hourly or per-diem basis (e.g. crisis residential).

Perhaps the most important financing issue is identifying the state match needed for enhanced service coverage. The Medicaid program is funded through federal and state dollars. Federal regulations *require* the single state Medicaid agency to share in the costs of Medicaid expenditures and *permit* other state and local governments to participate in the financing of the non-federal share of Medicaid expenditures. Each state's level of federal Medicaid funding, also known as the federal medical assistance percentage (FMAP) rate is based on the state's per capita income. Consequently, FMAP rates to lower income states is higher than FMAP rates to higher income states but fall within the range of fifty per cent (minimum federal share) to a maximum of seventy-eight percent (maximum federal share). In general, for federal Medicaid funds to be drawn down, a state must ensure that payment is rendered to a Medicaid provider for a Medicaid reimbursable service provided to a Medicaid eligible individual. Federal regulations also require that payments made to providers for services rendered must represent full payment for the service (i.e., providers may not be paid only the non-federal share while either the state or locality awaits federal funds to make up the difference to the provider). The federal share serves as a *reimbursement* for expenditures previously incurred by the state. This means that providers must have already received 100% payment for services at the established Medicaid rate. Once payment is made to the provider the single state Medicaid agency can claim for reimbursement of the federal share.

State Plans must provide that state funds will be used for both medical assistance (e.g.,

direct health care services) and administration (42 CFR 433.53). State Plans must also provide that state funds will be used to pay at least forty (40) percent of the non-federal share of total expenditures under the State Plan. This means that in the aggregate, other public funds (e.g., local funds) used to match federal Medicaid funds cannot exceed (60) sixty percent of the non-federal share of total Medicaid expenditures. For example, a state has total Medicaid expenditures in a given fiscal year of $10 million. The FMAP rate for the state is fifty (50) percent, or $5 million. The state matching funds required is also $5 million, of which, $2 million is required to originate from state funds. The remaining 60%, or $3 million, may be from other sources (e.g., other public funds).

Example

Total State Expenditures	Federal Share	Non-Federal Share	
	FMAP Rate – 50%	Matching Rate – 50% $5 Million	
		Amount of matching funds required to be from state funds	Amount of matching funds that may be from other public sources
$ 10 Million	$5 Million	$2 Million	$3 Million

State Plans must also provide that state and federal funds will be allocated among the political subdivisions of the state on a basis, which ensures that individuals in similar circumstances will be treated similarly throughout the state.

States must decide who will be responsible for providing the match for service coverage. The state Medicaid agency often provides the state match for most primary and acute care services. For other services and supports, other state agencies are becoming increasingly responsible for providing some or all the match for these services.

Policymakers will need to identify the fund source(s) for the state match to support the new service coverage. There are limited choices: either new funds must be appropriated or current funds will need to be "earmarked" for state match. Each option has various challenges. Most states budgets are not experiencing much growth. Where there is new growth, these funds are generally used for other priorities such as education, infrastructure (roads and bridges) and corrections.

Many states have identified current funds for potential state match for new services. This strategy has various practical and political consequences that states must weigh prior to finalizing any match decisions. Current funds that are supporting other services may need to be shifted to support new services. This may require the state to buy less of certain services to generate the match for new services. Reducing expenditures for current services must be done thoughtfully—preparing consumers and providers for this shift. In addition, it may take a full year to plan this strategy to shift funds to new services. Often this requires contracts to be changed and consumers to be offered new service options. In addition, the state agency responsible for generating the match is

agreeing to assume risk for the costs of these new services. For instance, if the state match for new services was projected to be $2M and the actual state share is $3M, the agency responsible for match will need to identify an additional $1M in their budgets to cover the match.

There have been a number of concerns that various federal agencies have identified that are beginning to impact state's decisions regarding matching fund strategies. For instances, Intergovernmental Transfers have been the subject of federal scrutiny as some states have utilized intergovernmental transfers as a means to pay less than their statutorily required forty percent, thereby shifting a larger portion of Medicaid costs to the federal government. CMS determined through its review of some states that the states "utilized financing techniques that did not comport with the intent of the Federal-state partnership." Specifically, CMS has discovered that several states make claims for Federal matching funds associated with certain Medicaid payments, payments of which the health care providers are not ultimately allowed to retain. Instead, through the IGT process, state and/or local governments require the health care provider to forgo and/or return certain Medicaid payments to the state (on the same day in many instances), which effectively shifts the cost of the Medicaid program to the Federal taxpayer. Health care-related taxes and provider-related donations have also been subject to federal scrutiny and provider-related donations are limited to a very few circumstances.

Reimbursement Methodologies

Developing a reimbursement methodology is also a critical financing issue for states. CMS generally allows states discretion to set reimbursement rates for Medicaid-covered services. However, CMS states must follow a few federal guidelines when developing their reimbursement methodologies:

- The state plan must describe the policy and methods used in setting rates for each type of service.
- The methodology used to calculate reimbursement rates must be consistent with efficiency, economy and quality of care**.**
- States must assure appropriate audit procedures if payments are based on the cost of services.
- Payments must be sufficient to enlist enough providers so that recipients can access services available under the Medicaid plan.
- The Medicaid agency must provide notice of any significant proposed changes in its reimbursement methodology.
- Providers must accept payment in full and may not bill individuals for amounts above the Medicaid rate.

The methodology used by states to set reimbursement rates must strike a balance between providing adequate financial incentives for an agency or professional to provide the

service and ensuring that states are not "overpaying" for services. States use a variety of methodologies to set rates, including fee schedules, cost-based reimbursement (prospective and retrospective), case rates, and capitation. Regardless of the methodology used, however, states must demonstrate that they have adequately considered the relationship between reimbursement rates and efficiency, economy, and quality of care.

States must describe their rate-setting methodology in Medicaid state plan amendments. Most states use a fee-for-service methodology. 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. The methodologies used to determine a provider's rate for a service vary among states. Generally, states use one or a combination of several options for developing rates.

COST REPORTS

Many states require Medicaid providers to submit periodic reports on the cost associated with the delivery of a specific service. These reports are a consistent and acceptable source of data that can be used to analyze a program's costs in order to establish reimbursement rates.

Not all provider costs may be allowable in the calculation of a rate for a particular service. Federal regulations bar consideration of certain categories of provider costs. States issue specific guidelines on what costs can be included, taking into account the federal limitations and sometimes adding additional state-level limits. Medicare program guidelines and principles for allowable costs usually form the basis for state guidelines. Typically, those costs that a prudent practitioner would reasonably and necessarily incur to provide the service are allowable.

States generally include various program and administrative costs when setting reimbursement rates. Programmatic direct costs include the allowable salaries, benefits and other costs of the program directly related to the delivery of the service.

States also allow certain indirect costs to be considered in the rate setting process. These indirect costs, while not directly part of the service, support program operations. These indirect costs include salaries and benefits of administrative and support staff, building and equipment maintenance, repair, depreciation, insurance expenses, employee travel and training expenses, utilities and supplies.

Some, but not all, states pay 100 percent of providers' Medicaid-allowable costs. In many instances, the state will pay the lesser of a provider's costs or a maximum percentage of allowable costs, which is usually set by the states at 85 to 95 percent of allowable provider costs.

Cost reports are usually developed on an annual basis and audited by the state to ensure accuracy and to inform reimbursement rate adjustments. Rates based upon cost reports can be applied statewide or to specific provider categories. Some states employ a cost settlement process to retroactively adjust payments to Medicaid providers. The

retroactive adjustment represents the difference between the amount received by the provider the previous year and the amount determined to be the provider's actual costs for delivering services. Some states make these adjustments only downward, while others will furnish the provider with an additional payment to cover costs that had not previously been accounted for.

Retroactive settlements may be significant, but not occur until several years have passed from the relevant cost period. This can impact the state agencies' budgets and provider revenues in unforeseen ways.

BUDGET MODELING

Some states collect budget, utilization and productivity information from agencies to establish a rate for a service. Similar to the cost reporting process described above, agencies must submit information annually on a standard form to the Medicaid agency or mental health or substance abuse authority. Using the collected data, states attempt to identify allowable and non-allowable budget line items to be considered in the rate-setting process. These states may also establish various "reasonableness" thresholds for certain budget items. For instance, states may only allow providers to budget up to a certain percentage of their costs for administration. Statewide budget averages derived from the collected data can be used to develop a unit rate to be paid to all service providers in the state.

USUAL AND CUSTOMARY CHARGES

States may develop a rate based on what programs charge for services. These states identify what are usual and customary charges for various professional and administrative components for providing the service. States that use this methodology must identify the percentage of customary charges that will be used for their rate-setting methodologies. Most states that use this methodology reimburse providers between 65 and 100 percent of their usual and customary charges, with most paying below 100 percent.

Reimbursement based on charges may not always be economic and efficient. Since no specific guidelines for practitioners exist to establish charges, providers may charge states more than is reasonable. As a result, states often include a maximum fee and pay either the provider's charge or the fee, whichever is less.

Medicare Reimbursement Methodology

Several states have applied Medicare methodology to develop a fee schedule for their Medicaid program. The Medicare program is a 100 percent federally funded insurance program for people over age 65 and individuals with disabilities who have worked and paid into the program enough to qualify for Medicare. The Medicare program covers a limited benefit for many of the services discussed in this paper. Since many of the licensed professionals who provide Medicaid services-- physicians, physician assistants, clinical social workers, psychologist, nurse specialists and practitioners-- are also eligible

to provide Medicare services, some states have concluded that published rates for comparable services provided through Medicare can, with some adjustments, be used as a good approximation to determine reimbursement rates for Medicaid.

In some instances, states have adapted the resource-based relative value scale (RBRVS) from the Medicare program for use in state Medicaid fee-for-service programs. In the RBRVS system, payments for services are determined by the resource costs needed to provide them. The cost of providing each service is divided into three components: practitioner work, practice expense and professional liability insurance. Payments are calculated by multiplying the combined costs of a service by a conversion factor (a monetary amount that is determined by the CMS). Payments are also adjusted for geographical differences in resource costs.

However, adoption of the Medicaid RBRVS methodology for some services needed for individuals in permanent supportive housing may not be appropriate. RBRVS is a practitioner-based payment methodology and does not account for services that are provided by a team of individuals or for program-based services, such as treatment services provided in a crisis residential program or a psychosocial rehabilitation program. In addition, the RBRVS is based on services delivered by a practitioner in a clinic setting and may not adequately account for services that are provided in a person's home or other natural community settings.

Recently, CMS has requested that states provide more clear descriptions of their reimbursement methodology for state plan amendments and waivers. They are specifically requesting that states provide this information when submitting a state plan amendment or Waiver request. The description of the reimbursement methodology should provide detailed information on salaries, direct costs and administrative costs and can account for productivity especially for services that are provided in the community.

Assessing the Relationship between Medicaid and Other Agencies

A key factor to the success of any multi-agency Medicaid initiative is a solid working relationship between state human service agencies and the single state agency for Medicaid. In most instances, the State Medicaid Agency will not be the champion for supportive housing. Other state agencies that have taken a leadership role in developing the services and supports for individuals in PSH will need to cultivate the relationship with their Medicaid agency. Policymakers should not underestimate the time needed to form this relationship.

In some states, the various human service agencies that provide mental health, substance abuse, corrections and public health services have develop successful relationships with the Medicaid agency. These states have often defined their relationships through formal agreements (e.g. memorandum of agreements/understanding) that identify the fiscal and administrative responsibilities of all parties. Several states (e.g. Ohio, Connecticut, Georgia, Hawaii, Michigan) have exemplary formal agreements and may serve as an example to other states. A good example of such an agreement is the Memorandum of

Understanding between the Hawaii Adult Mental Health Division (AMHD) and the Department of Human Services, MedQuest Division (MQD). This agreement requires AMHD to:

- Develop and implement processes for certifying Provider Agencies to determine eligibility for participation in the Community Mental Health Program. Specifically, the AMHD agrees to:
    - Develop and promulgate rules in the Hawaii Administrative Code regarding the AMHD process for determining Provider Agencies' eligibility for participation in the Community Mental Health Program;
    - Gather and review all applications from Provider Agencies seeking eligibility for participation in the Community Mental Health Program. AMHD provides MQD information on Provider Agencies' who have been approved to participate in the Community Mental Health Program. AMHD is also responsible for communicating decisions regarding eligibility to the Provider Agencies submitting an application;
    - Notify MQD immediately regarding changes in the Provider Agencies eligibility;
    - Recertify Provider Agencies every three years. Annually AMHD performs onsite reviews of each eligible Provider Agency to ensure they comply with programmatic, operational and fiscal requirements established in AMHD and MQD rules. AMHD has established monitoring schedules and criteria, and provides information on these reviews to MQD on a quarterly basis; and
    - Ensure that all Provider Agencies eligible for participation in the Community Mental Health Program have a current MQD Provider Agreement.
- Implement a utilization management process to evaluate the appropriateness of services, lengths of stay and quality of services. AMHD established utilization management policies and procedures for conducting these reviews. All utilization management decisions were disseminated to Provider Agencies. Appeals by Provider Agencies regarding these decisions will be reviewed in accordance with AMHD due process procedures.
- Receive and pre-adjudicate all claims for MQD covered mental health services from Provider Agencies eligible for participation in the Community Mental Health Program.
- Provide pre-adjudicated claim information to the MQD on a monthly basis.
- Conduct reviews of eligible Provider Agencies' documentation to ensure that they are maintaining sufficient records of services provided. AMHD provides MQD with quarterly reports regarding these reviews.
- Develop a provider manual for the Community Mental Health Program. AMHD provided a draft of this manual to MQD for its review and approval. Once MQD

approved the manual AMHD was responsible for distributing the manual to eligible Provider Agencies.

- Provide sufficient professional staff to coordinate, supervise and implement its responsibilities under this agreement.
- Agree to pay the non-federal share for Community Mental Health Program services that are determined to be eligible for Federal Finanacial Participation and furnished to eligible ABD Medicaid recipients. AMHD will provide this payment to MQD on a quarterly basis.

These agreements identify the functions that will be performed by the Medicaid agency and the other agency. In some instances, the other state agency is responsible for recruiting and certifying providers on behalf of the Medicaid agency. These agreements also specify the fiscal arrangements between the two agencies—generally identifying how and when state match will be transferred.

Critical to developing and maintaining the relationship between the agencies is the presence of a designated staff person that will be the liaison with the Medicaid agency. This would be a "go to" person in a state mental health authority or other agency that would be responsible for communications with their agency and Medicaid, monitoring the MOU/MOA (if one existed) and ensuring that their agency had a program integrity strategy to comply with current and proposed CMS regulations.

Recently, CMS has begun questioning some states' methods of delegation of Medicaid authority to other state and local authorities as a means of proper and efficient administration of the Medicaid program. CMS concerns appear to relate to subsequent delegated authority that the local behavioral health authorities exercise over Medicaid enrolled providers.

SECTION 5
Conclusions

There are a myriad of factors that influence the decision for policymakers to develop an effective strategy for seeking federal Medicaid dollars for individuals in permanent supportive housing. First, states should view any Medicaid strategy in the larger context of larger reform for Medicaid and other human service agencies. Several states (Florida, Kentucky, West Virginia and Idaho) have proposed sweeping reforms to their Medicaid program. These proposals include developing consumer-directed health care initiatives, changing their service coverage, implement disease management programs and initiating a premium purchasing strategy where Medicaid may pay the premium for some of the uninsured working population. Other states are developing universal healthcare strategies for individuals who are uninsured or underinsured (e.g. Massachusetts, New Mexico). Therefore, policymakers need to identify the extent to which Medicaid funding for PSH is a priority and/or how these individuals and services can be included in the broader system reform.

Ample time is needed to develop the right Medicaid strategy for PSH within your state. Developing the relationship with the state Medicaid agency may be time consuming, however, the return on the investment in this relationship is enormous. As indicated above, these agencies have many competing priorities. Other agencies, service providers and advocates must understand the environment these organizations operate. Complex (and changing) federal Medicaid requirements, the enormous financial risk these agencies assume and the challenges providing health care services to individuals who have extremely diverse health care needs make it impossible to obtain quick decisions regarding new coverage.

Even where Medicaid is used to pay for services in supportive housing, it remains just one piece in the patchwork of funding. Services in supportive housing are typically funded through an array of sources; most providers can reasonably expect Medicaid to pay for only about a quarter of these service costs. Therefore, policymakers also need to be cognizant of other state and local human service agencies reform initiatives that can sustain funding for PSH.

Finally, Attachment E provides a list of useful websites for the reader to keep abreast of the proposed changes in Medicaid at the federal level. For more detailed information on your state's Medicaid program contact your Single State Agency for Medicaid.

ATTACHMENTS

Attachment A

Services in Supportive Housing

These services or activities within a service may be provided to supportive housing tenants. Depending on the needs and eligibility of consumers, the capacity of service providers, and the comprehensiveness of a service system, most of these services and activities may be made available to supportive housing tenants by providers who work in supportive housing or in other community settings.

Health and Medical Services:	*Vocational Services:*
Routine medical care	Job skills training / education
Medication management or monitoring	Vocational / career assessment and counseling
Family planning	Computer classes / training
Vision	Job readiness training - resumes, interviewing skills
Dental	Job retention services - support, coaching
Nursing / visiting nurse care	Job development / job placement services
Home health aide services / personal care services	Transitional employment
HIV/AIDS Services	Onsite employment
Nutritional services	Opportunities for tenants to volunteer

Outpatient Mental Health and Substance Abuse Services	*Intensive Rehabilitative and Medical Services*
Psychosocial assessment / mental health status exam	Crisis intervention
Individual counseling	Other:
Group therapy	Methadone maintenance
Grief counseling	Detoxification services
Domestic violence intervention	Inpatient rehabilitation
Medication management / monitoring	
Psychiatric services	
Mental health clinic	
Day treatment program	
Psychiatrist / Psychiatric nurse	
Substance abuse counseling (individual)	
Substance abuse counseling (group)	

Recovery and Rehabilitative Supports and Services	*General Supportive Housing Services*
Support groups	New tenant orientation / move-in assistance
Peer mentoring / support	Case management or service coordination
Peer counseling / mentoring	Assessment and Individual service planning / goal setting
Education about mental illness	Entitlement assistance / benefits counseling
Education about psychotropic medication	Transportation
Job skills training / education	
Job readiness training - resumes, interviewing skills	*Educational Services:*
Job retention services - support, coaching	GED Preparation
Job development / job placement services	Literacy services
Transitional employment	High school / community college programs
Onsite employment	College preparedness
Recovery readiness services	
Relapse prevention and recovery planning	
Conflict resolution / mediation training	
Training in Cooking / Meal Preparation	
Training in personal hygiene and self-care	
Training in housekeeping and apartment safety	
Training in use of public transportation	
Training in personal and household safety	

Attachment B

Medicaid Coverage-Supportive Housing Crosswalk

The following chart is intended to provide information about which services or activities may be covered under different Medicaid options. The *service category* column sets forth a list of services in terms that are familiar to supportive housing providers, advocates and funders. The second column, *Possible Medicaid Services*, provides the service titles that are currently used in state plans or Waivers. The third column, *Medicaid Options*, describes the Medicaid strategy a state may use to cover the services in column one. The third column also describes other state plan service categories that if they exist in your state can be used to cover the services in column one (e.g. individual practitioner services, clinic option, etc.). The last five columns denote the Medicaid options described in column three.

Service Category	Possible Medicaid Service	Medicaid Options	Rehab Option	1915i	1915c	TCM	Other State Plan Service
General Supportive Housing Services							
New tenant orientation / move-in assistance	Community Support	State Plan--Rehabilitation Option, 1915 (i) and 1915 c	x	x	x		
Case management or service coordination	Community Support or Targeted Case Management	State Plan--Targeted Case Management and 1915 (i) and 1915 c		x	x	x	
Assessment and Individual service planning / goal setting	Assessment/Targeted Case Management	State Plan--Individual Practitioner, Outpatient, Clinic Option, Targeted Case Management Rehabilitation Option, 1915 (i) and 1915 c	x	x	x	x	X
Entitlement assistance / benefits counseling	Targeted Case Management	State Plan--Targeted Case Management				x	
Transportation	Emergency Transportation/non-medical transportation	State Plan--1915 (i) and 1915 c		x	x		
Health and Medical Services							
Routine medical care	Dependent on service	State plan-individual practitioner and outpatient					X
Medication management or monitoring	Medication Administration	State plan-individual practitioner and outpatient					X
Family planning	Family Planning	State plan-family planning services and outpatient					X
Vision	Vision	State plan-individual practitioner and outpatient					X
Dental	Dental	State plan-individual practitioner and outpatient					X
Nursing / visiting nurse care	Independent Practitioner or Home Health Services	State plan-individual practitioner and outpatient					X
Home health aide services / personal care services	Home health services or personal care or homemaker	1915 c Waiver			x		
HIV/AIDS Services	Dependent on service	State plan- Outpatient, Clinic Option			X		X
Nutritional services	Individual practitioner	State plan-individual practitioner and outpatient					X
Other	Companion Services	1915 c Waiver			x		
Other	Environmental Modifications	1915 c Waiver			x		

Service Category	Possible Medicaid Service	Medicaid Options	Rehab Option	1915i	1915c	TCM	Other State Plan Service
Outpatient Mental Health and Substance Abuse Services							
Psychosocial assessment / mental health status exam	Assessment	State plan-individual practitioner, outpatient hospital, clinic option, rehabilitation option and 1915 (i)	x	x			X
Individual counseling	Individual Counseling	State plan-individual practitioner, outpatient hospital, clinic option, rehabilitation option and 1915 (i)	x	x			X
Group therapy	Group Counseling	State plan-individual practitioner, outpatient hospital, clinic option, rehabilitation option and 1915 (i)	x	x			X
Other:	Family Counseling	State plan-individual practitioner, outpatient hospital, clinic option, rehabilitation option and 1915 (i)	x	x			X
Grief counseling	Individual Counseling	State Plan--Individual Practitioner, Outpatient, Clinic Option					X
Domestic violence intervention	Individual Counseling	State Plan--Individual Practitioner, Outpatient, Clinic Option					X
Medication management / monitoring	Medication Administration	State Plan-individual practitioner, outpatient hospital, clinic option, rehabilitation option and 1915 (i)	x	x			X
Psychiatric services	Dependent on Service	State Plan-individual practitioner, outpatient hospital, clinic option, rehabilitation option and 1915 (i)	x	x	x		x
Mental health clinic	Dependent on Service	State Plan--Individual Practitioner, Outpatient Hospital, Rehabilitation Option, Clinic Option or 1915 (i) and 1915 c	x	x	x		x
Day treatment program	Day Treatment	State Plan--Rehabilitation Option, Clinic Option or 1915 (i) and 1915 c	x	x	x		
Psychiatrist / Psychiatric nurse	Dependent on Service	State Plan--Individual Practitioner, Outpatient Hospital, Rehabilitation Option, Clinic Option or 1915 (i) and 1915 c	x	x	x		X
Substance abuse counseling (individual)	Individual Counseling	State plan-individual practitioner, outpatient hospital, clinic option, rehabilitation option and 1915 (i)	x	x			X
Substance abuse counseling (group)	Group Counseling	State plan-individual practitioner, outpatient hospital, clinic option, rehabilitation option and 1915 (i)	x	x			X
Recovery and Rehabilitative Supports and Services							
Support groups	Dependent on Service	State Plan--Rehabilitation Option 1915 (c) and 1915 (i)	x	x			
Peer mentoring / support	Peer Supports	State Plan--Rehabilitation Option, 1915 (i) and 1915 c	x	x	x		

Service Category	Possible Medicaid Service	Medicaid Options	Rehab Option	1915i	1915c	TCM	Other State Plan Service
Peer counseling / mentoring	Peer Support or Community Support	State Plan--Rehabilitation Option, 1915 (i) and 1915 c	x	x	x		
Education about mental illness	Community Support or Training to Unpaid Caregiver	State plan-individual practitioner, outpatient hospital, clinic option, rehabilitation option and 1915 (i)	x	x			X
Education about psychotropic medication	Medication Education	State plan-individual practitioner, outpatient hospital, clinic option, rehabilitation option and 1915 (i)	x	x			X
Other:	Psychosocial Rehabilitation Programs	State Plan--Rehabilitation Option, Clinic Option or 1915 (i) and 1915 c	x	x	x		
Job skills training / education	Community Support or Pre-vocational Services	State Plan--Rehabilitation Option, 1915 (i) and 1915 c	x	x	x		
Job readiness training - resumes, interviewing skills	Community Support or Prevocational Services	State Plan--Rehabilitation Option, 1915 (i) and 1915 c	x	x	x		
Job retention services - support, coaching	Community Support or Peer Support or Supported Employment	State Plan--Rehabilitation Option, 1915 (i) and 1915 c	x	x	x		
Job development / job placement services	Supported Employment	State Plan--Rehabilitation Option, 1915 (i) and 1915 c	x	x	x		
Transitional employment	Transitional Employment	State Plan—1915(c)			x		
Onsite employment	Supported Employment	State Plan--Rehabilitation Option, 1915 (i) and 1915 c	x	x	x		
Recovery readiness services	Dependent on Service	State Plan--Rehabilitation Option, 1915 (c) and 1915(i)	x	x	x		
Relapse prevention and recovery planning	Community Support	State Plan--Rehabilitation Option, Clinic Option or 1915 (i) and 1915 c	x	x	x		
Conflict resolution / mediation training	Community Support or Peer Support	State Plan--Rehabilitation Option, 1915 (i) and 1915 c	x	x	x		
Training in Cooking / Meal Preparation	Community Support or Independent Living Skills Training or Homemaker Services	State Plan--Rehabilitation Option, 1915 (i) and 1915 c	x	x	x		
Training in personal hygiene and self-care	Community Support or Independent Living Skills Training	State Plan--Rehabilitation Option, 1915 (i) and 1915 c	x	x	x		
Training in housekeeping and apartment safety	Community Support or Independent Living Skills Training or Homemaker or Personal Care	State Plan--Rehabilitation Option, 1915 (i) and 1915 c	x	x	x		
Training in use of public transportation	Community Support or Independent Living Skills Training	State Plan--Rehabilitation Option, 1915 (i) and 1915 c	x	x	x		
Training in personal and household safety	Community Support or Independent Living Skills Training	State Plan--Rehabilitation Option, 1915 (i) and 1915 c	x	x	x		

Service Category	Possible Medicaid Service	Medicaid Options	Rehab Option	1915i	1915c	TCM	Other State Plan Service
Intensive Rehabilitative and Medical Services							
Crisis intervention	Clinic Based or Mobile Crisis	State Plan--Individual Practitioner, Outpatient, Clinic Option, Rehabilitation Option, 1915 (i) and 1915 c	x	x	x		X
Other:	Assertive Community Treatment	State Plan--Rehabilitation Option, Clinic Option or 1915 (i) and 1915 c	x	x	x		
Methadone maintenance	Methadone maintenance	State Plan--Pharmacy					x
Detoxification services	Residential and Ambulatory Detoxification	State Plan--Inpatient Services or Rehabilitative Services, 1915 (i) or 1915 C	x	x	x		
Inpatient rehabilitation	Medically Monitored Detoxification	State Plan--Inpatient Services					X
Other:	Intensive Outpatient Program	State Plan--Outpatient Hospital Services or Rehabilitative Services, 1915 (i) or 1915 C	x	x	x		X

Attachment C

Sample "Rehab Option" Service Definitions

North Carolina
http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdef3-27-06rev.pdf

Illinois
http://www.ilga.gov/commission/jcar/admincode/059/059001320C01500R.html

New Mexico
http://www.bhc.state.nm.us/servicedefs.html

Minnesota
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_003494

Louisiana
http://www.mhrsla.org/providers/faq.asp

Maryland
http://www.dsd.state.md.us/comar/subtitle_chapters/10_Chapters.htm#Subtitle21

District of Columbia
http://dmh.dc.gov/dmh/cwp/view,a,3,q,518717.asp

Attachment D

State of Georgia's Proposed Changes to Rehabilitation Option

13.d.1 – Community Mental Health Rehabilitative Services in accordance with 42 CFR 440.130(d)

The covered Community Mental Health Rehabilitative Services will be available to all Medicaid eligibles with mental illness and substance abuse disorders and who are medically determined to need rehabilitative services. These services must be ordered by a physician or other licensed practitioner within the scope of his/her practice under state law and furnished by or under the direction of a physician or other practitioners operating within the scope of applicable state law, to promote the maximum reduction of symptoms and/or restoration of a recipient to his/her best possible functional level.

The covered Community Mental Health Rehabilitative Services are reimbursed when delivered within enrolled agencies meeting the requirements listed herein. The State does not arbitrarily limit Medicaid providers. The State enrolls any willing provider that meets the qualifications required to be a service provider as outlined in the Policies and Procedures Manual that is made available to all interested providers. Individual practitioners are not enrolled in this program. Provider agency qualifications to provide these services are ensured by provider compliance with requirements and standards of the Joint Commission on Accreditation for Healthcare Organizations (JCAHO), Commission on Accreditation for Rehabilitation Facilities (CARF), Council on Accreditation of Services for Children and Families, Inc. (COA), Council on Quality Leadership (CQL), and/or State certification. Individual practitioners working within these provider agencies are required to meet all applicable licensure and certification requirements and adhere to Georgia law and the scope of practice definitions of licensure boards.

The participants are given freedom of choice to choose a qualified, enrolled service provider. A toll-free access number provides information regarding the available services and providers to participants and family members seeking behavioral healthcare services. The Department of Human Resources, Division of Mental Health, Developmental Disabilities, and Addictive Diseases (MHDDAD) regional and central offices are also available to provide information to individuals seeking behavioral healthcare services through this program and participants may also access services by directly contacting providers of their choice.

Table of Practitioners Employed by Provider Agencies:

Professional Title	Minimum Level of Education/Degree/ Experience Required	License/ Certification Required	Supervision	State Code
Physician	Graduate of medical or osteopathic college	Licensed by the Georgia Composite Board of Medical Examiners	No. Additionally, can supervise others	43-34-20 to 43-34-37
Psychiatrist	Graduate of medical or osteopathic college and a residency in psychiatry approved by the American Board of Psychiatry and Neurology	Licensed by the Georgia Composite Board of Medical Examiners	No. Additionally, can supervise others	43-34-20 to 43-34-37
Physician's Assistant (PA)	Completion of a physician's assistant training program approved by the Georgia Composite Board of Medical Examiners f---- at least 1 year of experience in behavioral healthcare required to supervise CPRP, CPS, or PP staff	Licensed by the Georgia Composite Board of Medical Examiners	Physician delegates functions through Board-approved job description.	43-34-100 to 43-34-108
Advanced Practice Registered Nurse (APRN): Clinical Nurse Specialist/Psychiatric-Mental Health (CNS-PMH) and Nurse Practitioner (NP)	R.N. and graduation from a post-basic education program for Nurse Practitioners Master's degree or higher in nursing for the CNS/PMH -- Nurse Practitioners must have at least 1 year of experience in behavioral healthcare to supervise CPRP, CPS, or PP staff	Current certification by American Nurses Association, American Nurses Credentialing Center or American Academy of Nurse Practitioners and authorized as an APRN by the Georgia Board of Nursing	Physician delegates advanced practice functions through Board-approved nurse protocol agreements.	43-26-1 to 43-26-13, 360-32
Registered Nurse (RN)	Georgia Board of Nursing-approved nursing education program -- at least 1 year of experience in behavioral healthcare required to supervise CPRP, CPS, or PP	Licensed by the Georgia Board of Nursing	Physician	43-26-1 to 46-23-13
Licensed Practical Nurse (LPN)	Graduation from a nursing education program approved by the Georgia Board of Licensed Practical Nursing.	Licensed by Georgia Board of Licensed Practical Nursing	Physician or RN	43-26-30 to 43-26-43
Qualified Medication Aide (QMA)	Completion of a prescribed course conducted by the Georgia Department of Technical and Adult Education and pass examination for qualified medication aides approved by the Georgia Board of Licensed Practical Nursing.	Certified by the Georgia Board of Licensed Practical Nursing	Supervised by RN .performing certain medication administration tasks as delegated by RN or LPN.	43-26-50 to 43-26-60

Professional Title	Minimum Level of Education/Degree/ Experience Required	License/ Certification Required	Supervision	State Code
Psychologist	Doctoral Degree	Licensed by the Georgia Board of Examiners of Psychologists	No. Additionally, can supervise others	43-39-1 to 43-39-20
Licensed Clinical Social Worker (LCSW)	Masters degree in Social Work plus 3 years' supervised full-time work in the practice of social work after the Master's degree.	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	No. Additionally, can supervise others	43-10A
Licensed Professional Counselor (LPC)	Master's degree	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	No. Additionally, can supervise others	43-10A
Licensed Marriage and Family Therapist (LMFT)	Master's degree	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	No. Additionally, can supervise others	43-10A
Licensed Master's Social Worker (LMSW)	Master's degree in Social Work	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	Under direction and supervision of an appropriately licensed/credentialed professional.	43-10A
Licensed Associate Professional Counselor (LAPC)	Master's degree	Licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists	Under direction and supervision of an appropriately licensed/credentialed professional	43-10A
Certified Addiction Counselor, Level II (CAC-II)	Bachelor's degree or higher in one of the helping professions such as social work, community counseling, counseling, psychology, or criminology and requisite certification	Certification by the Georgia Addiction Counselors' Association or other similar private association of addiction counselors. Requires 3 years of experience in practice of chemical dependency/abuse counseling; 270 hours education in addiction field; and 144 hours clinical supervision.	Services limited to those practices sanctioned by the certifying association and shall in any event be limited to the provision of chemical dependency treatment	43-10A-7

Professional Title	Minimum Level of Education/Degree/ Experience Required	License/ Certification Required	Supervision	State Code
Certified Addiction Counselor, Level I (CAC-I)	High School Diploma/Equivalent	Certification by the Georgia Addiction Counselors' Association or other similar private association of addiction counselors. Requires 2 years of experience in the practice of chemical dependency/abuse counseling; 180 hours education in addiction field; and 96 hours clinical supervision.	Services limited to those practices sanctioned by the certifying association and shall in any event be limited to the provision of chemical dependency treatment	43-10A-7
Addiction Counselor Trainees	High school diploma/equivalent and actively pursuing certification as CAC-I	Employed by an agency or facility that is licensed to provide addiction counseling	Under supervision of a Georgia Addiction Counselor's Association Certified Clinical Supervisor	
Certified Psychiatric Rehabilitation Professional (CPRP)	High school diploma/equivalent, Associates Degree, Bachelor's Degree, Graduate Degree with required experience working in Psychiatric Rehabilitation (varies by level and type of degree)	Certified by the US Psychiatric Rehabilitation Association (USPRA, formerly IASPRS)	Under supervision of an appropriately licensed/credentialed professional	
Certified Peer Specialist (CPS)	High school diploma/equivalent	Certification by the Georgia Certified Peer Specialist Project Requires a minimum of 40 hours of Certified Peer Specialist Training, and successful completion of a certification exam.	Services shall be limited to those not requiring licensure, but are provided under the supervision of an appropriately licensed/credentialed professional.	
Paraprofessional (PP)	College training in one of the behavioral or social sciences, or similar advanced training.		Under supervision of an appropriately licensed/credentialed professional	

Limitations

Rehabilitative services do not include reimbursement for room & board and reimbursement will not be provided for services provided to individuals in an IMD. The covered services are available only to Medicaid eligible recipients with a written service plan, which contains medically necessary services ordered by a physician or other licensed practitioners operating within the scope of state law. All treatment and rehabilitative services are focused on the Medicaid eligible individual. Any consultation or treatment involving families or other persons is solely for the purpose of addressing the mental health needs of the Medicaid recipient.

Service utilization is managed through the use of prior authorizations that set maximum units within an authorization period. Authorization periods vary according to service and may range between 12 weeks to 12

months. At the outset of services and again when the authorization period expires or maximum units have been reached, a request must be submitted to the URAC-accredited External Review Organization to justify provision of services based upon medical necessity of the service for the Medicaid recipient.

The services are defined as follows:

Behavioral Health Assessment:

The behavioral health assessment process consists of a face-to-face comprehensive clinical assessment with the individual, which must include the individual's perspective, and may also include consumer-identified family and/or significant others as well as collateral agencies/treatment providers. The purpose of the assessment process is to gather all information needed to determine the individual's symptoms, strengths, needs, abilities and preferences, to develop a social and medical history, to determine functional level and to develop or review collateral assessment information. This service may be provided in or outside the clinic setting.

Distinct Billable Services:

Description	Practitioners
Mental Health Assessment by a non-physician	LCSW, LPC, LMFT, Psychologist or their supervisee/trainee functioning within the scope of the practice acts of the state. LMSW, LAPC, LAMFT RN, APRN, PA CAC-I and CAC-II (may only perform these functions related to treatment of addictive diseases).

Service Plan Development

The service plan development process results in a written, individualized service plan. The plan is formulated through a collaborative process with the individual that includes all necessary treatment and rehabilitative services. The individualized service plan includes the treatment objectives/outcomes, the expected frequency and duration of each service, the type of practitioner providing the service and its location, and the schedule of updates to the individualized service plan. Service plans must be reviewed at least annually or when there is a change in the individual's service needs. Each service plan and subsequent revisions must be authorized by a physician or other licensed practitioner authorized by state law to recommend a course of treatment. These services may be provided in or outside the clinic setting.

Distinct Billable Services:

Description	Practitioners
Mental Health Service Plan Development by a non-physician	LCSW, LPC, LMFT, Psychologist or their supervisee/trainee functioning within the scope of the practice acts of the state. LMSW, LAPC, LAMFT RN, APRN, PA CAC-I and CAC-II (may only perform these functions related to treatment of addictive diseases).

Diagnostic Assessment:

The psychiatric diagnostic examination provides a comprehensive assessment of the medical and psychiatric treatment needs of the individual. The results of nursing assessments and behavioral health assessments are used by the physician as an integral part of the psychiatric assessment process that results in a diagnosis and associated treatment decisions. Diagnostic assessments may involve specific psycho-diagnostic assessments performed by licensed psychologists or certain other licensed practioners, or their supervisee/trainee in the administration of psychological tests, the results of which assist in the determination of a diagnosis and treatment recommendations. These services may be provided in or outside the clinic setting.

Distinct Billable Services:

Description	Practitioners
Psychiatric Diagnostic Examination	Physician
	Psychologist CNS-PMH (Clinical Nurse Specialist in Psychiatric/Mental Health), Nurse Practitioner, Physician Assistant
Psychiatric Diagnostic Examination, Interactive	Physician
	Psychologist CNS-PMH (Clinical Nurse Specialist in Psychiatric/Mental Health), Nurse Practitioner, Physician Assistant
Psychological Testing – Psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology e.g. MMP, Rorschach, WAIS (per hour of psychologists or physicians time, both face-to-face with the patient and times interpreting test results and preparing the report)	Psychologist
Psychological Testing – Psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology (e.g. MMPI, Rorschach, WAIS) with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face.	LCSW, LPC, LMFT in conjunction with Psychologist Official supervisee/trainee of Psychologist

Crisis Intervention Services: This service entails a face-to-face short-term intervention with individuals in an active state of crisis. Interventions include a brief, situational assessment; verbal interventions to de-escalate the crisis; assistance in immediate crisis resolution; mobilization of natural support systems; and referral to alternate services at the appropriate level. This service is not duplicative of the comprehensive, in-depth assessments included in Behavioral Health Assessment or Diagnostic Assessment and do not duplicate the comprehensive and proactive planning for crisis management that is included in Service Plan Development. Crisis intervention services are available 24 hours a day, 7 days a week. Services may be provided in a clinic setting or can occur in a variety of other settings including the consumer's home, local emergency departments, or other community settings when the situation is such that it is medically necessary to deliver the services wherever the consumer is located outside the clinic.

Distinct Billable Services:

Description	Practitioners
Crisis Intervention Services	Physician LCSW, LPC, LMFT, Psychologist, Psychiatrist or their supervisee/trainee functioning within the scope of the practice acts of the state. LMSW, LAPC, LAMFT RN, APRN, PA

Psychiatric Treatment: Psychiatric treatment encompasses the provision of specialized medical and/or psychiatric interventions that will result in improved levels of functioning or maintaining existing levels of functioning. Psychiatric treatment includes the ongoing care related to the behavioral healthcare needs of the individual as specified in the individualized service plan through pharmacological management and individual psychotherapeutic services that must coupled with medical evaluation and pharmacological management. Service plans that include these services must be authorized by a physician. These services may be provided in or outside the clinic setting.

Distinct Billable Services:

Description	Practitioners
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately 20-30 minutes face-to-face with patient with medical evaluation and management services.	Physician
	CNS-PMH (Clinical Nurse Specialist in Psychiatric/Mental Health)
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately 45-50 minutes face-to-face with patient with medical evaluation and management services.	Physician
	CNS-PMH (Clinical Nurse Specialist in Psychiatric/Mental Health)
Pharmacological Management	Physician
	PA or APRN (if authority to perform this task is delegated by physician through approved job description or protocol)

Nursing Assessment and Care: Nursing Assessment and Care services are face-to-face contacts with a consumer to monitor, evaluate, assess, establish nursing goals, and/or carry out physicians' orders regarding treatment and rehabilitation of the physical and/or behavioral health problems of a consumer as specified in the individualized service plan. It includes providing special nursing assessments to observe, monitor and care for physical, nutritional and psychological issues, problems, or crises manifested in the course of the consumers treatment; to assess and monitor individual's response to medication to determine the need to continue medication and/or for a physician referral for a medication review; assessing and monitoring an individual's medical and other health issues that are either directly related to the mental health or substance related disorder, or to the treatment of the disorder (e.g. diabetes, cardiac and/or blood pressure issues, substance withdrawal symptoms, weight gain and fluid retention, seizures, etc); venipuncture required to monitor and assess mental health, substance disorders or directly related conditions, and to monitor side effects of psychotropic medication; consultation with the consumer's family and/or significant others for the benefit of the client about medical and nutritional issues; and provision of medication education to the consumer and family and training for self-administration of medication. Service plans that include these services must be authorized by a

physician. These services may be provided in or outside the clinic setting.

Distinct Billable Services:

Description	Practitioners
Nursing Assessment / Evaluation	Registered Nurse (RN), Licensed Practical Nurse (LPN), or Advanced Practice Registered Nurse (APRN)
RN Services, up to 15 minutes	RN or APRN
LPN/LVN Services, up to 15 minutes	LPN
Health and Behavior Assessment (e.g. health-focused clinical interview, behavioral observations, psycho-physiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient, initial assessment	RN, LPN, APRN
Health and Behavior Assessment (e.g. health-focused clinical interview, behavioral observations, psycho-physiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient, re-assessment	RN, LPN, APRN

Individual Outpatient Services: Individual outpatient services provide face-to-face counseling and psychotherapy services for symptom/behavior management of mental health problems and addictive diseases. Services are directed toward symptom reduction and restoration of functional abilities as delineated in the individualized service plan. This service may be offered in a clinic setting or in the community.

Billable Services:

Description	Practitioner
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately 20-30 minutes face-to-face with patient (appropriate license required)	Physician LCSW, LPC, LMFT, Psychologist, Psychiatrist or their supervisee/trainee functioning within the scope of the practice acts of the state. LMSW, LAPC, LAMFT CNS-PMH CAC-I and CAC-II (may only perform these functions related to treatment of addictive diseases).
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately 45-50 minutes face-to-face with patient (appropriate license required)	
Individual Psychotherapy, insight oriented, behavior-modifying and/or supportive in an office or outpatient facility, approximately 75-80 minutes face-to-face with patient (appropriate license required)	
Individual psychotherapy, interactive, using play equipment, physical devises, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20-30 minutes face-to-face with patient (appropriate license required)	
Individual psychotherapy, interactive, using play equipment, physical devises, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45-50 minutes face-to-face with patient (appropriate license required)	
Individual psychotherapy, interactive, using play equipment, physical devises, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75-80 minutes face-to-face with patient (appropriate license required)	

Family Outpatient Services: Family outpatient services provide face-to-face counseling, psychotherapy, and skills training services to the eligible individuals and their families for symptom reduction/behavior management of mental health problems and addictive diseases according to the individualized service plan. Services are directed toward the identified individual and the restoration of adaptive behaviors and skills, functional abilities, and the interpersonal skills and functioning of the individual within the family unit to the maximum extent possible. Services include counseling, therapy, and/or education and training for the individual and family members (for the benefit of the individual) regarding mental health and substance abuse disorders and prescribed medication (including adherence to medication regimen); problem solving,

interpersonal, communication and coping skills; adaptive behaviors and skills; and skills and abilities necessary to access community resources and support systems. This service may be offered in a clinic setting or in the community.

Billable Services:

Description	Practitioners
Family Outpatient Services – Behavioral health counseling and therapy (with client present) Family Outpatient Services – Behavioral health counseling and therapy (without client present) Family Psychotherapy without the patient present Conjoint Family Psychotherapy with the patient present	Physician LCSW, LPC, LMFT, Psychologist, Psychiatrist or their supervisee/trainee functioning within the scope of the practice acts of the state. LMSW, LAPC, LAMFT CNS-PMH CAC-I and CAC-II (may only perform these functions related to treatment of addictive diseases).
Family - Skills training and development	Physician RN, LPN, APRN, PA LCSW, LPC, LMFT, Psychologist, Psychiatrist or their supervisee/trainee functioning within the scope of the practice acts of the state LMSW, LAPC, LAMFT CAC-I and CAC-II (may only perform these functions related to treatment of addictive diseases). CPRP, CPS, PP under supervision of one of the licensed/credentialed professionals listed above

Group Outpatient Services: Group outpatient services provide face-to-face counseling, psychotherapy, and skills training services to the eligible individuals for symptom reduction/ behavior management of mental health problems and addictive diseases according to the individualized service plan. Services are provided to individuals in a group setting. Services may include counseling, therapy, and/or skills training/education for the individuals in the group regarding mental health and substance abuse disorders; problem solving, interpersonal, communication, relapse prevention, and coping skills; adaptive behaviors and skills; and skills and abilities necessary to access and benefit from community resources and natural support systems. These services may be provided in or outside the clinic setting.

Billable Services:

Description	Practitioners
Group Counseling – Behavioral health counseling and therapy	Physician LCSW, LPC, LMFT, Psychologist, Psychiatrist or their supervisee/trainee functioning within the scope of the practice acts of the state. LMSW, LAPC, LAMFT CNS-PMH CAC-I and CAC-II (may only perform these functions related to treatment of addictive diseases).
Group Counseling – Behavioral health counseling and therapy	
Group Counseling – Behavioral health counseling and therapy	
Group Psychotherapy other than of a multiple family group	
Group Skills training and development	Physician RN, LPN, APRN, PA LCSW, LPC, LMFT, Psychologist, Psychiatrist or their supervisee/trainee functioning within the scope of the practice acts of the state LMSW, LAPC, LAMFT CAC-I and CAC-II (may only perform these functions related to treatment of addictive diseases). CPRP, CPS, PP under supervision of one of the licensed/credentialed professionals listed above

Medication Administration: Medication Administration is the giving or administration of an oral or injectable medication. Medication administration includes educating the individual about their medications, assessment of the consumer's physical and behavioral status prior to medication administration, and determination of whether to administer the medication or refer the consumer to the physician for medication review. Service plans that include these services must be authorized by a physician.

Description	Practitioners
Comprehensive Medication Services	RN, LPN, APRN, PA, Qualified Medication Aide (QMA can do only when by and working in a community living arrangement)
Therapeutic, prophylactic or diagnostic injection	RN, LPN, APRN, PA
Alcohol, and/or drug services, methadone administration and/or service (provision of the drug by a licensed program)	RN, LPN, APRN, PA

Intensive Family Intervention: This is a time-limited, community-based, intensive behavioral health intervention delivered to children and youth with emotional disturbances or co-occurring emotional disturbances and substance use disorders. Services are directed towards the identified youth and his or her behavioral health needs and goals as identified in the individualized service plan. Services include therapeutic and rehabilitative interventions with the individual and family to correct or ameliorate symptoms of mental health and/or substance abuse problems and to reduce the likelihood of the need for more intensive/restrictive services. These services may be provided in or outside the clinic setting but services are delivered primarily in

the family's home and promote a family-based focus in order to evaluate the nature of the difficulties, defuse behavioral health crises, intervene to reduce the likelihood of a recurrence, ensure linkage to needed community services and resources, and improve the individual child's/adolescent's ability to self-recognize and self-manage behavioral health issues, as well as the parents'/responsible caregivers' skills to care for their children's mental heath and addictive disease problems. Specialized therapeutic and rehabilitative interventions are available to address special areas such as problem sexual behaviors and the effects of domestic violence.

Distinct Billable Services:

Description	Practitioners
Intensive Family Intervention (Professional licensed/credentialed to practice without supervision.)	Physician, Psychologist, Psychiatrist, LCSW, LPC, LMFT, CNS-PMH, CAC-II
Intensive Family Intervention (Paraprofessional or professional unable to practice without supervision)	Supervisee/trainee of LCSW, LPC, LMFT, Psychologist or Psychiatrist functioning within the scope of the practice acts of the state LMSW, LAPC, LAMFT CAC-I CPRP, CPS, PP under supervision of a Physician. LCSW, LPC, LMFT, Psychologist, Psychiatrist, CNS-PMH, CAC-I

Ambulatory Detoxification: This service is the medical management of the physical process of withdrawal from alcohol or other drugs in an outpatient setting. The services focus on the rapid physical stabilization of the consumer and entry into the appropriate level of care of treatment based upon the ASAM (American Society of Addiction Medication) guidelines placement criteria. The severity of the individual's symptoms, level of supports needed, and the physician's authorization for the service will determine the outpatient setting, as well as the amount of nursing and physician supervision necessary during the withdrawal process. The individual may or may not require medication. Twenty-four hour nursing services are not required, however, there is a contingency plan for "after hours" concerns/emergencies. Service plans that include these services must be authorized by a physician. This service is provided in a clinic or facility-based setting.

Individual Billable Service:

Description	Practitioners
Alcohol and/or drug services, Ambulatory Detoxification	Physician, Psychiatrist, PA, APRN, RN, LPN or other medical staff under physician's supervision.

Psychiatric Intensive Day Treatment (Partial Hospitalization): This service 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. This level of care of care for each consumer includes services available at least 20 hours per week and must be ordered by the physician. The maximum allowed to bill in one day is 5 hours and does not include any residential, room or board supports. Weekend services may be necessary to meet the needs of consumers requiring crisis stabilization or other services and physician and nursing care must be available on a daily basis. Interventions include medical and nursing services, psychotherapeutic and/or skills education/training as it pertains to the alleviation of identified behavioral health problems on the individualized service plan. Service plans that include these services must be authorized by a physician and provided by a

qualified agency. This service is provided in a clinic or facility-based setting.

Description	Practitioners
Psychiatric Intensive Day Treatment	Physician RN, LPN, APRN, PA LCSW, LPC, LMFT, Psychologist, Psychiatrist or their supervisee/trainee functioning within the scope of the practice acts of the state LMSW, LAPC, LAMFT CAC-I and CAC-II CPRP, CPS, PP under supervision of one of the licensed/credentialed professionals listed above

Psychosocial Rehabilitation: A therapeutic rehabilitative social skill building service provided to assist individuals in restoring the individual to the maximum possible functional level by improving social, interpersonal, problem-solving, coping, and communication skills. Services include, but are not limited to: didactic training, structured practice, skills training and coaching techniques focusing on the development of problem-solving abilities, social and communication skills, medication self-management abilities and functional abilities. This service is provided in a clinic or facility-based setting.

Description	Practitioners
Psychosocial Rehabilitation	Physician RN, LPN, APRN, PA LCSW, LPC, LMFT, Psychologist, Psychiatrist or their supervisee/trainee functioning within the scope of the practice acts of the state LMSW, LAPC, LAMFT CAC-I and CAC-II CPRP, CPS, PP under supervision of one of the licensed/credentialed professionals listed above

Substance Abuse Intensive Outpatient Services: This service is a time-limited treatment service for persons with addictive disorders (with or without co-occurring mental health problems) who require structure and support to achieve and sustain recovery. The following types of services are included in the intensive outpatient program: didactic educational sessions on addiction and recovery; counseling and skills training/education and coaching techniques related to utilization of relapse prevention skills and accessing community and social support systems. Services must be authorized by a physician or other licensed practitioner. This service is provided in a clinic or facility-based setting.

Description	Practitioners
Behavioral Health Day Treatment, Adult Program, Substance Abuse	Physician RN, LPN, APRN, PA LCSW, LPC, LMFT, Psychologist, Psychiatrist or their supervisee/trainee functioning within the scope of the practice acts of the state LMSW, LAPC, LAMFT CAC-I and CAC-II CPRP, CPS, PP under supervision of one of the licensed/credentialed professionals listed above

Community Support Services: Community support services consist of mental health and substance abuse rehabilitative services and supports necessary to assist the person in achieving rehabilitative and recovery goals as identified in the individualized service plan. The service includes skills training/education in a variety of areas including problem-solving, interpersonal, communication, and community coping skills, including adaptation to home, school and work environments; symptom monitoring and self management of symptoms. The focus of the interventions include assisting the individual in identification of service needs, minimizing the negative effects of symptoms of mental health problems and addictive diseases that interfere with the consumer's daily living skills, independent functioning and personal development; developing strategies and supportive interventions for avoiding out-of-home placement or the need for more intensive services; assisting consumers to increase social support skills that ameliorate life stresses resulting from the consumer's disability and coordinating rehabilitative services as specified in the individualized service plan. This service may be provided in the clinic setting or in the community.

Description	Practitioners
Community Support Services	Physician RN, LPN, APRN, PA LCSW, LPC, LMFT, Psychologist, Psychiatrist and supervisee/trainee functioning within the scope of the practice acts of the state. LMSW, LAPC, LAMFT CAC-I and CAC-II (may only perform these functions related to treatment of addictive diseases). CPRP, CPS, PP under supervision of one of the licensed/credentialed professionals listed above

Peer Support: This service provides structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills, by Certified Peer Specialists under the direct supervision of a mental health professional. Consumers actively participate in decision-making and program operation. Services are directed toward achievement of the specific goals defined by the individual and specified in the Individual Service Plan (ISP), and provided under the direct supervision of a Mental Health Professional. The interpersonal interactions and activities within the program are directed, supervised, guided and facilitated by the Mental Health Professional in such a way to create the therapeutic community or therapeutic effect required to achieve individual treatment goals within a controlled environment. This concept is similar to the manner in which the staff leader in group therapy sessions or therapeutic community setting utilizes the interactions of the group members to achieve the desired individual therapy

goals. This service may be offered in a clinic setting or in the community. Practitioners are required to hold current certification from the Georgia Certified Peer Support Project.

Description	Practitioners
Peer Support	CPS under supervision of a Physician, Psychologist, LCSW, LPC, LMFT, RN, APRN, PA, LMSW, LAPC, or LAMFT

Attachment E

Where to Get More Information

The following websites provide more detailed information on various Medicaid programs. It also provides the websites of organizations that offer summaries and position on the most recent Medicaid changes.

The Centers for Medicare and Medicaid Services	http://www.cms.hhs.gov/home/medicaid.asp
The National Association of Medicaid Directors	http://www.nasmd.org/issues/medicaid_transformation.asp
The Bazelon Center for Mental Health	http://www.bazelon.org
National Council for Community Behavioral Healthcare	http://www.thenationalcouncil.org/cs/public_policy
HCBS Clearinghouse for Community Living Exchange Collaboration	http://www.hcbs.org/
CMS Primer on How to Use Medicaid to Assist Persons who are Homeless (January 2007)	http://aspe.hhs.gov/daltcp/reports/handbook.pdf
HHS ASPE: Using Medicaid to Support Working Age Adults with SMI in the Community	http://www.cms.hhs.gov/HomelessnessInitiative/Downloads/HomelessPrimer2007.pdf