



# **RECOVERY IN THE COMMUNITY**

***Funding Mental Health Rehabilitative Approaches Under Medicaid***

**A REPORT BY THE  
BAZELON CENTER FOR MENTAL HEALTH LAW  
WASHINGTON DC  
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This report is the first of two discussing the use of the Medicaid program to fund recovery-oriented services for adults with serious mental illnesses. It was prepared by the Bazelon Center for Mental Health Law and the Technical Assistance Collaborative, Inc. The report was researched and written by Chris Koyanagi, policy director, and Rafael Semansky, senior research analyst, of the Bazelon Center, with assistance and review by John O'Brien and Patrick Lanahan, senior policy associates at the Technical Assistance Collaborative. Data collection was assisted by Erin Lankau, Leigh Ann Simmons, Ellen Lupinsky and Jess Colby, interns at the Bazelon Center. The publication was designed and edited by Lee Carty, communications director.

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# RECOVERY IN THE COMMUNITY

## Funding Mental Health Rehabilitative Approaches Under Medicaid

### INTRODUCTION

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**T**his report describes how states have covered community-based psychiatric rehabilitation and case management services for adults under Medicaid. Its focus is on evidence-based interventions and services that support a recovery-focused system of community care.

The Medicaid service categories most germane to a recovery-focused community system are the optional services of rehabilitation and targeted case management. These options cover services needed by adults with serious mental illnesses who also have significant limitations in functional capacity to perform self-maintenance and occupational, educational and/or social roles in the absence of ongoing services. Appropriate coverage of services and activities under these two options helps them live and work in community settings of their choice.

Although clinical mental health treatment (including medication management, therapy and other services by mental health professionals and para-professionals) can be covered under Medicaid's clinic option, clinical services are not the focus here.

This report is based on a review of Medicaid rules and regulations and managed care contracts in 50 states and the District of Columbia. State Medicaid provider manuals, state plans and managed care requests for proposals were also reviewed. To verify accuracy, each state's Medicaid and mental health agency received a summary of the covered services thus identified; all states but one responded. For 20 percent of the programs, we received responses from both agencies.

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The study found that states' use of Medicaid to fund rehabilitation and targeted case management services has increased significantly. In 1988, only nine states covered psychiatric rehabilitation under Medicaid and nine covered targeted case management for adults with serious mental illnesses. By 1992, 32 and 33 states respectively covered these options. In 2001, this study found that 49 states and the District of Columbia all covered psychiatric rehabilitation either in fee-for-service or through a statewide managed care plan and 42 covered targeted case management for adults with serious mental illnesses.

However, most of the states that cover these services have somewhat limited descriptions of what can be furnished under the rehabilitation option. In crafting these rules, states have sometimes missed opportunities to support flexible, individualized, consumer-driven services based on evidence-based practice. Various innovations do exist in several states, but many states have not revised their Medicaid plan and related rules for a number of years and most are operating with Medicaid rules that do not encourage recovery-oriented services and support systems. The result is less-than-optimal care for people on Medicaid and additional expense for the state, either for state-funded mental health services or, too often, for other state systems, including criminal justice and welfare.

This report is particularly timely in light of the 1999 U.S. Supreme Court ruling in the case of *Olmstead v. L.C.*<sup>1</sup> That ruling requires states to move at a "reasonable pace" to end the unnecessary institutionalization of people with disabilities, including those with serious mental illnesses. To fund the array of community-based mental health services essential to implement the *Olmstead* decision, states need the federal dollars available through the Medicaid rehabilitation and targeted case management options.

This review identifies significant gaps but also significant opportunities for the states. The majority could make progress in responding to *Olmstead* if they revisited and improved their Medicaid state plan provisions for community mental health services.

The report is organized so as to present first a general overview of Medicaid and a summary of issues that commonly arise in defining Medicaid mental health coverage. It then gives a detailed summary of federal rules on coverage of psychiatric rehabilitation and targeted case management services for adults with serious mental illnesses, summarizes how states, overall, have developed their rules in response to this federal guidance, and offers (in the appendix) examples from state regulations and rules to illustrate how the federal rules play out in practice. Finally, the tables in the appendix present data on individual states' coverage of specific services and activities.

This report focuses on services covered. A planned second volume (to be published in 2002) will discuss payment rates, provider qualifications, prior-authorization requirements, monitoring and other administrative matters.

Medicaid is a jointly funded federal-state health care program that reimburses providers of health care for eligible low-income individuals. The federal government shares the cost of the services, at a rate varying from 50 to 78 percent depending on the state's per capita income.

Federal law provides broad national guidelines on eligibility and definitions of covered services, while states have significant flexibility to define implementation details. In addition, the federal law sets forth a list of services that states must cover under their program ("mandatory services") and a list of services that a state may choose to cover ("optional services"). Many of the community services in the broad array required to meet the needs of adults with serious mental illnesses fall into the optional categories.

Each state's Medicaid program is described in its State Medicaid Plan, a document that specifies the amount, duration and scope of benefits provided, the qualifications of providers and other aspects of the program. The federal agency that administers Medicaid (the Centers for Medicare and Medicaid Services—CMS—in the U.S. Department of Health and Human

## **OVERVIEW OF MEDICAID**

Services<sup>2</sup>) approves each State Medicaid Plan by evaluating the state's choices against the broad federal requirements.

Within broad national guidelines, each state establishes its own eligibility standards, determines which services beyond those mandated by federal law, if any, will be available, sets payment rates and administers its state program. States also determine the specific elements of any optional Medicaid service, define who may provide it and who must refer the individual to the service or supervise it.

Once a service is defined by a state for a specific population, it must be made available on a statewide basis to all Medicaid-eligible state residents in that population for whom it is medically necessary. With one exception (targeted case management), states may not limit a Medicaid service geographically or by income or any other arbitrary category unless they obtain a waiver from this rule from the federal government.

Under federal law, a state must designate a "single state Medicaid agency" to administer its Medicaid program. The mental health authority must negotiate with that agency regarding definitions of covered services, reimbursement structure, rates to be paid to providers, and what aspects of Medicaid administration will be delegated to the mental health authority. In many states, the mental health authority contributes the state matching funds for Medicaid-covered mental health services. In several, the mental health authority has an agreement with the Medicaid agency that gives it responsibility for administering Medicaid with respect to mental health services. This gives the mental health authority greater flexibility to develop Medicaid mental health services that build and help to expand community-based systems of care.

**MENTAL HEALTH SERVICES  
UNDER MEDICAID**

Adults with serious mental illnesses require a comprehensive array of community mental health services and other supports to live independent and productive lives in our communities. The federal Center for Mental Health Services (CMHS) has defined the necessary array of community support services to include: medical and mental health treatment, crisis stabili-



zation, psychosocial rehabilitation, peer support, housing, income support, support to families and others, case management and outreach.<sup>3</sup> CMHS promotes a philosophy of recovery—an emphasis on the potential of all individuals to recover from the challenging impact of psychiatric disability, even though the mental disorder may not be cured in the medical sense. This requires a consumer-focused service system that meets all of an individual's needs in the community, thus encouraging independence, integration and productivity.

Medicaid-funded services should fit into the state's overall plan for a full community support system, including clinical care, job services and other non-Medicaid activities. Comprehensive planning processes (such as the process most states are now pursuing to meet *Olmstead* requirements) can enhance stakeholder support and ensure that rules reflect consumer concerns.

Provisions of federal law, particularly the optional status of many community-based services under Medicaid, can combine with intense state fiscal pressures and state-level relationships to complicate state mental health authorities' objectives. Medicaid agencies are under intense pressure to control spending. Other officials, such as the Governor or state legislators, may respond more readily to fiscal pressures than to the need for expanding the array of services offered by the public mental health system. The mandatory Medicaid services (such as inpatient hospital, physician services, and pharmaceuticals) consume a major portion of the state's available financial and management resources. Further, state officials are sometimes unable to see the connections between services that Medicaid funds, or does not fund, and costs borne by other arms of state government. For example, there is a clear connection between a lack of resources for community mental health services and increased expenses for criminal justice and social welfare.

While good Medicaid rules are important, states must also consider how they will fund both services that are not Medicaid-reimbursable and services provided by the public mental health system to people with serious mental illnesses who are

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**A philosophy of recovery requires a consumer-focused service system that meets all of an individual's needs in the community, thus encouraging independence, integration and productivity.**

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not covered by Medicaid. Over the past decade, many states have lost this flexibility. Medicaid dollars now represent about half of all state spending on community mental health services. With few other opportunities to increase their public mental health system resources, states have turned to Medicaid to obtain the federal matching funds. As a result, they have limited resources to fund services needed by non-Medicaid-eligible people with serious mental illnesses or services that Medicaid does not cover.

During the 1990s, the increased use of managed behavioral health care for Medicaid-covered individuals allowed a number of states to expand their Medicaid package of community mental health services. Some 16 states have now adopted state-wide (or virtually statewide) managed care arrangements for adults with serious mental illnesses, most of which “carve out” managed behavioral health care from the rest of their Medicaid program.<sup>4</sup> As they made the shift to managed care—a move designed to save resources overall—many states that had not previously opted to cover psychiatric rehabilitation services or targeted case management added these service options as part of the benefit package for managed care plans. Most of these states sooner or later also incorporated this expansion in their regular Medicaid state plan and rules.

**ISSUES FOR MENTAL HEALTH  
SYSTEMS USING MEDICAID**

Medicaid is an essential source of resources for state mental health systems. If used wisely, it can support expansion of evidence-based practices that support consumers in their recovery.

The advantages of using Medicaid include:

- ◆ It is a stable funding source.
- ◆ The federal match expands the resources available for community services and federal law limits payments for institutional services, thus abetting states’ efforts to redirect funds from institutional care.
- ◆ By defining appropriate best practices in Medicaid, states can encourage the provision of quality care.

- ◆ Through designation of Medicaid providers, states can stimulate the expansion of appropriate nontraditional providers.
- ◆ Although Medicaid cannot finance all of the services and supports on the CMHS list, federal law allows states to cover a broad array of services.

However, while using Medicaid funds to underwrite state mental health systems has several advantages, writing Medicaid rules is a complex endeavor. Drawbacks and potential problems can be avoided or alleviated only through careful planning and appropriate policy. In developing their Medicaid rules, states seek to design benefits that encourage best practice, do not hinder innovation and receive approval at the federal level. They must, therefore, balance the necessity of creating clear and specific definitions of covered services that will encourage evidence-based practice with the need to foster innovation and cover newly emerging approaches to care so as not to force rigidity and blind conformity to all aspects of a particular model. They must also ensure that Medicaid rules do not impede the goals of the mental health system.

Potential drawbacks of Medicaid in this regard—all of which can be overcome with strong state policy<sup>5</sup>—include:

- ◆ Medicaid's requirement that services be medically necessary can encourage over-reliance on a medical model of care.
- ◆ Concern over meeting federal standards can lead states to develop unnecessarily cumbersome and complex rules that compartmentalize services.
- ◆ Concern about cost has led some states to require accounting in extremely short time increments (e.g., 15 minutes).
- ◆ Concern about cost and quality has led some states to demand unduly restrictive licensing and credentialing requirements.
- ◆ Difficulties face small programs—such as those providing rehabilitation and case management services—in meeting detailed record-keeping requirements, especially when they lack the modernized billing systems required to claim Medicaid reimbursement.

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Other more significant problems can be addressed by states, but resolving them requires resources:

- ◆ low Medicaid reimbursement rates; and
- ◆ lack of providers to furnish recovery-oriented services.

Confusion over what is an allowable Medicaid service can also prevent states from covering an appropriate array of community services. The flexibility allowed under federal law, while on the whole advantageous to states, also creates uncertainty about what is likely to be considered an allowable cost. One of the 10 regional CMS offices must review and approve any major changes to a state's Medicaid plan, and these offices may differ somewhat in their interpretation of federal rules. As a result, some states are very cautious in describing their service options.

In a number of states, these difficulties have been overcome and strong policy has emerged when the Medicaid agency and the mental health authority have developed a good working relationship and collaborated on the development of rules for community-based mental health care.

This report is written to assist mental health advocates and state mental health and Medicaid policymakers by describing in detail the federal rules on covering psychiatric rehabilitation and targeted case management services, summarizing state rules and regulations and providing (in the appendix) examples of specific state rules and tables that detail which states have covered various components of these services.

**Basic Definition**

Federal Medicaid law defines a rehabilitation service as “any medical or remedial services (provided in the facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts, within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.”<sup>6</sup> Medical necessity for rehabilitation services is thus based on functional criteria, not just diagnosis.

To explain covered psychiatric rehabilitation services, the federal agency responsible for administration of Medicaid (then known as the Health Care Financing Administration) issued a policy memorandum in June 1992. This memorandum clarified for state Medicaid agencies that they could include psychiatric services under the Rehabilitation Option, provided the goal of the service is rehabilitative.<sup>7</sup>

Specifically referenced as covered services are restoration of basic skills necessary to function independently in the community, redevelopment of communication and socialization skills, and family education and other family services exclusively related to treatment or rehabilitation of the covered individual.

Specifically not covered are vocational services (especially job training) and academic education. Nonetheless, states can and do define work as a goal of rehabilitation services, as, for example, does Louisiana in its basic definition: “Services should enable the recipient to become a productive member of society, earn a wage and live as independently as possible, reducing dependency.”

Additional activities are allowable under federal rules, as described in more detail below. Some services can be included under either the Rehabilitation Option or other service categories. For example, personal-care services can be covered under

**PSYCHIATRIC  
REHABILITATION OPTION**

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**Medical necessity for  
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the rehabilitation option if the intent is to teach personal-care skills, rather than provide personal-care assistance.

### **Rehabilitation Providers**

Federal rules do not define agencies or individuals that may qualify as providers of rehabilitation services. This is left to the states.

## **REHABILITATION SERVICES 1. Basic living-skills training**

Federal guidance provides examples of services for “restoration of those basic living skills necessary to independently function in the community.”<sup>8</sup> These examples are food planning and preparation, maintenance of living environment, community awareness and mobility skills.

### **2. Social-skills training**

Lack of interpersonal skills can affect a person’s quality of life and ability to live in the community. Social and interpersonal skills are necessary for working, for getting along with landlords and neighbors, for social contacts and having a social network for support. Federal guidance recognizes the importance of social skills, and specifically references services for “redevelopment of those skills necessary to enable and maintain independent living in the community, including communication and socialization skills and techniques.”<sup>9</sup>

### **3. Residential support services**

Residential support services for individuals living in small facilities (16 or fewer beds) are covered under Medicaid, whether furnished in the individual’s own residence, in other locations (such as a homeless shelter or on the street) or in a facility-based program. Services should be aimed at ensuring successful community tenure. Residential services allow individuals to practice skills in different settings, improving the transferability of their skills. These services also enable early identification of problems in living situations while there is still an opportunity to intervene with landlords or neighbors and thus avoid eviction.

Although residential services in small facilities are covered, room and board is not. Room and board costs are covered under Medicaid only when the person lives in a covered residential facility (a community or general hospital or a nursing facility or, for children under 21, a psychiatric hospital or, for adults over 64 in states that have elected this option, in a psychiatric hospital or other “institution for mental diseases”).

#### **4. Employment-related services**

Vocational services are not covered by Medicaid. However, people with mental illnesses often lose interpersonal skills critical to successful employment. Many are able to obtain employment, having the education and job skills to do the work. But they also lose jobs quickly and often, typically because of an inability to get along with supervisors and co-workers, to concentrate on tasks at hand, to work at a reasonable pace or to persist at a task. Restoration of these skills is a Medicaid-covered psychiatric rehabilitation service, falling under the federal rules for training in basic or daily-living or social skills.

#### **5. Education**

Federal rules specifically exclude education from Medicaid reimbursement and academic teaching cannot be a covered Medicaid service. However, as with employment, successful participation in an education program requires certain social and basic and daily-living skills. Accordingly, specific educational goals can be included in an individual’s plan of care, provided the services furnished to attain the goals are rehabilitative in nature and designed to assist in the maximum reduction of disability and to restore the individual to his or her best possible functional level.

#### **6. Social and recreational activities**

The federal policy memorandum points out that it is not always possible to determine whether a specific service is rehabilitative by scrutinizing the service itself, and that it is “more meaningful to consider the goal of the treatment.”<sup>10</sup> By law,

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**The federal policy memorandum points out that it is not always possible to determine whether a specific service is rehabilitative by scrutinizing the service itself, and that it is “more meaningful to consider the goal of the treatment.”**

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the goal of rehabilitation services is “maximum reduction of physical or mental disability and restoration of a recipient to the best possible functional level.”<sup>11</sup> In this way, the federal requirement encourages, rather than limits, a recovery-based approach.

States and federal regional offices have interpreted this language to mean that certain social and recreational activities can be covered when the purpose of the activity is to improve the individual’s skills, to reduce mental disability and to help restore the individual to the best possible functional level.

### **7. Peer services**

Programs furnished or run by consumers can offer Medicaid-covered rehabilitation services if they meet certain standards. Consumers may be employed as mental health professionals, case managers or in other positions where they furnish specific Medicaid-covered services, including skill-building or disability management and education. Some consumer programs, such as drop-in centers—places for obtaining social support and assistance with problems—may provide some services that are Medicaid-reimbursable, such as case management or skill-building, and other services that are not, such as purely social events.

On the other hand, Medicaid does not cover self-help groups that are based on the premise that people with a shared condition can receive support and learn from each other (such as cancer-survivor or smoking-cessation groups). Accordingly, mental health consumer peer-support groups have not *per se* been a covered Medicaid service. States therefore need to use other resources, such as state general revenue funds or federal block funds, for such support groups. This reflects the reality that a full array of community services to help people avoid unnecessary hospitalization and achieve a quality of life in the community must include a number of services that are not Medicaid-reimbursable.

### **8. Family education**

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**A full array of community services to help people avoid unnecessary hospitalization and achieve a quality of life in the community must include a number of services that are not Medicaid-reimbursable.**

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Federal law permits payment for activities to assist families and significant others in providing care and support to the individual who is receiving services. Covered family services can include education for family caregivers about the covered individual's mental illness, training and clinical support for families in relating with the individual and in dealing with crises, direct and immediate crisis-intervention services, crisis-respite services and training in problem-solving skills—all services that enhance the community tenure of adults with serious mental illnesses. However, Medicaid payments can be made only for services that are directed exclusively to the well-being of a covered Medicaid recipient. Medicaid therefore does not permit payment for mental health counseling or other services to family members or significant others for their own problems unless that individual is also Medicaid-eligible.

#### **9. Substance abuse services**

Medicaid can cover an array of addiction-treatment services to meet the needs of people with serious mental illnesses and co-occurring substance abuse disorders. These services, which may be covered under either the Clinic Option or the Rehabilitation Option, include screening, intensive outpatient treatment, methadone maintenance, consumer-run services and ambulatory detoxification. Some states include these in their “mental health” benefit, while others have defined a full Rehabilitation Option benefit just for substance abuse. There are advantages to the latter approach, especially in states with strong substance abuse authorities that are independent of the mental health authority.

#### **10. Case management services**

Federal Medicaid rules allow coverage of case management services in four categories. The first three are:

- ◆ targeted case management, provided through Medicaid's Targeted Case Management Option;
- ◆ assertive case management (more often referred to by states

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**Medicaid can cover an array of addiction-treatment services to meet the needs of people with serious mental illnesses and co-occurring substance abuse disorders.**

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as intensive case management) and assertive community treatment (ACT)—both specifically referenced as Medicaid-covered services in federal guidance;<sup>12</sup>

◆ services case management, generally provided as part of another service, such as rehabilitation, and aimed at gaining access to, coordinating and monitoring various Medicaid-reimbursable services.

State rules often do not create separate categories for targeted case management and service case management and some also do not separate out intensive case management. ACT is usually clearly and separately defined.

The fourth category is administrative case management, related to issues such as Medicaid eligibility, and to the establishment and coordination of Medicaid services—e.g., for homeless people, to determine their eligibility and coordinate start-up and provision of Medicaid-covered care for them. This study did not review states' use of administrative case management. Administrative case management is primarily concerned with the “proper and efficient administration of a state plan.”<sup>13</sup> Services must be “consistent with simplicity of administration and in the best interests of the recipients of assistance.”<sup>14</sup> Administrative case management is therefore limited to assisting individuals in gaining access to Medicaid-funded services and includes activities related to eligibility determination.

#### ◆ **Targeted case management**

Targeted case management (TCM) is a Medicaid term for funding services that broker access to non-Medicaid services and supports. Under federal law, targeted case management consists of “services which will assist individuals...in gaining access to needed medical, social, educational and other services.”<sup>15</sup> The services and supports that may be brokered include housing, social services, vocational training and education.

Unlike other services, which Medicaid law requires be furnished statewide to all eligible persons, TCM can be limited both to a target population, such as people with serious mental illnesses, and to individuals residing in specified areas of the state.

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**If provided for the purpose of community transition, targeted case management services may be furnished during the last 180 consecutive days of a person's institutional stay, provided the person is in a Medicaid-covered facility.**

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If provided for the purpose of community transition, targeted case management services may be furnished during the last 180 consecutive days of a person's institutional stay, provided the person is in a Medicaid-covered facility.<sup>16</sup> This would include a community or general hospital or nursing home, but not an "institution for mental diseases" unless the individual is elderly and the state covers IMD services for those 65 and older. Targeted case management also cannot be furnished to individuals in a correctional facility.

◆ **Assertive case management**

In June 1999 the federal agency clarified that Medicaid can be used to pay for assertive community treatment and assertive case management (i.e., intensive case management).<sup>17</sup> These services are designed to meet the varied needs of individuals with the most severe disorders.

Assertive community treatment—an intensive approach to the treatment of people with the most severe mental illnesses—provides comprehensive services in the community through an interdisciplinary team. As described in federal guidance, services are furnished 24 hours a day, seven days a week. They incorporate comprehensive treatment planning, ongoing responsibility for care, staff continuity and small caseloads. ACT is best targeted to individuals with the greatest service need, particularly those with a history of multiple hospitalizations. Among these programs' frequent users are homeless people and those with co-occurring mental illness and addiction.

◆ **Intensive case management**

Intensive case management programs are similar to ACT in approach. Federal guidance emphasizes that an assertive, or intensive, case management program must incorporate shared caseloads and provide individualized, community-based services. However, such programs sometimes do not meet other specific standards for an ACT program, such as 24-hour a day availability.

Programs providing ACT and intensive case management

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**Assertive community treatment services incorporate comprehensive treatment planning, ongoing responsibility for care, staff continuity and small caseloads.**

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do not fit easily into a single Medicaid category and the federal guidance did not explain how programs may combine aspects of two or more Medicaid service options and bundle them together for a single reimbursement rate. States covering assertive community treatment or intensive case management have therefore structured reimbursement for these services in different ways.

◆ **Services case management**

Case management services that are delivered as part of an overall package of services under any Medicaid service category are covered. To distinguish this activity from other types of case management, the term services case management is sometimes used.

**11. Services planning**

Services planning under the Rehabilitation Option must focus on functional issues, so as to improve the individual's ability to live in the community. Federal law allows states to specify definitions and requirements for service planning. Federal rules require only that rehabilitation services (and therefore planning) focus on a rehabilitative goal and on maintaining, improving or preventing deterioration in the individual's level of functioning. Services-planning rules can accomplish a great deal in terms of engaging consumers in their services, and defining their own goals and objectives for services.

**12. Symptom and disability management**

Another important component of recovery is the management of symptoms and development of skills for coping with deficits caused by the mental disorder. While not specifically referenced in federal rules, helping individuals with mental illnesses to manage their symptoms and disability is clearly related to the stated goals of rehabilitation services, and states have included these activities within their Medicaid rules.

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**Services-planning rules can accomplish a great deal in terms of engaging consumers in their services, and defining their own goals and objectives for services.**

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### **13. Advance directives**

An important tool for self-management of disability is an advance directive. Federal guidance emphasizes the importance of consumer-directed care and points out that advance directives are “becoming an increasingly important tool for consumers...to articulate their decisions about treatment and to guide treatment when they can not make these decisions themselves.”<sup>18</sup> Medicaid requires states to develop and provide current information about state laws dealing with advance directives (for all health care).<sup>19</sup> The federal agency has “urged state mental health authorities to ensure appropriate attention to mental health issues in their advance directives policies, and to consider how these policies are operationalized in Medicaid program services.”<sup>20</sup>

### **14. Outreach**

Outreach is covered in any setting. It is particularly appropriate for use with homeless individuals who may not be currently on Medicaid but are very likely to be eligible due to the severity of their disability. Outreach to individuals who are already participating in services is covered for all Medicaid service options, including rehabilitation and targeted case management. Administrative case management can also be used to conduct outreach to people who may be eligible for Medicaid for the purpose of determining such eligibility, and to follow up with individuals who were previously in services but have lost touch with providers.

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**Advance directives are  
“becoming an  
increasingly important  
tool for consumers...to  
articulate their  
decisions about  
treatment...”**

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## REHABILITATION-FOCUSED COMMUNITY MENTAL HEALTH SERVICES: WHAT RESEARCH SHOWS

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As a result of research over more than two decades, we know a great deal about how to improve outcomes and enhance the recovery process for people with severe mental illnesses.<sup>21</sup> Research has demonstrated that individuals who receive psychiatric rehabilitation services experience significantly shorter hospitalization, improved social functioning, and greater satisfaction and fulfillment through employment, and are more likely to return to school or work as productive members of society.<sup>22</sup> Psychiatric rehabilitation has helped people with mental illnesses to achieve and maintain a higher standard of living.

More than 50 studies have shown that social-skills training helps to reduce relapses, alleviates stress on the family and increases social capacity. Research results show an increase in symptom and medication management, while the skills attained last for a long time. Social-skills training is often furnished “in vivo,” thus facilitating generalization of skills important for independent living and employment.<sup>23</sup>

Supported-employment programs have also been found successful in helping individuals with mental illnesses to find and maintain jobs. These programs place people in competitive jobs in integrated work settings and then provide ongoing mental health rehabilitation services. The evidence base for supported employment shows improved employment outcomes.<sup>24</sup> The results are positive work experiences, reduced dependence on government programs and benefits, higher self-esteem and, overall, a better quality of life.

Supported housing also has been found to decrease rehospitalization and homelessness, while increasing social and vocational functioning. The quality of life of people with mental disabilities greatly improves when they are able to live independently through supported housing.

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**Individuals who receive psychiatric rehabilitation services experience significantly shorter hospitalization, improved social functioning, and greater satisfaction and fulfillment through employment, and are more likely to return to school or work as productive members of society.**

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Supported-education students are more likely to return to college, compete competitively in employment, and have higher self-esteem. Research shows that supported education helps raise both employment levels and the hourly wages of those who participate in the programs.

Social/recreational components of a community program have also been assessed. Participants in such a program have reported significant improvement in their self-ratings of functioning and in their general life satisfaction.<sup>25</sup>

Training in self-managing illness and disability has been shown effective in helping individuals to learn and retain new information and skills and tailor their behavior to achieve positive outcomes. Such services include education in diagnosis and symptoms, effects of medication, stress-vulnerability and effects of alcohol and drugs, and training in recognition of early warning signs and in the development of coping skills.<sup>26</sup>

Opportunities for consumers to interact with other consumers who are now in recovery can be extremely beneficial. Although self-help groups *per se* cannot be covered under Medicaid, other peer services can be reimbursed. The research on peer-relationship issues is therefore relevant. For example, participation in self-help groups, such as Alcoholics Anonymous and similar organizations, often lessens feelings of isolation, increases practical knowledge and sustains coping efforts.<sup>27</sup> Although the research base is modest, several studies show improved client outcomes with such self-help programs.<sup>28</sup> In addition, several published studies on consumer-run programs have shown the feasibility and effectiveness of stand-alone consumer-provided services.<sup>29</sup>

There is compelling evidence from randomized trials for family-education programs.<sup>30</sup> These programs provide education, guidance, crisis intervention and training and support in effective problem-solving techniques and communication. Family psychoeducation assists family members in their interactions with individuals with serious mental illnesses. These interventions have strongly and consistently demonstrated their

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**Opportunities for consumers to interact with other consumers who are now in recovery can be extremely beneficial.**

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value in preventing or delaying symptom relapse and appear to improve the individual's overall functioning. Relapse rates have been halved in some studies.<sup>31</sup> In addition, costs of care have decreased.

Results of controlled studies of the effects of case management have yielded inconsistent findings, partly due to methodological problems in the studies, but also because case management services cannot be effective if services in the community are inadequate or when the case manager is not well integrated into the service team.<sup>32</sup> There is, however, a body of research on intensive case management and assertive outreach. Such services promote continuity of outpatient care and increase community tenure and residence stability for people with serious mental illnesses.<sup>33</sup> Various studies show a reduction in both hospitalization and the length of time spent in psychiatric institutions when individuals are engaged in intensive case management and assertive outreach.

For example, assertive community treatment, including case management, active treatment and rehabilitation services furnished by a single team using a highly individualized approach, has been proven effective in more than 25 randomized controlled studies.<sup>34</sup> ACT reduces the length of hospitalization, improves living conditions and is particularly effective for individuals who are severely impaired in functioning, who have high service utilization or those who are homeless.<sup>35</sup> Evidence is strongest for programs with a ratio of at least one staff for 10 individuals.<sup>36</sup>

Intensive case management has also been shown a cost-effective alternative to hospitalization.<sup>37</sup> Intensive case management programs are usually furnished to individuals with serious mental illnesses who are not so significantly impaired that they require ACT.

Research on addiction services for people who also have serious mental illnesses has shown that integrated treatment is the most effective. Research amassed over the past 10 years supports a shift to treatment that combines interventions directed

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**Intensive case management has also been shown a cost-effective alternative to hospitalization.**

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simultaneously to both serious mental illness and addiction by the same group of providers. Numerous controlled studies support the effectiveness of integrated treatment for people with dual diagnoses.<sup>38</sup>

Most successful models of combined treatment provide a comprehensive, long-term, staged approach to recovery and include case management, help in acquiring skills, supports to manage both illnesses, and assertive outreach to bring people into treatment. They typically take into account the cognitive and motivational deficits that characterize serious mental illness and are effective at engaging people with both diagnoses in outpatient services, maintaining continuity and consistency of care, reducing hospitalization and decreasing substance abuse while improving social functioning.<sup>39</sup> Cross-trained staff working in single service locations appears most effective.

A number of new and effective medications are now available to treat major mental illnesses. These new antipsychotics and antidepressants have favorable safety and side-effect profiles along with their therapeutic advantages.<sup>40</sup> Although the cost of these drugs has sometimes led to restrictions on their use, the more important issue for policymakers is value per health dollar. Appropriate guidelines for their use can ensure the effectiveness of these medications and, because consumers find them far easier to tolerate, the payoff is a greater likelihood of recovery.

Given this research base, there is every reason to incorporate these evidence-based services under a state's Medicaid plan. The National Institute of Mental Health and the Center for Mental Health Services are developing a set of tool-kits for the implementation of six of them: supported employment, illness self-management, integrated treatment for people with both mental illnesses and addiction, assertive community treatment, family education and medications. The tool-kits will be available in 2002.<sup>41</sup>

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**Numerous controlled studies support the effectiveness of integrated treatment for people with dual diagnoses of serious mental illness and addiction.**

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## COORDINATING MEDICAID WITH A STATE'S MENTAL HEALTH SYSTEM

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**T**his study reviewed the degree to which state rules under the rehabilitation and targeted case management options support a rehabilitative, recovery-focused community-based system of care for adults with serious and disabling mental illnesses. Overall, the results are encouraging, although much more could be done under existing federal rules.

All states but one have selected the rehabilitation option and the great majority (39) have chosen the targeted case management option for adults with serious mental illnesses. These data show an impressive growth in use of these options over the past several years. In a number of states, the services must be furnished in a manner consistent with the goal of recovery.

Most of the states using the rehabilitation option rely on a facility-based approach. In 42 states, rehabilitation services are to be furnished through specifically defined provider agencies, which must meet standards related to rehabilitation. Twenty-eight states define either psychiatric, psychosocial or social rehabilitation provider agencies and 14 cover clubhouse programs. These terms are generally used to describe programs with a strong rehabilitation philosophy, contrasted to clinical approaches, which may be offered through partial hospitalization or day treatment programs.

These data are confirmed by the fact that 42 states define as covered the basic rehabilitation services of daily living-skills training, 38 refer to social-skills training, 30 to employment-related services and 25 to residential-based services. Also very commonly covered (in 31 states) are family-education services. In 16 states, social and recreation services related to a rehabilitative goal could be furnished.

Almost half the states now address the needs of people with the most severe impairments to have access to ongoing and intensive services. Twenty-four states cover intensive case man-

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**All states but one have selected the rehabilitation option and the great majority have chosen the targeted case management option for adults with serious mental illnesses.**

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agement and 23 cover assertive community treatment. Fourteen states specifically discuss the need for outreach in their rehabilitation rules, but many others likely reimburse for appropriate outreach.

Some of the most important services are covered in very few states, however. For example, peer services of any form were specifically cited in only 10 states. In most, peer services are made available by having providers of the service be individuals in recovery or individuals who have experienced a serious mental illness. Few states discussed the need for peer services as a specific activity. Also poorly covered is integrated mental health and substance abuse treatment for consumers with co-occurring disorders. No more than six states referenced this service, although it is possible that integrated treatment is paid for in others, without specific definition.

Certain states also stand out as having weaker rules. While the great majority of states offer a significant scope of activities under their rules (see table 1), several do not cover basic rehabilitation activities. Twelve do not cover either basic living-skills training, social-skills training or both.<sup>42</sup> A state failing to cover these essential services is unlikely to be offering a rehabilitation or recovery-oriented approach. Three states<sup>43</sup> fail to cover either of these services; eight cover social-skills training but not daily living-skills training, while one covers training in basic living skills but not social-skills training. In addition, Delaware limits eligibility for rehabilitation services to a very narrowly defined population, using a definition more commonly seen for assertive community treatment programs than for rehabilitation.

The following sections discuss issues related to state definitions of the various components of rehabilitation and case management services. The first appendix provides a parallel set of examples from various state rules to illustrate how various states have dealt with these issues. Readers should be aware, however, that the extracts from state rules—quoted in this section—have been condensed, and are not verbatim descriptions.

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**A state failing to cover basic living-skills training, social-skills training or both is unlikely to be offering a rehabilitation or recovery-oriented approach.**

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**Basic Rehabilitation Services Definitions**

Some states include a basic definition of rehabilitation services in their rules, prior to detailing who may furnish services, what services may be furnished, under what conditions and to whom. Often these states use this basic definition to articulate the philosophy of rehabilitation they wish to encourage and emphasize. Pennsylvania, for example, articulates “the philosophy...that people with disabilities need opportunities to identify and choose for themselves their desired roles in the community with regard to living, learning, working and/or social environments.” Other states incorporate statements of philosophy in their definitions of rehabilitation providers or their rules on service planning.

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**Pennsylvania, for example, articulates “the philosophy...that people with disabilities need opportunities to identify and choose for themselves their desired roles in the community with regard to living, learning, working and/or social environments.”**

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A recovery philosophy can be woven into a state’s rehabilitation rules and recovery-oriented services can be funded. States have flexibility in defining the rehabilitative approach and the philosophy of rehabilitation they wish to emphasize, provided that the services delivered fall within the federal Medicaid guidance. That is, they must be deemed necessary to treat or ameliorate a mental disorder and be supervised by a licensed professional of the healing arts.

Currently, only a few states’ rehabilitation rules cite or appear based on a recovery philosophy (see tables). These states have been able to address in their rules the recovery issues of choice, empowerment, non-coercion, rights protection, and self-determination and responsibility for managing one’s own health. Many states, however, designed their rehabilitation rules many years ago, when recovery-based approaches were less prevalent, and have not addressed this issue since.

**Definitions of Facility-Based Rehabilitation Programs**

Standards for provider agencies are a state responsibility because the federal rules lack specific requirements for programs offering psychiatric rehabilitation. State standards address staffing, supervision, accreditation, administration and other requirements. States may use one or more of five national accrediting entities: the Commission on Accreditation of Rehabilitation Fa-

cilities (CARF), the Council on Accreditation (COA), the International Center for Clubhouse Development (ICCD), the National Committee for Quality Assurance (NCOA) or the Joint Commission on Accreditation of Health Organizations (JCAHO). They may also incorporate language that articulates the philosophy of rehabilitation the state wishes to encourage. The District of Columbia’s definition describes “a facility-based, structured clinical program to develop skills and foster social role integration through a range of social, educational, behavioral and cognitive interventions.” By thus defining appropriate facility-based providers, states are able to assure quality of programming and prevent inappropriate billing by entities that are unable to offer a comprehensive array of services.

Terms used to describe rehabilitation facilities vary from state to state, and some states cover more than one type of facility-based program.

- ◆ 24 states cover psychiatric/psychosocial rehabilitation programs.
- ◆ 10 states cover social rehabilitation programs.
- ◆ 32 states cover day treatment programs.
- ◆ 14 states cover clubhouses.

Facility-based programs are generally authorized to furnish services on site, in off-site locations and through mobile services. Mobile-services providers may be the covered facility itself or an ACT, intensive case management or crisis team.

Some facility-based programs do not offer all components of a rehabilitation program and/or offer important services not covered by Medicaid. These programs can still be covered as facility-based rehabilitation programs, but will require additional revenue from the state and other sources to continue providing non-Medicaid services. Clubhouse programs fit into this category, and without additional non-Medicaid resources, some essential elements of a clubhouse program may be lost.

Definitions of rehabilitation facilities reviewed for this report do not include partial hospitalization programs, which are day programs providing clinical care (often similar in the range of services and activities they provide to inpatient hos-

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**By defining appropriate facility-based providers, states are able to assure quality of programming and prevent inappropriate billing by entities that are unable to offer a comprehensive array of services.**

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**Rehabilitation programs focus on assisting individuals in attaining and maintaining goals relating to functioning (such as employment and living independently).**

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pitals). These programs aim to stabilize an individual's symptoms using various clinical modalities. In contrast, rehabilitation programs focus on assisting individuals in attaining and maintaining goals relating to functioning (such as employment and living independently). Most states define partial hospitalization programs in their Clinic Option rules, but some have included these definitions under the Rehabilitation Option. However, none of these Rehabilitation Option partial hospitalization programs have been included in the counts listed above.

**1. Restoration of basic or daily-living skills**

Forty-two states cover services to restore the skills required for independent functioning and numerous activities are listed in state rules as skills needed to achieve this goal. However, the various states use different terms to cover similar activities. Terms commonly used as examples in the state rules include:

- ◆ bathing
- ◆ budgeting
- ◆ bill-paying
- ◆ cooking
- ◆ community awareness
- ◆ community resources, use of
- ◆ decision-making
- ◆ dietary planning
- ◆ dressing
- ◆ eating
- ◆ economic issues
- ◆ environmental supports, development of
- ◆ food planning
- ◆ food preparation
- ◆ grocery shopping
- ◆ housekeeping
- ◆ laundry
- ◆ living space, effective management of
- ◆ maintaining an independent residence
- ◆ maintaining living environment
- ◆ managing money
- ◆ meal preparation
- ◆ medication use
- ◆ medication, self-administration
- ◆ mobility
- ◆ money management
- ◆ nutrition
- ◆ personal hygiene
- ◆ personal grooming
- ◆ retail purchasing
- ◆ self-care
- ◆ shopping
- ◆ transportation access
- ◆ use of public transportation
- ◆ using community services

Lists usually include a category of “other” skills needed for community living, making all definitions quite expansive. Some states, but not many, include activities of daily living (ADLs), which are generally assumed to be more appropriate for people with physical disabilities. However, services to restore basic or daily-living skills can be provided through training, guiding, supervising, cueing or reminding, or through techniques to teach how to overcome barriers by changing how the person interacts with his or her environment. The Missouri definition adds “interceding on behalf of individual clients within the community to assist them in achieving and maintaining community adjustment and maximizing community integration.”

## **2. Restoration of social/interpersonal skills**

Social-skills training addresses verbal and nonverbal interpersonal skills and competencies to live successfully in community settings. It can incorporate interpersonal communication skills, cognitive-skill remediation, problem-solving and conflict resolution, management of stress and relationship building, including basic conversation skills.

Thirty-eight states specifically include social-skills training in their definition of covered psychiatric rehabilitation services. Louisiana describes it as including “communication, interpersonal relationships (including roommates and neighbors), problem-solving and conflict resolution, management of sensory input and stress and decision-making.”

## **3. Residential services**

State rules on covered rehabilitation services focus on the activities that support the development of skills specific to community living. Clearly, basic or daily-living skills and social skills are essential to achieve this goal and therefore significant overlap exists between the definitions of residential services and of basic and daily-living skills and social-skills training. Indeed, many states simply merge the goal of obtaining or retaining an appropriate living situation with the goals of skills training.

States also cover activities related to finding and maintain-

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**Services to restore basic or daily-living skills can be provided through training, guiding, supervising, cueing or reminding, or through techniques to teach how to overcome barriers by changing how the person interacts with his or her environment.**

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ing housing, staff support in group residences, environmental supports and specific attention to interpersonal issues between consumers and their landlords or neighbors. Several include pragmatic approaches similar to Wisconsin's: "counseling the recipient in appropriately relating to neighbors, landlords."

Twenty-five states cover residential services and supports, either by referencing this goal in the definition of basic or daily-living skills or of social-skills training, or by including a separate description of residential services.

#### **4. Employment-related services**

As with residential services, the supports necessary for employment success may be covered under basic living-skills or social-skills training or may be separately referenced in the state rule. Thirty states specifically reference the importance of restoring certain skills in order to assist consumers in obtaining and maintaining employment.

Several states make specific reference to supported employment in their rules, covering the rehabilitation-skills development component of supported employment. Others refer to "pre-vocational" training services. For example, "objectives of pre-vocational services" in Arkansas' definition include "compliance with rules and instructions, punctuality, task completion, cooperation and communication with others, problem-solving and safety." Employment-related skills also include coping skills for a work environment and, as defined by Wisconsin, "counseling the individual to identify behaviors which interfere with seeking and maintaining employment."

Many states are careful to define the employment-related services that are *not* covered under Medicaid. Non-covered services include training in specific job skills and other direct employment training, as contrasted with covered services that help consumers with their interpersonal and daily-living skills (such as arriving on time, appropriately dressed). States funding supported employment or transitional employment programs must be particularly careful to exclude the non-Medicaid covered aspects of these programs, such as the teaching of specific job tasks.

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**Thirty states specifically reference the importance of restoring certain skills in order to assist consumers in obtaining and maintaining employment.**

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Nebraska, for example, does not cover “training for a specific job or assistance in obtaining permanent competitive employment positions.” And Maine excludes “vocational skills training and sheltered employment.”

## **5. Education**

This study did not identify education-related services as a separate category. In several states, however, education is sometimes referenced as an appropriate goal for consumers who receive services for restoring basic or community-living skills. Supported education has been covered in this manner. In Pennsylvania, for example, “services...frequently include counseling to help individuals to develop educational and career choices, assisting individuals to coordinate community services and campus-based services, teaching skills, such as asking for help or participating in class discussions, that individuals need to be successful and satisfied as students, and assisting in problem-solving if difficulties arise.”

As with employment services, states may, and some do, define the services excluded from Medicaid reimbursement (i.e., academic teaching).

## **6. Social/recreational activities**

Federal Medicaid rules do not cover purely social activities or recreational events without a rehabilitative focus. Sixteen state rules do, however, include coverage of services that offer individuals the opportunity to practice and improve social skills in various recreational settings, such as community activities, sports or hobbies.

Covered activities include improving natural support systems, relationship skills and coping skills and activities to “diminish tendencies towards isolation and withdrawal,” as Rhode Island’s rules state it. Ohio includes, “if necessary... accompanying the person to activity sites and assistance in daily-living activities.” To be covered, the service must be designed to assist the individual in reaching a goal in his or her service plan and must be written into the approved service plan.

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**Sixteen state rules include coverage of services that offer individuals the opportunity to practice and improve social skills in various recreational settings, such as community activities, sports or hobbies.**

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As with other complex coverage issues, states may also specify that activities with purely recreational or social purposes are not covered by Medicaid.

### **7. Peer services**

State rules defining peer services have two clear components: 1) definitions of the covered activities and 2) definitions of who is eligible to furnish various rehabilitation or case management services so as to include individuals who have experience with serious mental illness.

Ten states have referenced various forms of peer services in their Medicaid rehabilitation rules. The most frequent reference is in definitions of the qualifications of those who may deliver certain rehabilitation services. Federal rules do not specify who may deliver rehabilitation services, only that they must be supervised by a licensed professional of the healing arts. Using the flexibility this allows them, states have either required experience with mental illness as a qualification for certain staff positions or have counted such experience as “equivalent” to other staffing qualifications such as education and formal training. The key to this coverage is including mechanisms to credential peers in state law.

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**The key to coverage of peer services is including mechanisms to credential peers in state law.**

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Iowa’s definition is exceptionally comprehensive: “a person who has been diagnosed with a chronic mental illness who provides counseling and support services to other adults with the same or a similar mental illness and who has completed peer counseling and support training; abides by ethical guidelines applicable to a mental health counselor, provides services consistent with the rehabilitation component of the recipient’s plan under the supervisory oversight of a licensed professional or other provider, has demonstrated competency; and delivers the services through employment by or contract with a Medicaid provider.” ACT teams may be required to include a consumer.

Among the services states have authorized to be delivered by peers are social- and daily-living skills training, services to support residential or employment placements or develop natural support systems, and case management.

## **8. Family education**

Thirty-one states cover family education in some form. For example, South Carolina defines these services to “enable families and significant others to serve patients as knowledgeable support members of the patient’s treatment team.” Many definitions include family therapy, although most states have been careful to define these services so as to conform to federal requirements that they not include treatment for the family member or significant other, but are “services provided for the benefit of patients” (South Carolina) and “directed exclusively to the well-being and benefit of the person served and assistive to maintaining independent living in the community” (Ohio). Less often, services have the goal of helping to maintain the family and social network as a support system to the consumer. While not typically high-volume, these services can be very useful in supporting community-based systems of care.

## **9. Substance abuse services**

Given the significant number (40 percent or more) of people with serious mental illnesses who also have substance abuse disorders,<sup>44</sup> many states incorporate various addiction services and programming in their psychiatric rehabilitation rules. Integrated treatment provides both mental health and addiction services through a single treatment team or a program using a single service plan. Such arrangements are more effective than sequential treatment or parallel services for each disorder.<sup>45</sup>

Six states specifically include integrated treatment for mental illness and substance abuse disorders. Ohio specifies that “intensive outpatient services shall provide integrated treatment interventions” including “structured individual and group alcohol and drug addiction activities and services.” Minnesota, in defining an “outpatient rehabilitation program for chemical dependency,” requires that “rehabilitation services must be restorative or specialized maintenance therapy services and include medical treatment and physical or psychological therapy.”

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**South Carolina defines family education services to “enable families and significant others to serve patients as knowledgeable support members of the patient’s treatment team.”**

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**West Virginia lists components of the service, then notes that “the individual must be given the option of whether or not to utilize case management services and, if he/she chooses such services, must also be given a choice of state-approved providers.”**

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## **10. Case management**

Many states have created a single category of case management in their rules, incorporating several forms of federally defined case management services. Within this category, ACT teams are usually separately described, as is intensive case management. States that take this approach often offer both of these services, organized with slightly different rules and sometimes targeted to different groups—ACT programs usually to those with the most severe and persistent mental illnesses. Another service difference is a lower caseload in ACT programs.

Fifteen states offer both ACT and intensive case management. Nine use intensive case management services for their most impaired population and do not include ACT model programs at all. Seven other states rely solely on ACT.

### **◆ Targeted case management**

Targeted case management is limited to case management of non-Medicaid services and supports. Generally the federal definition appears to provide a clear basis for explaining targeted case management and state rules often restate the federal law verbatim (see page 58).

Some states have slightly expanded the federal definition or emphasized aspects of helping the targeted population of consumers with issues in their lives. New Hampshire lists “individual client advocacy to establish and maintain eligibility for programs of individual financial assistance, to uphold the client’s rights and support the client in obtaining other needed resources and services as specified in the service plan.” West Virginia lists components of the service, then notes that “the individual must be given the option of whether or not to utilize case management services and, if he/she chooses such services, must also be given a choice of state-approved providers.”

### **◆ Assertive community treatment**

Assertive community treatment is specifically referenced as a Medicaid-covered service.<sup>46</sup> Twenty-three states report including ACT teams in their Medicaid program. ACT definitions in-

clude clinical treatment, targeted case management, services case management and rehabilitation services. State definitions are very similar and are clearly based on the federal guidance, often restating each of the suggested elements but adding additional details. Many state rules also emphasize that ACT teams must include a consumer. Outreach is a priority, as in South Dakota's definition, which emphasizes that services "stress integration in normal community settings and must be responsive to cultural differences and special needs."

ACT definitions also include a definition of the target population, indicating that ACT services are available only to those most severely impaired, who use intensive services such as inpatient hospital care at high rates, are homeless and/or have a history of dropping out of services. Prior contact with the criminal justice system is also sometimes referenced.

Payment rates for ACT services must include costs of clinical care, various rehabilitation interventions and case management. In addition, several states have merged Medicaid reimbursement (for some aspects of ACT) with other dollars to cover a wider range of activities. Medicaid permits such bundling of rates for different services, but states generally must negotiate these rates with the federal regional office. Data on rates and bundling of service rates under ACT was not examined in this study. The issues will be addressed in volume II of this series.

#### ◆ **Intensive case management**

Definitions of intensive case management programs generally target a slightly less impaired population than ACT programs, but individuals receiving the service are nonetheless significantly disabled. The approach and the array of interventions are similar to ACT programs. Intensive case management generally (but not universally) uses interdisciplinary teams charged with providing case management, treatment and rehabilitation services to assist individuals with community living. Mobility is often a requirement, with, for example, services "furnished as needed in the place where the consumer resides or needs the service" in Pennsylvania.

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**Outreach is a priority, as in South Dakota's definition, which emphasizes that services "stress integration in normal community settings and must be responsive to cultural differences and special needs."**

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Twenty-four states cover intensive case management. In states covering both ACT and intensive case management, caseloads for intensive case management are generally higher (e.g., 22:1) than for ACT (12:1) but lower than for other case managers.

One emerging form of intensive case management is the Personal Assistance in Community Existence (PACE) program developed by the National Empowerment Center in Lawrence, Massachusetts. Although too new to appear in any state rules, PACE is designed as an assertive case management program using an empowerment model and based on recovery research.<sup>47</sup>

◆ **Services case management**

Services case management usually includes assessment to determine service needs, development of a specific plan of care, referral and related activities to help individuals obtain needed services, and monitoring and follow-up. New Hampshire includes “fostering natural support from the family and community, including consultation and education to family self-help, community self-help and other groups, organizations and individuals in the community and assuring that the client and, with client consent, significant others are educated about the client’s symptoms of illness and prescribed medications.”

These case management services may be furnished by staff who also provide other billable Medicaid services. However, Medicaid requires that only one service be furnished to an individual at a given time. Hence case management cannot be charged as part of a therapy session that is billed to Medicaid.

State definitions of case management are often lengthy and comprehensive. Many states have detailed rules regarding the role of case managers as the primary contact for Medicaid-covered individuals with serious mental illnesses who need ongoing community-based services, and initial crisis response is often the responsibility of the case manager. Often, case managers are also responsible for assisting individuals in the development of basic or daily-living skills or social skills.

Rules on required qualifications of case managers often encourage employment of peers in the role.

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**In its definition of services case management, New Hampshire includes “fostering natural support from the family and community....”**

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## **11. Service planning/assessment**

An appropriate, rehabilitation-focused functional assessment is critical to ensure that an individual will receive appropriate and necessary care. State rules for clinic services include requirements for clinical assessments. Many states repeat or adopt similar clinical assessment requirements in their rehabilitation rules. Most then expand this to include a functional assessment and appropriate planning for rehabilitation services.

These states require functional assessments to determine the individual's skills, strengths and deficits prior to the development or revision of an individual's service plan. Assessments generally relate to social functioning, ability to perform various basic or daily-living activities, ability to concentrate, capacity for persistence and maintaining pace (factors key to employment) and other issues.

Functional assessments build on individual strengths and lead to the establishment of goals and hoped-for outcomes of the services addressing the needs identified through the assessment. This is followed by the development of an individualized-services plan designed to meet those goals. Many states require that service plans be based on the goals of recovery (see page 45). For example, in New York, "a recipient selects a specific environment in which he or she intends to live, work, learn and/or socialize."

In a number of states, consumers fully participate in service planning and make choices among service options. For example, consumers may "participate in developing" or "be involved in" their service plan or engage in what Michigan terms "person-centered planning" that "honors the individual's preferences, choices and abilities." In New Hampshire's rule, "there shall be active recipient involvement, which requires that assessment and intervention procedures be explained to and understood by the recipient." Michigan's definition also specifies that "a person's cultural background shall be recognized and valued in the decision-making." There may also be a requirement that service plans be written in language a lay consumer can understand.

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**Functional assessments build on individual strengths and lead to the establishment of goals and hoped-for outcomes of the services.**

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Consumers frequently have the opportunity to sign the service plan if they are satisfied with it, or to include a written statement explaining their disagreement. Services plans are reviewed periodically, and the consumer and the service team may work together toward agreement on a revised plan.

## **12. Disability management**

It is part of good psychiatric care for physicians to explain the reasons for the use of medication, to monitor side effects, and to help consumers recognize signs that their medication may need to be adjusted and understand the importance of taking the medication as prescribed. Many states re-emphasize this role of medication management in their rehabilitation rules.

Disability management, however, is a broader term. It is recovery-related in its goal of enabling an individual to self-manage his or her illness, disability and life. Consumers are educated in a range of monitoring and coping skills related not only to overt symptoms but also to the negative effects of mental disorders on their ability to function in daily life. Disability management goes beyond teaching consumers about their symptoms and the medication they have been prescribed; it ensures that they have choices of treatment and service options.

While most state rules cover medication management, only 24 specifically deal with issues related to self-management of the impairment and its impact on the individual's functioning.

## **13. Advance directives**

Incorporation of state policies on advance directives in Medicaid rehabilitation rules is appropriate. Rehabilitation programs, with their emphasis on recovery, consumer choice and consumer empowerment, present good opportunities for consumers to be informed about:

- ◆ their right to have an advance directive;
- ◆ procedures for establishing a directive and/or appointing a health care agent; and
- ◆ the impact of the advance directive on their care should they be hospitalized in the future.

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***Disability management is recovery-related in its goal of enabling an individual to self-manage his or her illness, disability and life. It goes beyond teaching consumers about their symptoms and the medication they have been prescribed; it ensures that they have choices of treatment and service options.***

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For such an approach to be effective, however, parallel policies are needed to ensure that state hospital admissions and clinical staff—including staff in any private hospitals with which the state contracts for Medicaid-covered mental health services—take into account the consumer’s wishes as expressed in the advance directive.

Advance-directive policies are not normally incorporated in Medicaid psychiatric rehabilitation or targeted case management rules and were therefore not reviewed across all the states. However, one state, Vermont, has included advance directives in its rehabilitation rules and its agency “will provide training to staff and encourage staff to work with clients to develop crisis plans that reflect clients’ wishes.”

#### **14. Outreach**

States with intensive case management and ACT teams emphasize outreach to current consumers through those mechanisms (see above). Outreach covered through administrative case management would also not appear in the states’ rehabilitation rules, and administrative rules were not reviewed. Accordingly, outreach activities identified for this study are those separately defined in a state’s rehabilitation rules.

Fourteen states specifically refer to outreach services as a component of their rehabilitation services. Some states that do not reference outreach in their rules may nonetheless include the cost of outreach to those already in services, allowing providers to bill it as a standard part of a service. However, a direct reference to outreach in the rehabilitation rules helps to ensure that people do not become disconnected from services at times of crisis and that those in great need, such as homeless individuals, receive attention. Arizona’s managed care definition of rehabilitation services, for example, lists “services designed to seek out and encourage homeless individuals who are seriously mentally ill,” and Ohio gives community support program staff “the ability to provide services in various environments such as jails, homeless shelters, juvenile detention centers, street locations, workplace, etc.”

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**Vermont has included advance directives in its rehabilitation rules and its agency “will provide training to staff and encourage staff to work with clients to develop crisis plans that reflect clients’ wishes.”**

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## **OTHER ISSUES** *Crisis services*

Data on state definitions of crisis services are not included in this report because all states cover clinical crisis services. However, some state definitions go further and address the fact that other crises in an individual's life can threaten continued community tenure and lead to significant clinical crises. For example, a crisis related to housing (being evicted), at work (being fired), in relationships (breaking up with a significant other) or family (falling out with loved ones) places great strain and stress on the individual. Some state definitions of crisis services specifically reference the need for a crisis response for such events. Examples of broad state definitions of crisis services therefore appear in Appendix 1, under the Other Issues category.

### **Traditional healers**

For many Native Americans, traditional healers play an extremely important role in health care. States with significant Native American populations can address this issue by including coverage of traditional healers' services. Arizona includes "traditional healing services provided to tribal members...by Medicine Men or other trained healers."

### **Telemedicine**

In frontier or rural areas, access to providers can be a significant problem. Some psychiatric rehabilitation services can be appropriately delivered using telemedicine, such as the "interactive, visual, real-time telecommunication" listed in the Maine definition. The Maine rules list as nonreimbursable, however, the "costs of technology, transmission charges or charges for an attendant who instructs a patient in the use of the equipment or supervises/monitors a patient during a telemedicine encounter, or for consultations between professionals."

## **THE IMPACT OF MANAGED CARE**

Medicaid fee-for-service remains by far the most prevalent Medicaid approach for financing the intensive services required for adults with serious mental illnesses. Although 56 percent of all Medicaid beneficiaries are enrolled in managed care pro-

grams<sup>48</sup> and 82 managed care programs in 42 states provide some form of mental health/or substance abuse care,<sup>49</sup> adults with significant mental health needs generally do not receive services to address these needs through such plans.

Services for adults with serious mental illnesses are almost entirely covered through fee-for-service arrangements or specialized behavioral health carve-out managed care plans. Only five states contract with HMOs for intensive community services for people with serious mental illnesses, such as rehabilitation services.<sup>50</sup> Three of these states also have contracts with behavioral health carve-outs to furnish expanded services.<sup>51</sup>

We analyzed the most significant arrangement in each state, whether fee-for-service or some form of managed care. For states where individuals might be enrolled either in managed care or in fee-for-service, both the contracts and fee-for-service regulations were reviewed. In California, these two different financing arrangements nonetheless offered the same benefit package. The tables in the Appendix have information on:

- ◆ fee-for-service Medicaid programs (40 states);
- ◆ managed behavioral health carve-out programs that are either statewide or cover a significant portion of the state (16 states);
- ◆ integrated managed health care entities such as HMOs (five states).

A number of states have incorporated broader definitions of psychiatric rehabilitation in their managed care contracts or have expanded Medicaid coverage to add psychiatric rehabilitation for the first time as they transitioned to managed care. Managed care arrangements operate under waivers and are established on a cost-neutral basis; this allows more flexibility for the state to control utilization and cost. As a result, most Medicaid agencies allow more flexibility in rehabilitation service definitions and practice under managed care than under fee-for-service. In the summarizes of state definitions in Appendix I, managed care rules are clearly identified to distinguish them from rules approved for fee-for-service Medicaid programs.

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**Managed care arrangements operate under waivers and are established on a cost-neutral basis; this allows more flexibility for the state to control utilization and cost. As a result, Medicaid agencies allow more flexibility in rehabilitation service definitions and practice under managed care than under fee-for-service.**

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**T**his report clearly shows that nearly all the states are using the Medicaid rehabilitation option to furnish services to adults with serious mental illnesses. This option allows states to offer a range of services to address the impact of such disorders on an individual's functioning, particularly on the services the person needs to live and work in the community. Most states couple their rehabilitation services with targeted case management, in order to fund the essential linkage to help individuals access other, non-Medicaid benefits and supports such as housing, disability benefits or job training.

A significant minority of states have also broadened the activities funded under the rehabilitation and targeted case management options to offer real choices among services. These states have adopted recovery-oriented approaches to include peer services, social and recreational activities with a rehabilitation purpose, family education, and disability management. A number of states have also adopted newer practices, such as intensive case management and assertive community treatment, in response to encouragement from the federal agency.

However, wide variation remains in the degree to which states offer recovery-focused services that assist people in managing their own disability (often with the help of family or significant others) and gaining more control over their lives. The more expansive definitions of these services occur in a minority of states. In part, this may be the result of a state's failure to revise its Medicaid rules. The states may be using rules developed a number of years ago, emphasizing only the more basic aspects of rehabilitation, such as training in daily living or social skills, and largely ignoring the goal of recovery.

Accordingly, there is much room for improvement in the details of state rules on rehabilitation and targeted case management. Now states have available to them some valuable examples of strong provisions based on a recovery philosophy.

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**Now states have available to them some valuable examples of strong provisions based on a recovery philosophy.**

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By adapting such examples to make needed improvements in their Medicaid programs, they can enable many more adults with serious mental illnesses to live with dignity in their communities.

## NOTES

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1. 119 S. Ct. 2176 (1999).
2. Formerly known as the Federal Health Care Financing Administration (HCFA).
3. Mulkern, V. (1995). *The Community Support Program: A Model for Federal-State Partnership*. Mental Health Policy Resource Center, Washington D.C.
4. Arizona, California, Colorado, Florida, Hawaii, Iowa, Maryland, Massachusetts, Michigan, New Mexico, Oklahoma, Oregon, Pennsylvania, Tennessee, Utah and Washington. In addition, Texas and Florida have significant programs for managed mental health care, although these are not statewide.
5. Volume II of this series will address these issues in depth.
6. Social Security Act, Section 1905(a)(13).
7. *Rehabilitation Services for the Mentally Ill—Information Memorandum from Director, Medicaid Bureau, Health Care Financing Administration, U.S. Department of Human Services to All Regional Administrators, June 1, 1992 (FME-42)*.
8. *Ibid.*
9. *Ibid.*
10. *Ibid.*
11. Social Security Act, Title XIX, Section 1905(a)(13).
12. Letter to State Medicaid Directors from Sally K. Richardson, Director, Center for Medicaid and State Operations, Health Care Financing Administration, U.S. Department of Health and Human Services, Baltimore MD. June 7, 1999.
13. Preamble to Proposed Rule on Case Management, *Federal Register*, Vol. 58, No. 198, p 53481, October 15, 1993.
14. *Ibid.*
15. Social Security Act, Section 1915(g)(2).
16. Health Care Financing Administration, Letter from Timothy Westmoreland, Director, Center for Medicaid, to State Medicaid Directors, Olmstead Update No. 3, July 25, 2000.
17. Letter to State Medicaid Directors from Sally K. Richardson, 1999.

18. Ibid.
19. 42 C.F.R. Sections 431.20, 434.20 and 489.100.
20. Letter to State Medicaid Directors from Sally K. Richardson, 1999.
21. Bond, G.R., Becker, D.R., Drake, R.E. et al. (2001) Implementing Supported Employment as an Evidence-Based Practice. *Psychiatric Services* 52:3, 313-322.
22. Unless otherwise attributed, all research findings cited in this section are reported in Jonikas, J., Cook, J., Research in Psychosocial Rehabilitation. R. Hughes and D. Weinstein (eds.), *Best Practices in Psychosocial Rehabilitation* (pp 63-94). Columbia, MD: International Association of Psychosocial Rehabilitation Services (2000).
23. Drake, R. Evidence-Based Practices for People with Severe Mental Illness. Presentation at National Corrections Conference, Boston, MA. July 19, 2001.
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25. Petryshen, P., Hawkins, J.D. and Fronchak, T. (2001) An Evaluation of the Social Recreation Component of a Community Mental Health Program. *Psychiatric Rehabilitation Journal* 24:1, 293-298.
26. Drake presentation, 2001.
27. *Mental Health: A Report of the Surgeon General*. (1999) U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. p. 94.
28. Ibid., p. 290.
29. Solomon, P. & Draine, J. (2001) The State of Knowledge of the Effectiveness of Consumer Provided Services, *Psychiatric Rehabilitation Journal*, 25:1, 20-27.
30. Dixon, L., McFarlane, W., Lefley, H., et al. (2001) Evidence-Based Practices for Services to Families of People with Psychiatric Disabilities. *Psychiatric Services* 52:7, 903-910.
31. Practice Guideline for the Treatment of Patients with Schizophrenia, Supplement to *American Journal of Psychiatry*, 154:4, p. 30. April 1997. Recent studies include: Hogarty, G.E., Anderson, C.M., Reiss D.J., Kornblith S.J., Greenwald, D.P., Ulrich R.F., Carter M. (1991) Family psychoeducation, social skills training and maintenance chemotherapy in the aftercare treatment of schizophrenia, II: Two-year effects of a controlled study on relapse and adjustment. *Archives of General Psychiatry* 48:340-347; McFarlane, W.R., Stastny, P., Deakins, S. (1992) Family-aided assertive community treatment: a comprehensive rehabilitation and intensive case management approach for persons with schizophrenic disorders. *New Directions in Mental Health Services* 53:43-54; and Randolph E.T., Eth, S., Glynn, S.M., Paz, G.G., Leong, G.B., Shaner, A.L., Strachan, A., Van Vort, W., Escobar, J.L., Liverman, R.P. (1994) Behavioral family management in schizophrenia: outcome of a clinic-based intervention. *British Journal of Psychiatry* 164:501-506.
32. Practice Guideline, 1997. p. 29.
33. *Mental Health: A Report of the Surgeon General*, 1999. p 287.

34. Phillips, S.D., Burns, B.J., Edgar, E.R., et al. (2001) Moving Assertive Community Treatment into Standard Practice. *Psychiatric Services* 52:6, 771-779.
35. Practice Guideline, 1997. p. 29; Penn, D.L., Mueser, K.T. (1996) Research update on the psychosocial treatment of schizophrenia, *American Journal of Psychiatry* 153:607-617; Scott, J.E., Dixon, L.B. (1995) Psychological interventions for schizophrenia, *Schizophrenia Bulletin*, 21: 621-630; Burns, B. J., Santos, A.B. (1995) Assertive community treatment: an update of randomized trials. *Psychiatric Services* 46:669-675; and Test, M.A. (1992) Training in community living, in *Handbook of Psychiatric Rehabilitation*. Edited by Liberman, R.P. Needham Heights, Mass, Allyn and Bacon. pp. 153-170.
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37. Weisbrod, B.A., (1983) A Guide to Benefit-Cost Analysis, as Seen Through a Controlled Experiment in treating the Mentally Ill, in Helpman, E. (Ed), *An Economic Perspective*. San Diego, CA: Academic Press.
38. Drake, R.E., Essock, S.M., Shaner, A., et al. (2001) Implementing Dual Diagnosis Services for Clients with Severe Mental Illness. *Psychiatric Services* 52:6, 469-476.
39. Ibid. and Drake presentation, 2001.
40. Mellman, T, Miller, A.L., Weissman, E.M., Crismon, M.L., et al. (2001) Evidence-Based Pharmacologic Treatment for People with Severe Mental Illness: A Focus on Guidelines and Algorithms. *Psychiatric Services* 52:5, 619-625.
41. Articles based on the tool-kit evidence have already been published in *Psychiatric Services* and are referenced in this section.
42. Hawaii also does not cover basic living- and social-skills training in its statewide managed care plan at this time. However, Hawaii is not included in this count because it has a state-plan amendment pending before the federal agency that would include these and several other rehabilitation services.
43. Arkansas (FFS), Kentucky (FFS) and Minnesota (FFS).
44. Rouse, B. A.(Ed.). (1995) Substance Abuse and Mental Health Statistics Sourcebook, Substance Abuse and Mental Health Services Administration, DHHS Publication No. (SMA) 95-3064, Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office; and Clark, R.E. and Drake, R.E. (1992) Substance Abuse and Mental Illness: What Families Need to Know. *Innovations & Research*, Vol 1., No 4.
45. Drake presentation, 2001, and Drake, Essock, et al., 2001.
46. Letter to State Medicaid Directors from Sally K. Richardson, 1999.
47. Fisher, D. & Ahern, L. (2001) The PACE/Recovery Curriculum, The Empowerment Center, Lawrence, MA.
48. Medicaid Managed Care Trends (2000) U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services: Baltimore MD.

49. State Profiles, 1999. (2000) On Public Sector Managed Behavioral Health Care. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.
50. Florida, Massachusetts, New Hampshire, Oklahoma and Oregon.
51. Florida, Massachusetts and Oregon.



## **APPENDIX 1**

### **Examples of State Rules**

This appendix provides examples of state rules (edited for clarity and conciseness) on various aspects of recovery-focused community mental health services and highlights some critical issues that states addressed as they developed these definitions. Refer to pages 22 to 39 for more discussion on issues that arise when states define these activities for Medicaid reimbursement. Note that Pennsylvania's rules, excerpted in several of the sections, have been developed but are on hold as of this writing.

The examples include extracts from both fee-for-service and managed care rules, and this is noted in the text. For several categories, examples of language defining non-covered services is also included.

## BASIC DEFINITIONS OF MEDICAID-COVERED REHABILITATION SERVICES

The examples from state rules on this page illustrate:

- ◆ The goals of rehabilitation services, particularly as they differ from symptom-control Clinic Option goals.
- ◆ How states have incorporated a recovery-focused orientation in their rehabilitation rules.
- ◆ Who is eligible for psychiatric rehabilitation services.
- ◆ Descriptions of a role for individuals served in a rehabilitation program in the administration and other functions of

the program.

### **Fee-for-service**

**Pennsylvania**—Psychiatric rehabilitation assists individuals to develop, enhance and/or retain: psychiatric stability, social competencies, personal adjustment and/or independent-living competencies so they experience more success and satisfaction in environments of their choice and function as independently as possible. Interventions should occur concurrently with clinical treatment and begin as soon as clinically possible. A planned program of goalsetting, functional assessment, identification of needed and preferred skills and supports, skill-teaching and managing supports and resources is needed to produce the desired outcomes consistent with a person's cultural environment.

**North Carolina**—Services designed to serve individuals who have impaired role-functioning that adversely affects at least two of the following: employment, management of financial affairs, ability to procure needed public support services, appropriateness of social behavior or activities of daily living. Assistance is also provided to members in organizing and developing their strengths and in establishing peer groups and community relationships.

**Louisiana**—Mental health rehabilitation services are provided to assist the recipient in coping with the symptoms of his or her illness, minimize the disabling effects of mental illness on his/her capacity for independent living, and prevent or limit periods of inpatient treatment. Psychosocial-skills training is designed to increase independent function in the individual's living environment through integration of therapeutic principles in the recipient's daily activities. Services should enable the recipient to become a productive member of society, earn a wage and live as independently as possible, reducing dependency. Outcomes to be achieved include restoration, reinforcement and enhancement of skills and/or knowledge necessary for the recipient to achieve maximum reduction of psychiatric symptoms, minimize the effect of mental illness and maximize the recipient's strengths.

### **Managed care**

**Oklahoma**—Psychosocial rehabilitation services are designed to assist participants in obtaining or developing the skills, resources, abilities and support systems necessary to establish self-sufficiency in the community. Participants shall be given the opportunity to be involved in all functions of the program, including administration, intake and orientation of new participants, outreach, hiring and training of staff, advocacy and evaluation of program effectiveness. The goal of services shall be improved client func-

culturally competent.

**Fee-for-service**

**Pennsylvania**—The philosophy of psychiatric rehabilitation practice is that people with disabilities need opportunities to identify and choose for themselves their desired roles in the community with regard to living, learning, working and/or social environments. A key element is experiencing a valued role in the community and obtaining and using the power to make choices about one’s life. Such experiences are essential to the cognitive and behavioral change that underpin the recovery process for any person.

Services are: person-centered and empowering; focused on strengths and wellness, not on deficiencies or illness; community-based with emphasis on ongoing natural supports; consistent with the individual’s cultural values and addressing the individual’s unique needs.

Services incorporate the ultimate goals of psychiatric rehabilitation, which are recovery, re-establishment of normal roles in the community, development of a personal support network and increased quality of life.

**Missouri**—Encouraging and promoting recovery efforts, consumer independence/self-care and responsibility. Services provided according to individual need toward goals of community inclusion, integration and independence. Participation in support and self-help activities and groups that promote recovery.

**District of Columbia**—Rehabilitation services shall be founded on the principles of consumer choice and individuals’ active involvement in their rehabilitation, and provide both formal and informal structures through which consumers can influence and shape service development. Services shall facilitate the develop of the consumer’s skills, including the ability to make decisions regarding self care, management of illness, life work and community participation. The services promote the use of resources to integrate the consumer into the community.

**Georgia**—Rehabilitation services are consumer-driven and founded on the principles and values of consumer choice and active involvement in one’s own rehabilitation. Psychosocial rehabilitation is a therapeutic, rehabilitative, social skill-building service to increase and maintain consumer competence in normal life activities and gain the skills necessary to allow them to remain in or return to the community. The program utilizes a comprehensive approach to work with the whole person, mind, body and spirit, to facilitate recovery. Its goal is the fullest possible integration of the individual as an active and productive member of his or her family, community and/or culture.

**Managed care**

**Iowa**—To develop psychiatric rehabilitation programs to aid in the recov-

tioning through use of an empowerment model.

**REHABILITATION PHILOSOPHY**

The examples from state rules on this page illustrate:

- ◆ How some states have specifically referred to recovery as a goal and to the need to furnish recovery-oriented services.
- ◆ Service planning requirements that emphasize a recovery focus by requiring that individuals define their own goals and needs and have meaningful choices among service options.
- ◆ The need for individuals to manage not only their symptoms but also factors related to the management of their disability and disorder.
- ◆ Incorporation of references to the role of peers in a recovery-focused program.
- ◆ The need for services to be

ery of persons with serious mental illness.

## **FACILITY-BASED REHABILITATION DEFINITIONS**

The examples from state rules on this page illustrate:

- ◆ How the philosophy of rehabilitation the state wishes to encourage is incorporated into the program definitions.
- ◆ How states have outlined the goals of facility-based programs and listed the activities for which they may bill Medicaid.
- ◆ How the program will operate—for example, hours of availability.
- ◆ Defining the types of programs that will qualify: psychosocial rehabilitation programs, social rehabilitation programs, clubhouses, etc.

### **◆ Accreditation requirements. Fee-for-service**

**Georgia**—An organized program based on psychosocial rehabilitation philosophy, principles and values to assist individuals with long-term psychiatric disabilities in increasing their functioning so that they are successful and satisfied in the environments of their choice with the least amount of ongoing professional intervention. Services include individual or group skill-building activities that focus on development of problem-solving techniques, medication management, cognitive and psychosocial functioning and the individual's management of his/her illness. Services must be provided in a facility-based setting. A rehabilitation program must operate no less than 25 hours a week, no less than five hours a day.

**Pennsylvania**—Programs help individuals to identify goals, plan strategies and acquire necessary skills to reach and maintain desired goals and help develop necessary supports to maintain those goals. Psychiatric rehabilitation programs provide both informal and formal structures through which participants can influence and shape program development.

Agencies may provide site-based and/or mobile psychiatric rehabilitation services. Site-based programs include the clubhouse model and other approaches that may draw upon a combination of models such as the clubhouse, the Boston University approach and social skills training model. Clubhouse programs must be certified as a clubhouse through the International Center for Clubhouse Development.

**District of Columbia**—Rehabilitation is a facility-based, structured clinical program to develop skills and foster social role integration through a range of social, educational, behavioral and cognitive interventions. Rehabilitation services are curriculum-driven and psychoeducational and assist the consumer in the acquisition, retention or restoration of community living, socialization and adaptive skills. Rehabilitation services include cognitive-behavioral interventions and diagnostic, psychiatric, rehabilitative, psychosocial, counseling and adjunctive treatment. Rehabilitation services are offered most often in group settings and may be provided individually.

### **Managed care**

**Michigan**—Clubhouse programs are department-approved programs which form an array of consumer-directed and professionally provided supports for individuals with serious mental illnesses. The program provides both informal and formal structures through which consumers can influence and shape program development. Covered psychosocial services are provided during an "ordered day." Interventions are to develop, enhance and/or retain psychiatric stability, social competencies, personal and emotional adjustment and/or independent-living competencies, when

ment.

**Fee-for-service**

**Missouri**—Training, coaching and supporting in daily-living skills, including housekeeping, cooking, personal grooming, accessing transportation, keeping a budget, paying bills and maintaining an independent residence. Assisting the client in accessing and utilizing a variety of community agencies and resources to provide ongoing social, educational, vocational and recreational supports and activities. Interceding on behalf of individual clients within the community to assist them in achieving and maintaining community adjustment and maximizing community integration.

**Ohio**—Basic living-skill training to promote redevelopment or restoration of skills necessary to increase independent functioning in community settings, such as food planning and preparation, maintaining living environment, community awareness and mobility, patient education regarding symptom management.

**Nebraska**—Skill-building in the use of public transportation and/or assistance in accessing suitable local transportation to and from the day rehabilitation program.

**South Carolina**—Individual living-skills rehabilitative services to strengthen and develop environmental supports and enable the client to maintain community tenure and improve his/her capacity for independent living. Includes assistance and training in: personal hygiene and grooming, effective management of living space, including housekeeping, meal preparation, retail purchasing, shopping and laundry; managing money; using community resources.

**Managed care**

**Michigan**—Community-living training and support services focus on encouraging personal self-sufficiency, facilitating independence and promoting the individual’s community integration. Examples include assistance, support (including reminding and observing and/or guiding) and/or training in activities such as meal preparation, laundry, routine, seasonal and heavy household care and maintenance, activities of daily living (bathing, eating, dressing, personal hygiene, shopping, money management), reminding, observing and/or monitoring of medications; non-medical care and attendance at medical appointments.

**Non-covered services**

**Maine**—Any services or components of services the basic nature of which is to maintain or supplement housekeeping, homemaking or basic services for the convenience of a person receiving covered services (including housekeeping, shopping, child care and laundry services).

these abilities are impaired due to mental illness.

**BASIC OR DAILY LIVING SKILLS TRAINING**

The examples from state rules on this page illustrate:

- ◆ The methods used to develop skills, such as training, supervising, reminding, supporting, guiding, cueing, coaching.
- ◆ States have incorporated various components of daily-living skills.
- ◆ Rules defining the purpose of improving basic or daily-living skills so as to increase independence, encourage self-sufficiency and promote community integration.
- ◆ How some state definitions of basic living-skills training overlap in some states with the definition of services to assist an individual with employment-related skills or skills to ensure success in a residential place-

## SOCIAL-SKILLS TRAINING

The examples from state rules on this page illustrate:

- ◆ That social-skills training is often defined as services whose goal is to overcome barriers of social isolation and withdrawal and to ensure successful community integration and community living
- ◆ The emphasis on interpersonal-communication skills and techniques, including problem solving and conflict resolution, management of stress, relationship building.
- ◆ How definitions of social-skills training overlap in some states with the definition of services to assist an individual with employment-related skills or skills to ensure success in a residential placement.
- ◆ How descriptions of social-skills training may overlap with descriptions of services designed to give individuals the opportunity to practice and hone their skills in real-life situations (see social/recreational services, below).

### **Fee-for-service**

**Missouri**—Training individuals to live within the community, to overcome the barriers of social isolation, to foster individual development of social skills and interpersonal relationships and to improve self-expression.

**Louisiana**—Psychosocial-skills training includes communication, interpersonal relationships (including roommates and neighbors), problem-solving and conflict resolution, management of sensory input and stress, and decision making.

**Texas**—Skills training to increase community tenure, establish support networks, increase community awareness, develop coping strategies and function effectively in their social environment (family, peers).

**Florida**—Redevelopment of communication and socialization skills and techniques.

**Maine**—Emotional-development skills training aimed at promoting behaviors that affect a person's relations with others and the person's attitudes, interests, values and emotional expressions.

### **Managed care**

**Tennessee**—Interpersonal-skill training: training in communication, assertion, decision-making, getting along with others, making friends and appropriate expression of feelings.

## RESIDENTIAL SERVICES

The examples from state rules on this page illustrate:

- ◆ The residential settings states have referred to as appropriate sites for residential services.
- ◆ The goal for services being to improve or maintain functional skills that ensure the ability to live in the community or independently.
- ◆ Types of activities that can be furnished (finding and maintaining housing, staff support in group living, environmental supports and attention to issues between individuals and their landlords or neighbors).

**New Hampshire**—Rehabilitative services include services and environmental supports necessary to sustain the client in his or her current living situation, including the teaching of necessary skills such as conflict resolution, personal responsibility and communication. For clients whose plans indicate residential or supported housing services, plans shall include specific, measurable objectives to be achieved through the provision of these services.

**North Carolina**—Assistance for consumers in locating, financing and maintaining safe, clean, affordable housing. Assisting consumers in developing psychosocial skills, including building relationships with landlords, neighbors and others effectively.

**Wisconsin**—Counseling the recipient in appropriately relating to neighbors, landlords.

**Pennsylvania**—Psychiatric rehabilitation services may be furnished in the person’s home and support the living situation. For example, the person may set a goal which needs substantial community exploration or practice, such as planning to live independently, or the nature of the goal indicates the preferred site for service delivery and supports in the community. Services include: identifying skills and supports necessary for success and satisfaction in the living environment, teaching identified skills and working with individuals to choose, get and keep more independent living arrangements, such as one’s own apartment.

**Georgia**—Residential rehabilitative supports aid in developing daily-living and community-living skills necessary to independently utilize community-based services and participate in social and recreational activities to increase community stability. Services restore and develop skills in functional areas which interfere with consumers’ ability to develop or maintain social relationships or to independently participate in social, interpersonal or community activities.

**Montana**—Mental health group home services means a supported living environment provided under a group-home endorsed mental health center license and providing independent living and social-skills development services.

## EMPLOYMENT-RELATED SERVICES

The examples from state rules on this page illustrate:

- ◆ Different terms that states use to refer to employment-related services (pre-vocational, employment support or by stating employment as one goal of skills development and restoration services).
- ◆ Specific services covered, such as social skills for interview and job application, punctuality, compliance with rules and instructions, task completion, cooperation, communication with others, problem-solving and coping skills, interventions to support the individual in maintaining employment, and services to identify behaviors that interfere with employment and to alleviate problem behaviors.
- ◆ State requirements on incorporation of the employment goal and services in the individual's service plan.
- ◆ Coverage for the services portion of a supported employment or transitional employment program .
- ◆ How managed care contracts have referred to employment-related services.
- ◆ How states have clarified the federal law, which does not permit inclusion of job-skills training.

**Nebraska**—Pre-vocational services, including services designed to rehabilitate and develop the general skills and behaviors needed to prepare the client to be employed and/or engage in other related substantial gainful activity.

**Wisconsin**—Employment-related services consist of counseling the recipient to identify behaviors which interfere with seeking and maintaining employment; development of interventions to alleviate problem behaviors; and supportive services to assist the recipient with grooming, personal hygiene, acquiring appropriate work clothing, daily preparation for work, on-the-job support and crisis assistance.

**Arkansas**—Pre-vocational services are rehabilitative services addressing the specific goals and objectives of a patient's plan of care that are related to participating in employment. Objectives of pre-vocational services may include such rehabilitation goals as compliance with rules and instructions, punctuality, task completion, cooperation and communication with others, problem solving and safety. The objectives of pre-vocational services must be to further assist the patient in a maximum reduction of his or her disability and to restore the individual to his or her best possible functional level. Pre-vocational services must be listed in the plan of care as rehabilitation services directed to rehabilitation goals.

**Rhode Island**—Includes interventions to achieve required levels of concentration and task orientation and to facilitate the establishment and maintenance of effective communications with employers, supervisors and co-workers. Programs geared towards developing appropriate behaviors for operating in an overall social or work environment are reimbursable.

**Texas**—Employment-related support and skills training, focused on managing behaviors or symptoms that interfere with an individual's ability to obtain or retain employment. Assessments include gathering baseline information on the individual's strengths and deficits, determining the impact of symptoms on employment. Services include instruction in dress, grooming, socially acceptable behaviors and etiquette necessary to obtain or retain employment; instruction in use of public transportation; interventions or supportive contacts on or off the job site to reduce behaviors and symptoms that interfere with job performance and interventions designed to develop natural supports on or off the job site to compensate for skill deficits that interfere with job performance; and instruction in utilizing resources and programs related to employment, such as unemployment benefits, workers compensation and social security.

### Managed care

**Michigan**—Integrated employment services to assist individuals in obtaining and maintaining paid employment. Ongoing support services, without which employment would be impossible, are provided continu-

*Continued on the next page*



**EMPLOYMENT-RELATED  
SERVICES  
(continued)**

ously as needed; capacity to intervene to provide assistance to the individual and/or employer in episodic occurrences of need is included in this sub-element. Examples include job development, job placement and long-term follow-along services required to maintain employment. Employment preparation is not included in this sub-element. Consumer-run businesses (vocational components of Fairweather Lodges) are included here.

**Non-covered services**

**Nebraska**—The program does not provide training for a specific job or assistance in obtaining permanent competitive employment positions for clients.

**Maine**—Programs, services or components of a service the basic nature of which is to provide a vocational program. Includes vocational skills training and sheltered employment.

**Iowa**—Job and task-specific vocational services and services which are solely educational in nature.

**Arkansas**—Pre-vocational services may not be job-task oriented. While a patient may incidentally acquire or improve a job skill, learning or improving job-task skills are not the goals of pre-vocational services.

## **EDUCATION-RELATED SERVICES**

The examples from state rules on this page illustrate:

- ◆ Inclusion of education as one goal of skills-development and restoration services
- ◆ Coverage of supported education, where services are furnished to enable the individual to complete a particular level of schooling.
- ◆ How states have clarified that academic teaching is not a covered Medicaid service.

**Pennsylvania**—Supported education refers to the provision of various services that help individuals to be successful and satisfied in a formal educational program in the community, such as a college or other post-secondary program. Services provided in supported education frequently include counseling to help individuals to develop educational and career choices, assisting individuals to coordinate community services and campus-based services, teaching skills, such as asking for help or participating in class discussions, that individuals need to be successful and satisfied as students, and assisting in problem-solving if difficulties arise.

### **Non-covered services**

**Maine**—Programs, services or components of service which are academic or educational in nature are not reimbursable. Academic services include transitional subjects such as science, history, literature, foreign languages and mathematics.

**Rhode Island**—Structured socialization activities to diminish tendencies toward isolation and withdrawal.

**Pennsylvania**—Recreation, leisure and social activities that are part of an individualized rehabilitation plan are eligible for Medicaid reimbursement. Psychiatric-rehabilitation services include helping individuals to identify goals related to social environments, and also include skill teaching to increase the person’s success and satisfaction in target social environments. Examples of skills are: introducing yourself to others, inviting others to activities and discussing topics other than yourself.

**Louisiana**—Skills training to succeed in the environment, including natural support-system development and self-directed engagement in community social activities.

**Missouri**—Participation in informal and organized group activities to help reduce stress and improve coping that are normative to the community, such as exercise, self-education, sports, hobbies, supportive social networks, etc.

**Nebraska**—Planned recreation activities focused on identified rehabilitative needs.

**Ohio**—Assistance in increasing social-support skills and networks that ameliorate life stresses resulting from the person’s disability and are necessary to enable and maintain the individual’s independent living. If necessary, includes accompanying the person served to activity sites and assistance in daily-living activities.

**Non-covered services**

**Ohio**—Services are not for the exclusive purpose of social or recreational activity but must evidence a clear therapeutic objective specifically identified in the individual service plan of the person serviced, and group activities are consistent with the treatment objectives stated in the individual service plan and reflected in the progress notes.

**Pennsylvania**—Recreation, leisure and social activities not related to a rehabilitation plan are not eligible for Medicaid reimbursement. Such activities are considered to be enrichment activities and do not have specific, identifiable outcomes related to setting and accomplishing rehabilitation goals in social environments.

**SOCIAL AND RECREATIONAL ACTIVITIES**

The examples from state rules on this page illustrate:

- ◆ How states have clarified the goal of services relating to social and recreational activities with an emphasis on activities to prevent isolation and withdrawal, increase community integration and improve skills for normal community living or to create or improve personal-support systems to ensure community living.
- ◆ Requirements for ensuring that social and recreational activities are directed toward goals in the individual’s rehabilitation plan and mandating inclusion of such services in the individual’s plan of care.
- ◆ Definitions of covered activities, such as participation in activities to improve coping skills, interpersonal skills or other daily-living and social skills.
- ◆ Definitions of non-covered recreational activities

## PEER SERVICES

The examples from state rules on this page illustrate:

- ◆ The definitions of staff qualifications used by states to ensure that some services are provided by individuals who have or have had a major mental illness.
- ◆ The definitions of services that are considered “peer services.”
- ◆ Requirements for how peer services must be designed to meet specific goals in the individual’s service plan and documentation of services in the individual’s service plan.
- ◆ References to supervision by a qualified, licensed professional of the healing arts of all peer services (as is required for other rehabilitation services).
- ◆ Encouragement for allowing a supervising professional also to be an individual in recovery.
- ◆ Types of consumer-run services that have been covered, including consumer-run drop-in programs, peer-run hospital-diversion services and services furnished through consumer-run businesses.

**Georgia**—A peer specialist is a current or former recipient of mental health services who provides direct services to consumers in emergency, outpatient or inpatient settings. A peer specialist must be certified by the Georgia Department of Human Resources and have a high school diploma or equivalent. Peer specialists perform a range of tasks to assist consumers in regaining control over their own lives and over their recovery processes. Peer specialists model competence and the possibility of recovery and assist consumers in developing the perspective and skills that facilitate recovery.

**Iowa**—Peer-support counseling may be provided only by a peer-support counselor, defined as a person who has been diagnosed with a chronic mental illness who provides counseling and support services to other adults with the same or a similar mental illness and who has completed peer counseling and support training; abides by ethical guidelines applicable to a mental health counselor, provides services consistent with the rehabilitation component of the recipient’s plan under the supervisory oversight of a licensed professional or other provider, has demonstrated competency; and delivers the service through employment by or contract with a Medicaid provider.

**Georgia**—Adult peer support service provides structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports and maintenance of community-living skills, under the direct supervision of a mental health professional (who can, potentially, be a consumer in recovery). The specific functional issues to be addressed must be delineated and progress notes must document consumer progress relative to goals in the service plan. There is a maximum face-to-face ratio of an average of not more than 15 consumers to one direct-service staff. Scheduled activities include: meals and snacks, art and other recreational/leisure activities, educational seminars, informal and formal peer-support meetings, planning and feedback committees.

**Colorado**—Providing information and assisting in accessing peer-oriented groups, including but not limited to social, support, counseling and advocacy groups.

### Managed care

**Iowa**—All providers are encouraged to staff psychiatric rehabilitation services with accredited practitioners who are also individuals in recovery.

**Tennessee**—Adult respite services should be encouraged to employ consumers as respite-care staff members. Respite services can include foster family-like placements, board-and-care placements, hotel/motel rooms or support for a volunteer-staffed respite apartment.

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**PEER SERVICES  
(continued)**

**Michigan**—Peer-delivered or peer-operated support services are activities intended to provide consumers with opportunities to learn and share coping skills and strategies, move into more active assistance and away from passive patient roles and identities, and to build and/or enhance self-esteem and self-confidence. Such services may include consumer-run drop-in centers and other peer-operated services (e.g. peer-run hospital diversion services).

## FAMILY EDUCATION

The examples from state rules on this page illustrate:

- ◆ Terms used by states to define family education, including family psychoeducation, family education and consultation, and caregiver services.
- ◆ Goals of services, such as restoration, enhancement or maintenance of functioning, maintaining independent living, or assisting individuals to manage symptoms of their illness better.
- ◆ Those who may receive services, including families, significant others and groups of families.
- ◆ Requirements for the individual to agree before a particular family member or significant other may be provided services.
- ◆ Activities covered, including education regarding symptoms, symptom management, medication management, crisis response, how to assist the individual in improving his or her interpersonal, communication, daily-living and problem-solving skills and achieve behavior changes necessary for successful community living.

**Ohio**—Support, including education and consultation, for family/significant others, directed exclusively to the well-being and benefit of the person served and assistive to maintaining independent living in the community. Intended outcome must be improved client function and the service must be part of the individualized service plan.

**South Carolina**—Caregiver group services provided for the benefit of patients, furnished to individuals serving in primary caregiving roles to enable families and significant others to serve patients as knowledgeable support members of the treatment team.

**Maine**—Family education and consultation, if desired by the consumer and his or her family, in order to help family members develop support systems and help the person manage his or her mental illness.

**District of Columbia**—Services include education, support and consultation to the consumer's family and/or support system, directed exclusively to the well-being and benefit of the consumer.

**Georgia**—Family services are directed toward the restoration, enhancement or maintenance of functioning of the identified consumer. Services are directed toward achieving specific goals in the individual's treatment plan, such as improving interpersonal and communication skills, problem-solving and independent-living skills, and achieving changes in behavior necessary for successful community living. Family services address issues such as symptom/behavior management, development or enhancement of specific problem-solving skills and coping mechanisms, development or enhancement of adaptive behaviors and skills, development and enhancement of interpersonal skills, management of resources, cognitive issues, development or enhancement of skills necessary to access community resources and support systems. Helps the family to understand addiction, the steps necessary for recovery and the methods of intervention the family can use.

**Alabama**—A combination of time-limited, goal-oriented rehabilitation services designed to assist clients in reaching and maintaining a drug and alcohol-free lifestyle.

**Ohio**—Intensive outpatient services shall provide integrated treatment interventions. Intensive outpatient services are structured individual and group alcohol and drug addiction activities and services that are provided at an outpatient program for three or more hours per day for at least three days per week. This ambulatory treatment modality is often referred to as partial hospitalization, partial program, night treatment program or intensive outpatient services and offers treatment services and activities usually found in a residential program. Services must include: assessment, individual and group counseling, crisis intervention, activity therapies and/or alcoholism and drug-addiction client education. Services may also include occupational therapy, expressive therapies, referral and information, drug screening urinalysis, medication administration, medical services, case management services and nutrition counseling.

**Minnesota**—An outpatient rehabilitation program for chemical dependency is one providing at least 10 hours of therapy/counseling a week per client. Services include group, collateral and individual therapy/counseling and may be provided to recipients who are residents in a supervised living facility or board and lodging facility or to recipients living in their own home. Rehabilitation services must be restorative or specialized maintenance therapy services and include medical treatment and physical or psychological therapy. Services must be provided under the recommendation of a physician and must be part of the recipient’s plan of care.

**Oklahoma**—A therapeutic, structured, comprehensive program designed to provide treatment to improve or maintain a client’s life management skills and ability to function in the community. The program is usually offered on a scheduled basis, a minimum of 2 hours per day at least 3 days a week.

## **SUBSTANCE ABUSE SERVICES**

The examples from state rules on this page illustrate:

- ◆ Goals of intensive outpatient services, including maintaining a client in a drug- and alcohol-free lifestyle and restoring skills necessary to function in the community.
- ◆ Definitions of intensive outpatient services and substance abuse rehabilitation services, including an array of services such as counseling, crisis intervention, activity therapies, occupational therapy, medication administration and case management.
- ◆ Inclusion of integrated treatment for individuals with co-occurring mental illness and addiction disorders.
- ◆ Settings in which substance abuse rehabilitation services may be furnished.

## TARGETED CASE MANAGEMENT

The examples from state rules on this page illustrate:

- ◆ Lists and definitions of the specific components of targeted case management: assessment, service planning, linking and coordination of various services, re-assessments, follow-up and monitoring to ensure that the individual accesses the relevant services or supports.
- ◆ The links between targeted case management services and the mental health services furnished to an individual and listed in the service plan to meet the goals of the plan and support the individual's ability to live in the community.
- ◆ The manner in which individuals must be given a choice of case manager as well as a choice of whether or not he or she wishes targeted case management services.

**Pennsylvania**—Targeted case management services provide access to comprehensive medical and social services to encourage the cost-effective use of medical and community resources, promoting the well-being of the recipient while ensuring the recipient's freedom of choice.

**New Hampshire**—Linkages of the client with programs, resources and services in the plan, including legal, housing, vocational, social, educational and health care services. Individual client advocacy to establish and maintain eligibility for programs of individual financial assistance, to uphold the client's rights and support the client in obtaining other needed resources and services as specified in the service plan.

**Idaho**—Targeted case management helps the client obtain and coordinate health, educational, vocational and social services furnished in the least restrictive, most appropriate and most cost-effective setting. TCM services consist of: comprehensive assessment (regarding psychiatric history and mental status, medical history and medical status, vocational, financial, social relationship/support, family, basic living skills, housing, and community/legal status), comprehensive service plan development and implementation, crisis assistance (for those at risk due to imminent danger of loss of income or home, in need of medical care, adult protection, etc.), linking/coordination of services, independence assistance to assist client in accessing community services such as transportation. The client chooses if he or she wants TCM services and has free choice of providers.

**West Virginia**—Targeted case management services assist Medicaid-eligible recipients in gaining access to needed medical, behavioral health, social, educational and other services. Components include: assessment, service planning, linkage/referral, advocacy, crisis response planning and service plan evaluation. The individual must be given the option of whether or not to utilize case management services and if he/she chooses such services, must also be given a choice of state-approved providers.

**Indiana**—Targeted case management services are goal-oriented activities that assist individuals by locating, coordinating and monitoring necessary care and services that are appropriate and accessible to the recipient. The major components of service are essential to reducing disabilities resulting from the impairment of the person served. Activities include: identification and outreach to link individuals with appropriate services and supports to engage them in the service system; individual assessment of basic needs and specialized needs for treatment, service planning, implementation (including obtaining commitments for multiple services to ensure success of the treatment plan), monitoring to ensure services are delivered, and reassessment. The case manager will assist individuals served in achieving their objectives and maximizing their independence and productivity by providing training and facilitating linkages for them in the use of community resources for successful attainment of treatment-plan goals.



**Rhode Island**—A self-contained program with the fixed point of responsibility for providing treatment, rehabilitation and support services to identified consumers with severe and persistent mental illness. Using an integrated service approach, RI ACT merges clinical and rehabilitative staff expertise to assist consumers with: symptom stability, maintenance of substance free lifestyles, maintenance of safe, affordable housing in normative settings that are clean, attractive and promote personal stability and well-being, establishment of natural community-based support networks to combat isolation and withdrawal, minimizing involvement with criminal justice system, and (for higher functioning clients) services to enable the client to function at a work-site.

**Georgia**—An intensive case-management community service for those discharged from multiple or extended stays in public hospitals or who are difficult to engage in treatment. Intensive, integrated rehabilitative, crisis, treatment and community-support services are provided by an interdisciplinary staff team and are available 24 hours a day, seven days a week. The goal of ACT is for consumers to experience increased community tenure and decreased frequency and/or length of hospitalization and/or crisis services. Through individualized team supports, consumers will achieve housing stability, decreased symptomatology and medication side effects, and improved social integration and functioning. Specific activities include medication administration and monitoring; self medication; crisis assessment and 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.

**District of Columbia**—ACT is an intensive integrated rehabilitative, crisis, treatment and community support provided to adult consumers with serious and persistent mental illness by an interdisciplinary team, with dedicated staff time and specific staff-to-consumer ratios provided in non-office settings. The ACT team provides community support services, interwoven with treatment and rehabilitative services and available 24 hours per day, 7 days per week. The ACT team shall complete a comprehensive assessment and develop a self-care oriented service plan. Services include: medication prescription, administration and monitoring; crisis assessment and intervention; symptom assessment, management and individual supportive therapy; substance abuse treatment for consumers with co-occurring addictive disorders; psychosocial rehabilitation and skill development; interpersonal social and interpersonal skill training; and education, support and consultation to consumers' families and/or support system, directed exclusively to the well being and benefit of the consumer.

**South Dakota**—ACT program is a self-contained program, with the fixed responsibility for providing treatment, rehabilitation and support services to identified consumers who are the most severely mentally ill and re-

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## ASSERTIVE COMMUNITY TREATMENT

The examples from state rules on this page illustrate:

- ◆ State definitions of the target population for ACT programs.
- ◆ An important goal for ACT programs is generally to avoid the use of more intensive and more restrictive services.
- ◆ State rules on individuality, flexibility and intensity of services.
- ◆ Responsibilities of the ACT teams with respect to issues such as venue for services, individual services, assertive outreach and follow-up.
- ◆ Requirements for addressing co-occurring substance abuse.
- ◆ Rules on inclusion of consumers on ACT teams.

**ASSERTIVE COMMUNITY  
TREATMENT  
(continued)**

quire the most intensive services. The program serves consumers who have historically failed in community settings and who have had frequent hospitalizations. An ACT team is organized as a mobile group of mental health professionals who merge clinical, medical and rehabilitation staff expertise within one service delivery system, supervised by a clinical supervisor. Services stress integration in normal community settings and must be responsive to cultural differences and special needs. Outreach is the team's highest priority, with a majority of clinical contacts occurring in settings outside of an office. The program is aimed at helping those with severe and persistent mental illness live successfully in the community and reduce the need for repeated or prolonged psychiatric hospitalizations.

**Georgia**—A team must include one certified Peer Support Specialist who carries out rehabilitation and support functions and who should be a person in recovery.

**Maine**—ACT teams utilizing a staff-to-client ratio of not more than 1:12 assume comprehensive clinical responsibility for persons with severe and persistent mental illness and a history of failure in other approaches.

**North Carolina**—Recommended is a consumer/staff ratio of 10 to 1, with a maximum of 12 to 1.

**Georgia**—Community support team provides treatment and restorative interventions to assist individuals in gaining access to necessary services, reducing psychiatric and addiction symptoms and developing optimal community-living skills. Services must include assistance in crisis situations, psycho-education and support for individuals and their families; development of interpersonal, community-coping and independent-living skills, development of symptom monitoring and management skills, monitoring medication and self-medication. The goal of services is for consumers to experience a decrease in crisis episodes and increased community tenure, time working or with social contacts, and personal satisfaction and independence. Through supports, consumers will reside in independent or semi-independent living arrangements and be engaged in the recovery process.

**Missouri**—A level of support designed to help consumers who are experiencing an acute psychiatric condition to be served in the community, alleviating or eliminating the need to admit them into a psychiatric hospital or residential setting. A comprehensive, time limited, in-the-community service which embraces the wraparound philosophy provided by specialized clinical support teams/specialized intervention services that will maintain the consumer within the family and significant support systems. This level of support is intended for consumers who have extended or repeated hospitalizations or crisis episodes and when symptoms interfere with individual/family life in a highly disabling manner. The program shall assure effective and appropriate interventions during critical situations which pose risk of serious harm to the client or the client’s ability to live outside of an institution or a more restrictive setting.

**Maine**—Intensive service using a team approach to case management for individuals who may be living in a homeless shelter, dually diagnosed with substance abuse, frequent recipients of emergency room, inpatient and other crisis services, or to consumers who would prefer ICM to other options. ICM teams provide intensive interventions and supports to clients who otherwise might not be engaged in more traditional mental health services, and include all activities covered under community support services.

**South Dakota**—CARE program is a self-contained program with a fixed point of responsibility for treatment, rehabilitation and support services to identified consumers with severe and persistent mental illness, to help them live successfully in the community. The team is a mobile group of professionals who merge clinical, medical and rehabilitation staff expertise within one service delivery team. Services stress integration in normal community settings and are responsive to cultural differences and special needs. Outreach is a high priority and the majority of clinical contacts occur in settings outside of an office. The team provides case management; crisis assessment and intervention; liaison services between institutions and community services; symptom assessment and manage-

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**INTENSIVE CASE MANAGEMENT**

The examples from state rules on this page illustrate:

- ◆ The overlap between ACT definitions and definitions of intensive case management, and the differences, particularly with respect to populations targeted.
- ◆ State definitions of the target population for intensive case management programs.
- ◆ Description of services, including case management, crisis intervention to avert hospitalization and services to help individuals remain in the community, such as skill-building and support services.
- ◆ Responsibilities of the providers of intensive case management with respect to outreach and follow-up for those who appear to be withdrawing from services or community life.
- ◆ Requirements for addressing co-occurring substance abuse.

**INTENSIVE CASE  
MANAGEMENT  
(continued)**

ment; medications; direct assistance to ensure the consumer obtains the basic necessities of daily life and performs basic daily-living activities; and development of psychosocial skills, and encourages family participation, as appropriate.

**Pennsylvania**—Intensive case management offers high support to the individual and linkages to services in the community to maintain stability and to keep the person in the community. A consumer has the right to refuse to participate in intensive case management without prejudice to other parts of his treatment program. Intensive case management assists individuals in obtaining needed resources and services. Intensive case managers do not provide services directly, instead they link individuals with other providers and assure that services are delivered. Intensive case management is often used to facilitate transitions from hospital to community and decrease the use of expensive services. Intensive case management is directed toward individuals who are heavy users of services and who experience frequent crises. Intensive case management increases cooperation with treatment.

Services are available 24 hours a day, seven days a week if needed. Reasonable attempts shall be made to contact the consumer at least every two weeks. If contact cannot be made, then attempts to locate another member of the family or a friend shall be documented. Intensive case management services are furnished as needed in the place where the consumer resides or needs the service. Services include assisting consumers in accessing appropriate mental health services and obtaining and maintaining basic living needs and skills (housing, food, medical care, recreation, education and employment), services for independence of living, vocational/educational participation, and adequate social supports. Intensive case management service planning is goal- and outcome-oriented. Intensive case management is designed to reduce hospital lengths of stay.

***Managed care***

**Michigan**—A comprehensive and integrated set of medical or rehabilitative services provided primarily on a one-to-one basis in the consumer's residence or other community settings by a mobile multi-disciplinary mental health treatment team. The team provides an array of essential treatment and psychosocial interventions for individuals who would otherwise require more intensive and restrictive services. The team provides additional services essential to maintaining an individual's ability to function in community settings, including assistance with addressing basic needs (food, housing and medical care) and supports to allow individuals to function in social, educational and vocational settings.

**Montana**—Case management includes: assessment, assistance in daily living, case planning, coordination, referral and advocacy and crisis response. Coordination, referral and advocacy means providing access to and mobilizing resources to meet the needs of a client, including advocating with the local human services system, social security system, etc., making appropriate referrals, including to advocacy organizations and service providers, and insuring that needed services are provided, and intervening on behalf of a client who otherwise could not negotiate or access complex systems without assistance and support.

**Texas**—Case management services are provided to support and assist the person in achieving personal goals and may include: screening and assessment, crisis intervention, service planning and coordination, monitoring and evaluating the effectiveness of the services and the need for additional or different services.

**Pennsylvania**—A service to assess an individual’s strengths and needs and to assist him or her in accessing resources and services that build upon strengths and meet needs in order to achieve stability in the community. Activities include: assessment, service planning, linking with services, aggressive and creative attempts to help the consumer gain access to services, monitoring service delivery, problem resolution to assist the consumer in gaining access, informal support network building (with permission and cooperation of consumer) to enhance the informal support network and alleviate dependency on the resource coordinator, and assistance in using community resources, such as public transportation, recreation facilities, stores, etc.

**New Hampshire**—Service planning, mobilization and monitoring including establishment and maintenance of a supportive relationship with a client to assure that problem solving, goal setting and development of the skills necessary for successful community integration occur. Fostering natural support from the family and community, including consultation and education to family self-help, community self-help and other groups, organizations and individuals in the community and assuring that the client and, with client consent, significant others are educated about the client’s symptoms of illness and prescribed medications.

**Non-covered services**

**Texas**—Services billable as a distinct Medicaid-covered benefit.

**SERVICES CASE MANAGEMENT**

The examples from state rules on this page illustrate:

- ◆ Definitions of case management services, excluding targeted case management of non-Medicaid services and ACT and intensive case management.
- ◆ Components of case management services, such as assessment, service planning, service coordination, referral and advocacy on behalf of the individual with various service providers.
- ◆ Descriptions of other responsibilities of a case manager, including family education.
- ◆ Clarification of services not billable as case management.

## SERVICES PLANNING

The examples from state rules on this page illustrate:

- ◆ Definitions of functional assessments building on individual strengths and leading to the establishment of goals and hoped-for outcomes for services to address needs identified through the assessment. Assessments relate to social functioning, ability to perform various basic or daily living activities, ability to concentrate, capacity for persistence and maintaining pace (factors key to employment) and other issues.
- ◆ Definitions of goal-setting, with a recovery focus.
- ◆ Rules on the development and content of individualized service plans, based on the individual's goals.
- ◆ Rules for service-planning conferences and consumer involvement and/or agreement in service planning.
- ◆ Consumers' role in choice of services.

### **Fee-for-service**

**Louisiana**—An individualized plan identifies the recipient's needs, outcomes and services to be provided. Service agreements must be done collaboratively by a team consisting of the recipient and the clinical manager and other staff.

**Pennsylvania**—A functional or goal-based individualized assessment includes the completion of an evaluation of social and environmental supports and of strengths and unmet needs in areas of psychosocial functioning as they relate to the person's goals and priorities consistent with the person's culture. A functional-assessment tool is used to assess the presence of functional impairments in the following domains: vocational, education self-maintenance, living self-maintenance, managing illness and wellness, and social. Service planning includes developing a participant-specific rehabilitation plan, which establishes goals and objectives and plans for skill and support development. Providers always consider individual preference as critical to all planning and include the participant as the primary member of the rehabilitation team.

**New York**—Psychiatric goalsetting is the process by which a recipient selects a specific environment in which he or she intends to live, work, learn and/or socialize. The psychiatric rehabilitation goal identifies a specific environment and specific time frames and is mutually agreed upon by the recipient and staff.

**New Hampshire**—There shall be active recipient involvement, which requires that assessment and intervention procedures be explained to and understood by the recipient. The plan includes a comprehensive identification of the recipient's skills, strengths and deficits in relation to the skill demands and supports required in the particular environment in which the recipient wants or needs to function, as such environment is consistent with the goals listed in the client's independent-service plan. A client-centered conference is covered, which must include the client, family and significant others, and case managers shall provide advocacy for the client's goals and independence, supporting the client's participation in the meeting and affirming the client's dignity and rights in the service-planning process.

**Iowa**—The interdisciplinary team is designated by the recipient and must include all persons, providers or others whose participation is necessary relative to the recipient's needs and situation. The plan must be broad in scope and include a rehabilitation service component, and identify: social, cultural and other factors affecting the recipient's ability to function; appropriate services; individualized goals; the objective for the recipient in the form of measurable and time-limited statements of what is to be accomplished; and specific services to meet the recipient's stated goals and objectives. A case planner must assist the recipient in obtaining all the services identified in the plan.

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**SERVICES PLANNING  
(continued)**

**South Dakota**—The case service plan is developed in conjunction with the consumer, in language the consumer understands, and whenever possible is signed by the consumer or contains a written notation stating the reason the consumer’s signature is not present.

***Managed care***

**Michigan**—Person-centered planning is the process for service planning and supporting the individual receiving services. It builds upon the individual’s capacity to engage in activities that promote community life. It honors the individual’s preferences, choices and abilities. The development of the plan, including the identification of possible services and professionals, is based upon the expressed needs and desires of the individual and the individual’s preferences shall always be considered, if not always granted. A person’s cultural background shall be recognized and valued in the decision-making.

## DISABILITY MANAGEMENT

The examples from state rules on this page illustrate:

- ◆ Rules on how individuals can be assisted in managing their disability and overall life situation, as well as their symptoms.
- ◆ Descriptions of skills that individuals need to manage their disability, such as identification of behaviors that interfere with performance and the development of coping skills to minimize the negative effects of their illness on their daily lives.

**Georgia**—Psychosocial rehabilitation programs improve the individual's management of his/her illness and facilitate recovery. Services facilitate the development of the ability to make decisions regarding management of illness and include education on self-management of symptoms, medications and side effects, identification of rehabilitation preferences and goals. Psychosocial rehabilitation programs offer a range of activities from which consumers choose those that will most effectively support achievement of their individual rehabilitation and recovery goals.

**Louisiana**—Psychosocial skills training in adaptation skills including identification of behaviors that interfere with performance and development of coping skills and management of symptoms to minimize negative effects which interfere with recipients's daily living, financial management, personal development and community integration. Medication education to develop skills for complying with medication, including training on side effects and interactions.

**District of Columbia**—Community support services shall assist the consumer in symptom self-monitoring and self-management for the identification and minimization of the negative side effects of psychiatric symptoms which interfere with the consumer's daily living, financial management, personal development or school or work performance.

**Rhode Island**—Services to assist clients in managing symptoms of their illness and disabilities in the context of daily living so as to deal with their overall life situations, including accessing needed services to meet basic human needs. Includes: assisting in development of symptom self-management, communication skills and appropriate social networks to assist clients in gaining effective control over their symptoms and life situations, minimizing social isolation and withdrawal brought on by mental illness, and increasing opportunities for leading a normal, socially integrated life.



**Managed care**

**Vermont**—Clients have the right to accept or refuse medical treatment and to execute and formulate Durable Powers of Attorney for Health Care that authorize a trusted person as an agent or proxy to make decisions if they cannot act for themselves. Designated agencies must document the advance directive in the clinical record and must inform clients of their rights to accept or refuse treatment and to formulate an advance directive at the time of enrollment into the community rehabilitation and treatment program. All designated agencies must have a written policy describing procedures for handling durable powers of attorney for health care. The agency will not condition provision of care on the basis of whether an individual has executed a durable power of attorney for health care. The agency will provide training to staff and encourage staff to work with clients to develop crisis plans that reflect client's wishes.

**ADVANCE DIRECTIVES**

The example from state rules on this page illustrates:

- ◆ Clients' rights to formulate an advance directive for care that will be furnished when they cannot act for themselves.
- ◆ Responsibilities of agencies to inform clients of their rights and to have written policies describing their procedures for handling advance directives.
- ◆ Requirements for the agencies to provide training to staff and to encourage staff to work with clients to develop crisis plans that reflect clients' wishes.

## OUTREACH

The examples from state rules on this page illustrate:

- ◆ Requirements for providers to conduct outreach and follow-up.
- ◆ Populations for whom outreach is particularly required, such as homeless persons or those having contact with the law.
- ◆ Outreach required under ACT.

**Ohio**—Necessary monitoring and follow-up to determine if the services accessed have adequately met the recipient’s needs and to determine needed follow-up activity. Special attention shall be given to locating and serving individuals with severe mental disabilities who are homeless and others at risk who are not already clients of the mental health system. All staff providing community support program services shall have the ability to provide services in various environments such as jails, homeless shelters, juvenile detention centers, street locations, workplace, etc.

**Louisiana**—Follow up to prevent recipients from falling out of the service system, involving, when necessary, aggressive outreach. Follow-up procedures shall not violate the recipient’s rights to refuse service or to choose another service provider. Follow-up efforts shall be documented in the recipient’s record.

**Rhode Island**—Services (through ACT teams) to minimize involvement with the criminal justice system, including: identifying precipitants of a consumer’s criminal involvement; providing necessary treatment, support and education to help eliminate unlawful activities that may be a consequence of the illness; and advocating and collaborating with police, court personnel and jail/prison officials to ensure appropriate use of legal and mental health services.

### **Managed care**

**Arizona**—Services designed to seek out and encourage homeless individuals who are seriously mentally ill to obtain treatment and/or other services to maintain or improve their functional level.

**CRISIS SERVICES**

**District of Columbia**—Face-to-face or telephone immediate response to consumers involved in an active crisis, consist of immediate response to evaluate and screen the presenting situation, assist in immediate crisis stabilization and resolution and ensure the consumer’s access to care at the appropriate level. Services may be delivered in natural settings. Providers shall obtain consultation, locate other services and resources and assist the consumer in obtaining follow-up services.

**Missouri**—Crisis intervention and resolution, face-to-face emergency or telephone intervention service available 24 hours a day on an unscheduled basis to the client, designed to resolve the crisis, provide support and assistance and promote a return to routine adaptive functioning.

**TRADITIONAL HEALERS**

**Arizona**—Native American traditional healing services provided to tribal members in need of treatment for mental health or substance abuse by Medicine Men or other trained healers. Routine or advanced techniques aimed to relieve the emotional distress evident by disruption of the client’s functional ability.

**TELEMEDICINE**

**Maine**—Services provided by enrolled providers delivering covered services. An interactive, visual, real-time telecommunication. Telemedicine must be a medically appropriate means of provider-patient interaction. Nonreimbursable are costs of technology, transmission charges or charges for an attendant who instructs a patient in the use of the equipment or supervises/monitors a patient during a telemedicine encounter, or for consultations between professionals.

**OTHER ISSUES**

The examples from state rules on this page illustrate:

- ◆ Definitions of crisis services.
- ◆ Coverage of traditional healers.
- ◆ Definitions of services that may, and may not, be furnished through telemedicine.



Reviewing Medicaid regulations and contracts in 50 states and the District of Columbia, the Bazelon Center identified mental health services definitions in 58 programs. We based this review both on actual regulations and contract language and on expert opinion. We examined state Medicaid regulations, provider manuals, state plans, managed care requests for proposals and contracts to identify Medicaid-defined services. Then we sent a summary of the identified services to the state Medicaid agency and the state mental health commissioner.

The Medicaid arrangements in this study vary by state. We attempted to analyze the most significant arrangement in each state, whether fee-for-service or some form of managed care. In several states, we reviewed more than one financing mechanism (although sometimes these have the same benefit packages).<sup>1</sup>

For fee-for-service, we identified mental health services covered through the rehabilitative option and excluded services provided under physician services, hospital services and the clinic option. For managed care, we identified all services, since managed care waivers allow states to expand services beyond what had been available through the options the state selected under the fee-for-service program.

Some Medicaid programs pay for rehabilitative services by billing the individual components of a program. For instance, several states have providers bill for the individual components of an ACT program. We counted all instances where programs bill for individual components.

To increase comparability across programs, the number of study categories was limited to commonly provided mental health services. Rehabilitative programs were broken down to fit into the categories. For instance, if a state provides a day treatment program that includes independent-living skills, social-skills training and supported employment, then all three categories were counted as listed services. On the other hand, we did not break

out components of ACT, targeted case management or intensive case management. Though many of these services include outreach, family consultation and crisis services, we considered these to be standard aspects of case management and therefore did not count these components separately.

Managed care arrangements raised several unique concerns. Some states, such as Colorado, require managed care contractors to provide flexible, individualized optional services, leaving the contractor free to determine the exact nature of those services. This made it difficult to identify specific services selected by each contractor. Accordingly, optional services are not counted as defined services, but are indicated in the optional service column in the appendix. The specific services are described in the table in the appendix.

For ACT, we counted Programs of Assertive Community Treatment loosely modeled after the Madison, Wisconsin program. We did not independently evaluate program fidelity. Since many states require that providers bill for the individual components of ACT, we counted these states as having ACT.

We identified outreach to new clients disconnected from the mental health system, such as the homeless and individuals in nursing homes or jails. We excluded outreach by case managers to existing clients who have been hospitalized or lost to follow-up.

Targeted case management was counted only if the state has defined Medicaid's case management option for adults with serious and persistent mental illnesses. It provides "assistance to gain access to needed medical, social, educational and other services." Though managed health care plans often provide case management for serious illnesses, it was counted only if it was for adult with serious mental illnesses.

We counted pre-vocational training, assistance in transferring skills from one setting to another and increasing attention span, concentration, ability to get along with co-workers and supervisors. We excluded occupational therapy.

1. California, Florida, Hawaii, Iowa, Massachusetts, Oklahoma, Pennsylvania and Texas.

## **APPENDIX 3: TABLES**

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- 1. Overview of Managed Care and Carve-Out Programs**
- 2. States' Use of Rehabilitation and Targeted Case Management Medicaid Options in FFS and Managed Care**
- 3. Rehabilitation Services: Coverage of Facility-Based Programs by State**
- 4. Substance Abuse Services: Managed Care Coverage by States**
- 5. Explanation of Information in Tables 2-4**





**Table 1: Overview of Managed Care and Carve-Out Programs**

<b>State</b>	<b>Managed Care Program</b>	<b>Behavioral Health: Carve Out (CO) and Integrated (HMO)</b>
Arizona	Arizona Health Care Cost Containment System: Regional Behavior Authority	CO
California	Medi-Cal Specialty Mental Health Services	CO
Colorado	Medicaid Mental Health Capitation and Managed Care Program	CO
Delaware	Diamond State Health Plan: Public Managed Care Organization	CO
Florida	Prepaid Mental Health Program	HMO/ CO
Hawaii	QUEST Behavioral Health	CO
Iowa	Iowa Plan for Behavioral Health	CO
Maryland	Specialty Mental Health System	CO
Massachusetts	Mass Health	HMO/ CO
Michigan	Managed Specialty Supports and Services Contract	CO
New Mexico	Salud!	HMO
Oklahoma	Sooner Care Plus	HMO
Oregon	Oregon Health Plan: Behavioral Health Carve Out	HMO/ CO
Pennsylvania	Health Choices Behavioral Health Services - SE/SW Regions	CO
Tennessee	TennCare Partners Behavioral Health, Inc.	CO
Texas	NorthSTAR	CO
Utah	Prepaid Mental Health Plan	CO
Washington	Integrated Community Mental Health Program	CO

**Table 2: States' Use of Rehabilitation and Targeted Case Management Medicaid Options in FFS and Managed Care**

State	Type	Note	Rehabilitation Option	TCM Option	Facility-Based Rehabilitation	Basic/Daily-Living Skills Training	Social-Skills Training	Residential Services	Employment Related Services
Alabama	FFS		Yes	Yes	+	+	+		
Alaska	FFS		Yes	Yes		+			+
Arizona	MCO		Yes	Yes	+	+	+	+	+
Arkansas	FFS		Yes	No	+				+
California	FFS	+	Yes	Yes	+	+	+	+	+
California	MCO	+	Yes	Yes	+	+	+	+	+
Colorado	MCO	+	Yes	No	+	+	+		
Connecticut	FFS	+	Yes	No					
Delaware	MC		Yes	No	1	1	1	1	1
District of Columbia	FFS	+	Yes	Yes	+	+	+	+	+
Florida	FFS		Yes	Yes	+	+	+		
Florida	MCO	+	Yes	Yes	+	+	+		
Georgia	FFS	+	Yes	Yes	+	+	+	+	+
Hawaii (2)	MCO		Yes	No	+				
Idaho	FFS		Yes	Yes		+	+		+
Illinois	FFS		Yes	Yes	+	+	+		
Indiana	FFS		Yes	Yes	+	+			
Iowa	FFS	+	Yes	Yes	+	+	+	+	+
Iowa	MCO		Yes	Yes	+				
Kansas	FFS		Yes	Yes		+	+	+	+
Kentucky	FFS		Yes	Yes	+				
Louisiana	FFS		Yes	No	+	+	+	+	+
Maine	FFS		Yes	No	+	+	+	+	
Maryland	MCO		Yes	Yes	+	+	+	+	+
Massachusetts	FFS	+	Yes	No	+	+			
Massachusetts	MCO		Yes	No	+				
Michigan	MCO	+	Yes	Yes	+	+	+	+	+
Minnesota	FFS	+	Yes	Yes	+				
Mississippi	FFS		Yes	Yes	+	+	+		
Missouri	FFS		Yes	Yes	+	+	+		+
Montana	FFS		Yes	Yes	+	+	+	+	+
Nebraska	FFS		Yes	No	+	+	+	+	+
Nevada	FFS	+	Yes	Yes	+	+	+	+	+
New Hampshire	FFS	+	Yes	Yes	+	+	+	+	+
New Jersey	FFS	+	No	Yes					
New Mexico	MCO		Yes	Yes			+		
New York	FFS	+	Yes	Yes	+	+	+	+	+
North Carolina	FFS		Yes	Yes	+	+	+		+
North Dakota	FFS	+	Yes	Yes	+	+	+	+	
Ohio	FFS		Yes	Yes		+	+	+	+
Oklahoma	FFS	+	Yes	Yes	+	+	+		+
Oklahoma	MCO		Yes	Yes	+	+	+		
Oregon	MCO		Yes	Yes	+	+	+		+
Pennsylvania	FFS		No	Yes					
Pennsylvania	MCO		Yes	Yes	+	+	+	+	+
Rhode Island	FFS	+	Yes	No	+	+	+	+	+
South Carolina	FFS		Yes	Yes	+	+	+	+	
South Dakota	FFS		Yes	Yes			+	+	+
Tennessee	MCO	+	Yes	No	+	+	+	+	+
Texas	FFS	+	Yes	Yes	+	+	+	+	+
Texas	MCO		Yes	Yes	+	+	+	+	+
Utah	MCO		Yes	Yes	+	+	+		
Vermont	FFS		Yes	Yes	+	+	+		
Virginia	FFS	+	Yes	Yes	+	+	+		
Washington	MCO		Yes	No	+	+		+	+
West Virginia	FFS		Yes	Yes	+	+			+
Wisconsin	FFS		Yes	Yes	+	+	+	+	+
Wyoming	FFS		Yes	Yes	+	+			
Total No. of FFS Programs			38	33	32	33	29	19	23
Total No. of MC Programs			18	12	16	13	13	8	9
Total No. of State Programs			50	39	42	42	38	25	30

<sup>1</sup> Delaware, only those receiving ACT services can receive rehabilitation services—a uniquely stringent criterion.

Hawaii filed a state plan amendment on September 29, 2001, which will greatly expand the range of rehabilitation option activities.

**Table 2 (continued): States' Use of Rehabilitation and Targeted Case Management Medicaid Options in FFS and Managed Care**

State	Social/ Recreational Services	Peer Services	Family Education Services	Integrated MH/SA Counseling	Assertive Community Treatment	Intensive Case Management	Outreach
Alabama	+		+		+		
Alaska							
Arizona							+
Arkansas							
California			+		+	+	
California			+		+	+	
Colorado	+					+	+
Connecticut							
Delaware			1	1	+		
District of Columbia		+	+		+	+	
Florida			+		+	+	
Florida		+			+	+	+
Georgia	+	+	+		+		
Hawaii (2)	+		+				+
Idaho			+				
Illinois			+	+	+		
Indiana						+	
Iowa		+					
Iowa		+			+	+	
Kansas							
Kentucky				+			
Louisiana	+		+				
Maine			+		+	+	+
Maryland	+				+	+	
Massachusetts			+				
Massachusetts			+		+		
Michigan		+	+		+	+	
Minnesota	+					+	
Mississippi							
Missouri	+					+	+
Montana			+		+	+	
Nebraska	+						
Nevada	+	+		+	+		+
New Hampshire	+		+	+	+	+	+
New Jersey						+	
New Mexico			+				
New York	+				+	+	
North Carolina	+		+		+		
North Dakota			+				
Ohio	+		+				
Oklahoma			+		+		
Oklahoma						+	+
Oregon			+	+			
Pennsylvania							
Pennsylvania		+	+				
Rhode Island			+		+	+	
South Carolina	+		+			+	
South Dakota			+		+	+	+
Tennessee		+	+			+	+
Texas			+		+		
Texas			+	+	+	+	+
Utah			+				
Vermont			+				+
Virginia						+	
Washington		+	+			+	+
West Virginia							
Wisconsin	+	+	+		+	+	
Wyoming			+		+		
Total No. of FFS Programs	13	5	23	4	18	16	6
Total No. of MC Programs	3	6	11	2	8	10	8
Total No. of State Programs	16	10	31	6	23	24	14

1. In Delaware, only those receiving ACT services can receive rehabilitation services—a uniquely stringent criterion.

2. Hawaii filed a state plan amendment on September 29, 2001, which will greatly expand rehabilitation option activities.

**Table 3: Rehabilitation Services  
Coverage of Facility-Based Programs by State**

State	Type	Note	Psychiatric/ Psychosocial Rehabilitation	Social Rehabilitation	Clubhouse	Day Treatment	Other Psychiatric Rehabilitation
Alabama	FFS		+			+	
Arizona	MCO		+	+	+	+	
Arkansas	FFS					+	
California	FFS	+				+	
California	MCO	+				+	
Colorado	MCO	+				+	
Connecticut	FFS	+					
Delaware	MC					1	
District of Columbia	FFS	+	+				
Florida	FFS			+		+	
Florida	MCO	+		+		+	
Georgia	FFS	+	+	+		+	+
Hawaii (2)	MCO		+			+	
Illinois	FFS		+	+		+	
Indiana	FFS		+		+	+	
Iowa	FFS	+		+	+	+	
Iowa	MCO					+	
Kentucky	FFS		+	+	+	+	
Louisiana	FFS		+			+	
Maine	FFS					+	
Maryland	MCO		+	+	+		
Massachusetts	FFS	+				+	
Massachusetts	MCO					+	
Michigan	MCO	+			+	+	+
Minnesota	FFS	+				+	
Mississippi	FFS		+		+		
Missouri	FFS		+				
Montana	FFS					+	
Nebraska	FFS		+				
Nevada	FFS	+	+				
New Hampshire	FFS	+	+	+		+	+
New Jersey	FFS	+					
New York	FFS	+				+	
North Carolina	FFS		+		+	+	
North Dakota	FFS	+				+	
Oklahoma	FFS	+	+	+	+	+	
Oklahoma	MCO		+	+	+	+	
Oregon	MCO		+				
Pennsylvania	MCO		+		+		
Rhode Island	FFS	+	+				
South Carolina	FFS		+		+		
Tennessee	MCO	+				+	
Texas	FFS	+				+	
Texas	MCO		+			+	
Utah	MCO				+	+	
Vermont	FFS					+	
Virginia	FFS	+	+	+	+	+	
Washington	MCO		+		+	+	
West Virginia	FFS					+	
Wisconsin	FFS					+	
Wyoming	FFS					+	
Total No. of FFS Programs			17	8	8	25	2
Total No. of MC Programs			8	4	7	13	1
Total No. of State Programs			24	10	14	32	3

1. In Delaware, only those receiving ACT services can receive rehabilitation services—a uniquely stringent criterion.

2. Hawaii filed a state plan amendment on September 29, 2001, which will greatly expand the range of rehabilitation option activities

**Table 4: Substance Abuse Services  
Managed Care Coverage by State**

State	Note	Integrated MH/SA Counseling	Detoxification	Methodone	SA Counseling	Consumer Run	Drug Screening	Other
Arizona			+	+			+	
California	+							
Colorado	+							
Delaware			+	+			+	
Florida	+							
Hawaii				+				
Iowa			+		+		+	
Massachusetts			+	+	+			
Michigan	+		+	+	+			+
New Mexico					+			
Oklahoma			+		+			
Oregon		+	+	+	+		+	
Pennsylvania			+	+	+			
Tennessee	+		+		+			
Texas		+	+	+	+			
Utah			+	+	+			
Total No. of Programs:		2	11	9	10	0	4	1

**Table 5: Explanation of Information in Tables 2 - 4**

Tables 2-4 include notations to indicate state data that require more explanation. The following chart presents this information. The information concerns services that states authorize but do not mandate under their managed care contracts, as well as additional details concerning state rules and service definitions.

State Medicaid Program	Optional Services in Managed Care Contracts	Explanations of Other Services (see tables 2-4)
California FFS/MC		<ul style="list-style-type: none"> <li>◆ Intensive Case Management: Offered only in some counties</li> <li>◆ Assertive Community Treatment: Offered only in some counties</li> </ul>
Colorado MC	<ul style="list-style-type: none"> <li>◆ Facility-Based Psychiatric Rehabilitation: Clubhouse</li> <li>◆ Assertive Community Treatment</li> <li>◆ Peer Services: Peer support services, peer-run services, other (peer-run employment)</li> <li>◆ Outreach: Telephone counseling and monitoring</li> </ul>	<ul style="list-style-type: none"> <li>◆ Peer Services: Peer-run employment</li> </ul>
Connecticut FFS		<ul style="list-style-type: none"> <li>◆ Psychiatric Rehabilitation Option: The state has the option, but it has not been implemented.</li> </ul>
DC FFS		<ul style="list-style-type: none"> <li>◆ Psychosocial Rehabilitation Option: Pending final CMS approval.</li> <li>◆ Peer Services: Peer specialists</li> </ul>
Florida MC	<ul style="list-style-type: none"> <li>◆ Peer Services: Peer-run services</li> <li>◆ Support Services: Housing and employment</li> </ul>	<ul style="list-style-type: none"> <li>◆ Peer Services: Consumer-driven services</li> </ul>
Georgia FFS		<ul style="list-style-type: none"> <li>◆ Facility-Based Psychiatric Rehabilitation: Day supports for adults</li> </ul>
Iowa FFS		<ul style="list-style-type: none"> <li>◆ Psychosocial Rehabilitation Option: Pending final CMS approval</li> </ul>
Massachusetts FFS		<ul style="list-style-type: none"> <li>◆ Substance Abuse: Acupuncture detoxification</li> </ul>

**Table 5 (continued)**

<b>State Medicaid Program</b>	<b>Optional Services in Managed Care Contracts</b>	<b>Explanations of Other Services (see tables 2-4)</b>
Minnesota FFS		<ul style="list-style-type: none"> <li>◆ Intensive Case Management: Only partially funded by Medicaid</li> <li>◆ Substance Abuse: Substance abuse rehabilitation</li> </ul>
Nevada FFS		<ul style="list-style-type: none"> <li>◆ Intensive Case Management: Only available to criminal justice offenders</li> </ul>
New Hampshire FFS		<ul style="list-style-type: none"> <li>◆ Psychiatric/Psychosocial Rehabilitation Option: Offered in restorative partial hospitalization</li> </ul>
New Jersey FFS		<ul style="list-style-type: none"> <li>◆ Psychiatric/Psychosocial Rehabilitation Option: The state provides rehabilitation services through partial hospitalization in the clinic option.</li> </ul>
New York FFS		<ul style="list-style-type: none"> <li>◆ Assertive Community Treatment: In draft regulations</li> <li>◆ Client Medication Management Education: In draft regulations</li> </ul>
North Dakota FFS		<ul style="list-style-type: none"> <li>◆ Client Medication Management Education: Program rolling out statewide</li> </ul>
Oklahoma FFS		<ul style="list-style-type: none"> <li>◆ Assertive Community Treatment: Pilot program began 5/1/01.</li> </ul>
Rhode Island FFS		<ul style="list-style-type: none"> <li>◆ Housing Support: The Personal Care Option also contributes to this service.</li> </ul>
Tennessee MC	<ul style="list-style-type: none"> <li>◆ Facility-Based Psychiatric Rehabilitation: Psychiatric/ Psychosocial rehabilitation</li> <li>◆ Assertive Community Treatment</li> </ul>	<ul style="list-style-type: none"> <li>◆ Peer Services: Peer providers of crisis respite services</li> </ul>
Texas FFS		<ul style="list-style-type: none"> <li>◆ Substance Abuse: Nursing services related to detoxification</li> </ul>
Virginia FFS		<ul style="list-style-type: none"> <li>◆ All substance abuse services are for pregnant women; eligible women may receive all needed therapeutic services.</li> </ul>