

# Medicaid Rehabilitative & Targeted Case Management Services

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# Rehabilitative Definition

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Section 1905(a)(13) of the Act and 42 CFR § 440.130(d) provide that States may cover rehabilitative services: “including any medical or remedial services (*provided in a facility, a home, or other setting*) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;”

# Covered Rehabilitative Services

- Rehabilitative services may include assistive devices, medical equipment, and supplies, not otherwise covered under the State plan, which are determined necessary to the achievement of the individual's rehabilitation goals.
- Assessments
- Behavior modification therapy
- Psychosocial rehabilitation
- Medication management
- Substance use disorder services
- Crisis intervention
- Social skills development
- Independent living skills
- Person-centered plan development
- Occupational, physical, and speech therapies
- Nursing

# Rehabilitation

## Rehabilitative services:

- Should be “rehabilitative” in nature (e.g. restore a lost function).
- Should cover effective services
- Should be braided with other funds when Medicaid cannot cover an effective service in its entirety
- Should support recovery in people with mental illnesses
- Can cover the development of a person-centered rehabilitation plan

# Therapeutic Foster Care

- Medicaid coverage:
  - Medically necessary rehabilitation services for an eligible child that are clearly distinct from packaged therapeutic foster care services and that are provided by qualified Medicaid providers
  - Medicaid services must be offered to all children who need them regardless of their foster care status
  - Medicaid beneficiaries must be able to choose any willing and qualified provider of services (e.g. not limited to foster care parents)

# Therapeutic Foster Care

- Foster Care Activities Not Eligible for FFP
  - **Research**
  - **Gathering and completion of documentation required by foster care programs**
  - **Assessing adoption placements**
  - **Recruiting or interviewing potential foster care parents**
  - **Serving legal papers**
  - **Home investigations**
  - **Providing transportation**
  - **Administering foster care subsidies**
  - **Placement arrangements**

# Delivery of Peer Support Services

- CMS Published a State Medicaid Director's Letter #07-011, August 15, 2006
  - Supervision
  - Care Coordination
  - Training and Credentialing

# Supervision

Supervision must be provided by a mental health professional (as defined by the State) who is competent in supervising peer support providers and services.

# Care Coordination

- As with all Medicaid funded services, peer support services must be coordinated within the context of a comprehensive, individualized plan of care.
- CMS recommends the use of a person-centered planning process to help promote participant ownership of the plan of care.

# Training and Credentialing

- Peer support providers must complete training and certification as defined by the State.
- Training must provide peer support providers with a basic set of competencies necessary to perform the peer support function.

# Training and Credentialing (cont)

- The peer must demonstrate the ability to support the recovery of others from mental illness and/or substance use disorders.
- Ongoing continuing educational requirements for peer support providers must be in place.
- There is no prohibition on consumer owned and/or operated peer support services

# 15 Minute Units

- There is no requirement for the use of 15 minute intervals for rehabilitation services rate setting purposes.
- In reviewing time-related units of service, CMS recognizes that rates up to and including weekly rates can be economic and efficient.
- As part of the State plan amendment review, CMS requires that a state demonstrate how the rate was developed and that non-Medicaid costs are excluded in developing the rate.

# 15 Minute Units

- Action:
  - We recently reviewed with the regional offices that 15-minute time checks should not be required.
  - CMS is in the process of looking at its entire state plan process in order to provide more transparent, consistent guidance in the development of state plan amendments and associated reimbursement rates.
  - We will be reaching out to states soon for input on developing this guidance.

# Medicaid Case Management

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Sections 1905(a)(19) & 1915(g)(2) of the Social Security Act

# History: Case Management

- **Defined at 1915(g) of the Social Security Act**  
Case management services means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.
- **Later provisions allowed States to limit the providers for persons with developmental disabilities or chronic mental illness.**
- **Deficit Reduction Act of 2005, Section 6052**
  - Effective January 1, 2006
  - Further defined and provided examples of Medicaid case management and targeted case management
  - Defined activities that are not reimbursable

## Section 6052 Defines Case Management

- Case management services assist eligible individuals in gaining access to needed medical, social, educational, and other services. Activities include:
  - **Assessing individual service needs**
  - **Taking client history**
  - **Referring to any needed services**
  - **Developing a care plan**
  - **Monitoring and follow-up activities**

# Reimbursement under Medicaid is not available when CM activities:

- Constitute the direct delivery of underlying medical, educational, social, or other services to which an individual has been referred including foster care program activities

## Statutory Exclusions:

- Services for individuals under the age of 65 residing in Institutions for Mental Disease (IMDs)
- Services for individuals involuntarily living in the secure custody of law enforcement, judicial or penal systems (inmates of public institutions)

# Current Status

- CMS 2237 F rescinded certain provisions of CMS 2237 IFC including:
  - Definition and requirements related to TCM for transitioning individuals residing in institutions to the community (Guidance from State Medicaid Director Letter, 7/25/2000, Olmstead Update #3, would be applied providing FFP for up to 180 days for TCM for the purpose of transitioning)
  - Services provided on a one-to-one basis to an individual by one case manager
  - Requirement to specify the methodology under which case management providers would be paid and rates calculated that employs a unit of service that does not exceed 15 minutes
  - FFP exclusion for CM activities integral to another covered Medicaid service
  - FFP exclusion for CM activities integral to the administration of another non-medical program such as guardianship or child protective services
  - Case management services cannot be claimed as administrative activities
- CMS 2237 IFC, as revised by the CMS 2237 F rescission rule, was effective July 1, 2009. Future rulemaking will finalize CMS 2237 IFC.

# Current Status

**Certain provisions of CMS 2237 IFC were effective July 1, 2009. Some primary provisions are listed below. State plans must:**

- Allow individuals the **free choice** of any qualified Medicaid provider;
- **Not use case management to restrict access** to other services under the plan;
- **Not compel** individuals to receive case management services;
- Indicate that case management services will **not duplicate payments** made to public agencies or private entities;
- Prohibit providers of case management services from exercising the **agency's authority** to authorize or deny the provision of other services under the plan;
- Require providers to maintain **case records**;
- Define the **target group** and services; specify the frequency of assessments and monitoring; specify **provider qualifications**;
- Specify if case management services are being provided to **individuals in institutions**;
- Include a separate plan amendment when **subgroups** differ in terms of services, provider qualifications, or payment methodology; and
- Identify limitations to be imposed on **providers** for target groups comprised of individuals with developmental disabilities or chronic mental illness.

**FFP is not available** when case management activities constitute the direct delivery of underlying medical, educational, social or other services to which an eligible individual has been referred, including foster care program activities.

# Questions?