RECOVERY IN THE COMMUNITY

Volume 2

Program and Reimbursement Strategies for Mental Health Rehabilitative Approaches Under Medicaid

A report by the
Technical Assistance Collaborative
Boston, Massacshusetts
in collaboration with the
Bazelon Center for Mental Health Law
Washington DC

June 2003

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Publication of this report is possible thanks to the general support provided to the Bazelon Center by the John D. and Catherine T. MacArthur Foundation, the Evenor Armington Foundation and the Public Welfare Foundation.

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RECOVERY IN THE COMMUNITY
VOLUME II

Program and Reimbursement Strategies for Mental Health Rehabilitative Approaches Under Medicaid

Introduction

This report describes how states have developed and implemented community mental health services under the Medicaid Rehabilitation Option. It is the second of two reports produced by the Bazelon Center for Mental Health Law on use of the option for individuals with serious mental illnesses. The first, *Recovery in the Community, Funding Mental Health Rehabilitative Approaches Under Medicaid*, provided information about the federal Medicaid rules governing the Rehabilitation Option, along with research on recovery and rehabilitation and an analysis of how states have covered community-based psychiatric rehabilitation and case management services for adults under Medicaid.

When states submit their Medicaid state plan amendments to add or change their current Rehabilitation Option, they develop regulations and guidelines for these services. These specify the practitioners who can authorize and provide each service in the state, establish a reimbursement methodology for the covered services and explain how agencies and individual practitioners participate in an organized network of rehabilitation and recovery services.

This report discusses the strategies states use to: (1) identify the practitioners who can provide Medicaid rehabilitation services; (2) reimburse providers for these services; and (3) organize agencies and practitioners into provider networks that will promote recovery and rehabilitation for adults with serious mental

illnesses. It is based on a review of federal and state rules, regulations and policies that pertain specifically to the Medicaid Rehabilitation Option for community mental health services. Approximately 40 state Medicaid plan amendments and policy manuals were reviewed for this analysis.

This report is intended to provide factual information about the Medicaid Rehabilitation Option to state Medicaid agencies, mental health authorities, legislators, providers, individuals in recovery and their families, and other stakeholders.

States have great flexibility in designing and operating their Medicaid programs. This allows them to ensure a focus on recovery and fund evidence-based services and promising practices.

States have great flexibility in designing and operating their Medicaid programs. This allows them to ensure a focus on recovery and fund evidence-based services and promising practices. As the first report indicated, states may cover a wide range of community mental health services, including assertive community treatment, peer services and crisis services. However, the lack of detailed federal guidelines for the Rehabilitation Option has created some misconceptions among state Medicaid agencies and mental health authorities, providers, individuals who use these services and others. For instance, many are confused about the qualifications necessary for individuals who are to supervise care or provide services, the calculation of reimbursement rates and the types of agencies that are permitted to provide Medicaid-covered mental health services.

This report is written to address these and other common misconceptions about community mental health services covered under the Medicaid Rehabilitation Option. It provides an overview of various strategies employed by states to maximize the flexibility of this benefit under existing federal Medicaid regulations.

Chapter 1
Practitioner Qualifications

INTRODUCTION

The Center for Medicare and Medicaid Services (CMS) gives states flexibility in defining the practitioners who can authorize or deliver services. States are responsible for developing practitioner qualifications and for designing and implementing processes to ensure that practitioners meet these qualifications. States may develop practitioner qualifications for authorizing and providing Medicaid Rehabilitation services based on existing state laws, rules or standards.

When developing or amending these rules, state policymakers should take several issues into consideration:

◆ States may wish to incorporate or reference existing standards in their definition of rehabilitation providers, but will generally need to expand upon them. To do this, policymakers need a solid grasp of their state's laws (practice acts) that govern licensing or certification of mental health practitioners. Under federal law, rehabilitation services must be authorized by a licensed health professional. State practice acts may be vague, however, and may not provide clear guidance as to what services a practitioner may authorize or provide. Or they may be too prescriptive and define the practitioner's activities narrowly—excluding practitioners from authorizing or providing certain rehabilitative services. In addition, policymakers should review service standards that may provide more explicit information on practitioners' responsibility for providing services.

◆ States must assess the pool of licensed or certified practitioners who are available and willing to authorize and provide services. Federal Medicaid law requires that these services be provided statewide. Narrowly defining the types of practitioners who can authorize or provide mental health rehabilitative services may have adverse implications for consumer choice and service availability.

◆ States must also consider the prominent role of paraprofessionals and other non-licensed/non-degreed individuals in providing services for individuals with serious mental illnesses. As the recovery movement has expanded, and with it the involvement of paid consumers in service delivery, several states have revised their practitioner qualifications to include peer specialists.

AUTHORIZING OR RECOMMENDING SERVICES

Individual practitioners perform a key function in the delivery of community mental health services. CMS requires that mental health services be medically necessary and be recommended by a physician or other licensed practitioner of the healing arts (LPHA). Currently, no federal LPHA definition exists. CMS allows states to define credentials for LPHAs and grants them flexibility in outlining the process for recommending services.

Some states have developed explicit LPHA definitions within their Medicaid program rules. These definitions are part of state statutes or regulations and take into account the state's licensing and credentialing laws. Some of these states have defined LPHAs broadly to cover physical and mental health practitioners who can deliver rehabilitative services, including physicians, registered nurses, occupational and physical therapists, dentists and podiatrists.

CMS allows states to define credentials for licensed practitioners and grants them flexibility in outlining the process for recommending services.... Some states have defined these broadly to cover physical and mental health practitioners who can deliver rehabilitative services.

The most recent review of state definitions indicates that the following mental health practitioners are most likely to be defined as LPHAs:

◆ psychiatrists
◆ psychologists
◆ licensed clinical social workers
◆ registered nurses
◆ advanced practice nurses

A matrix of the licensed professionals designated as LPHA in the states utilizing this classification is included in Appendix A.

States that do not have explicit LPHA definitions instead use state-specific health practice statutes or regulations to comply with the LPHA requirement. The wording and interpretation of practice acts varies widely. For example, practice acts may state that an individual can "authorize" or "recommend" services. Some states

have interpreted this "recommend" clause to include individuals who by state law can "prescribe" or "oversee" services.

This has created confusion and caused some tension between policymakers who administer Medicaid and groups representing licensed professionals. To ensure that they comply with the intent of state law regarding an LPHA's scope of practice, policymakers may be more conservative in their interpretation of who can recommend services. Individual practitioners and professional associations may seek a broader interpretation to increase the number of individuals who can be considered LPHAs. Attempts to limit the types of practitioners or providers with the authority to recommend may also create tension between trade organizations representing different practitioners and providers.

CMS and states have interpreted the "recommended by" clause in federal law to include specific activities performed by qualified LPHAs. These activities include:

- ◆ initial and ongoing evaluation and diagnostic services;
- ◆ development and/or approval of an individual's service plan that includes rehabilitative services; and
- ◆ ongoing review of the individual's recovery to determine the continued need for services.

In some states, only physicians or other LPHAs can develop an individual's service plan. In other instances, the service plan may be developed by staff who are not LPHAs but work closely with a consumer to develop and implement the service plan. In these cases, an LPHA must review and sign the service plan.

In some states, only physicians or other licensed practitioners can develop an individual's service plan. In others, the service plan may be developed by other staff who ... work closely with a consumer to develop and implement the service plan.

DELIVERING SERVICES

CMS allows states great flexibility to determine the qualifications of practitioners who can provide mental health services under the Medicaid Rehabilitation service category. However, CMS often requests information about the qualifications of these practitioners and requests that the state Medicaid plan amendments describe the specific practitioners who can deliver each mental health service.

Some states have established a mental health professional (MHP) category specifically for providing mental health

rehabilitation services. The MHP definition includes practitioners from various mental health disciplines and with different educational degrees. Most states' MHP definitions require the individual to have a license from the appropriate state board and/or a doctorate or masters degree from an accredited university or college with a major in the field of counseling, social work, psychology, nursing or rehabilitation. The majority of MHP definitions also require an established level of commensurate experience (e.g., two or three years of experience in the delivery of mental health services).

The MHP designation allows states to require additional qualifications in their practitioner definitions without changing state practice acts. For instance, a social worker or psychologist may be an MHP if licensed and if he or she has spent a certain number of years delivering mental health services. Practitioners who are often included in a state's MHP definition are:

- physicians
- physician assistants
- psychiatrists
- psychologists
- marital and family therapists
- licensed clinical social workers
- registered nurses
- advanced practice nurses
- clinical nurse specialists
- mental health counselors

A matrix of the practitioners designated as MHP in states utilizing this classification is included in Appendix B.

Several other categories of practitioners may also deliver mental health services under the Medicaid Rehabilitation category, including paraprofessionals, mental health technicians and peer specialists.

Paraprofessionals and Mental Health Technicians

Several other categories of practitioners may also deliver mental health services under the Medicaid Rehabilitation category, including paraprofessionals, mental health technicians and peer specialists. These practitioners must be supervised by an MHP or other licensed professional. Most states have developed their own definitions of mental health technicians or paraprofessionals.

A review of these state-specific definitions indicates two trends

in the definitions. First, states require mental health technicians or paraprofessionals to have a high school diploma or equivalent (e.g., GED). Second, states require individuals to have a minimum of three years' experience in a mental health or social service setting.

In some cases, a mental health technician or paraprofessional must undergo a training on mental health services sponsored or approved by the state Medicaid and mental health authority.

Peer Specialists

Several states have developed specific qualifications for peer specialists. Peer specialists perform a range of tasks designed to assist consumers in regaining control of their lives and their individual recovery processes. They help consumers develop the perspective and skills to facilitate recovery and promote community living and adjustment.

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States that have developed qualifications for peer specialists under the Rehabilitation Option generally require individuals to:

- have a high school diploma or high school equivalent;
- be a current or former recipient of mental health services for a major mental illness, as defined by the federal Substance Abuse and Mental Health Services Administration (SAMHSA);
- self-identify as consumer; and
- have been in treatment for a defined length of time.

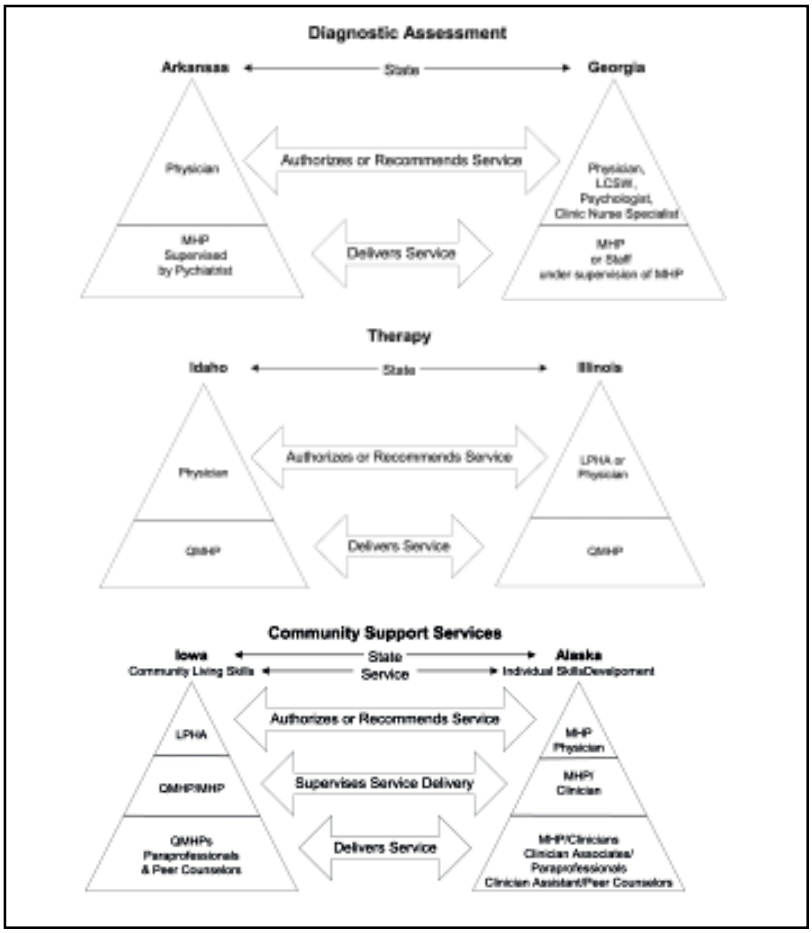
Some states have additional criteria for their peer specialists. For instance, Georgia's peer specialists must have one year of advocacy, advisory or governance experience, recovery experience and/or knowledge of how to support others in recovery. They must also have one year of experience with organizing or facilitating self-help groups, including but not limited to recovery dialogues. They must also demonstrate their efforts at self-directed recovery and must possess good verbal and written communication, interpersonal and problem-solving skills. In addition, they need basic knowledge of community supports, including state and federal benefits. Peer specialists must undergo a two-week training and certification process sponsored by the Department of Human Resources.

Deciding Who Delivers Services

Many states have developed professional hierarchies for defining which professional(s) may provide which mental health services under the Rehabilitation Option.

Many states have developed professional hierarchies for defining who can deliver mental health services under the Rehabilitation Option. The hierarchy differentiates which professional(s) may provide which services. For instance, the provision of medically oriented services—e.g., assessment or medication management—may be limited to physicians or nurses. States may require that counseling or therapy services be delivered by a psychiatrist, a licensed psychologist, social worker or marriage and family counselor. Community support services, such as skill building or case management, may be delivered either by a licensed professional or by a paraprofessional working under the supervision of a licensed professional.

The diagrams below illustrate how practitioner hierarchies are designed in select states for community support, therapy and assessment services.



Ensuring that Practitioners Meet Qualifications

In a given state, hundreds of practitioners may deliver mental health services under the Medicaid Rehabilitation service category. To ensure that practitioners meet and continue to meet the LPHA, MHP or other practitioner definition, states use several processes. For instance, most states require each agency that provides mental health services to implement an internal credentialing process to make certain practitioners meet the state practice acts and service standards for authorizing or providing mental health services. States may perform a random review of the credentials for practitioners under the oversight of a particular agency. This review can verify that professional practitioners are licensed and have the experience required by the state to deliver the service.

Other states have developed an independent credentialing process to ensure that practitioners meet state qualifications for authorizing or delivering mental health services. Practitioners in these states submit the necessary information (e.g., current practice licenses or credentials) to the state agency responsible for reviewing individuals' credentials. Generally, staff must be re-credentialed every two years.

States have the discretion to allow paraprofessionals and other practitioners to deliver mental health services "under the supervision of a mental health professional."

Supervising Services

States have the discretion to allow paraprofessionals and other practitioners to deliver mental health services "under the supervision of a mental health professional." States operationalize this clause differently. For instance, some states require an agency to have a table of organization that shows a line of accountability between the supervising mental health practitioner (MHP) and the paraprofessional. Some states also specify in their standards the frequency and amount of supervision to be provided by the MHP. States may also require the MHP and the paraprofessional both to sign progress notes and other documentation in the consumer's service record.

Chapter 2
Rate Setting and Rehabilitation Services

INTRODUCTION

CMS generally allows states the discretion to set reimbursement rates for Medicaid-covered services, including men tal health services under the Rehabilitation Services category. However, CMS does require states to follow a few federal guidelines when developing their reimbursement methodologies:

◆ The state plan must describe the policy and methods used in setting rates for each type of service.

◆ The methodology used to calculate reimbursement rates must be consistent with efficiency, economy and quality of care.

◆ States must assure appropriate audit procedures if payments are based on the cost of services.

◆ Payments must be sufficient to enlist enough providers so that recipients can access services available under the Medicaid plan.

◆ The Medicaid agency must provide notice of any significant proposed change in its reimbursement methodology.

◆ Providers, including community mental health rehabilitative service providers, must accept payment in full and may not bill individuals for amounts above the Medicaid rate.

Reimbursement rates must strike a balance between offering adequate financial incentives for an agency or professional to provide the service and ensuring that states are not "overpaying" for services. States use various methodologies to set rates, including fee schedules, cost-based reimbursement (prospective and retrospective), case rates and capitation. Regardless of the methodology used, however, states must demonstrate that they have adequately considered the relationship between reimbursement rates and efficiency, economy and quality of care.

Low reimbursement rates may have negative effects, including a reduction in access to care. If reimbursement rates are too low, providers may choose not to provide the service.

Lower rates may also offer incentives for providers to deliver the service in a more structured, clinic-based setting, rather than

in an individual's or family's natural environment. Clinic-based providers are able to "double schedule" individuals to compensate for those who miss scheduled appointments and may also be able to predict individuals' participation in structured programs based on historical attendance. Accordingly, clinic-based settings give providers greater predictability in productivity and ensure some level of consistent revenue. However, it is important for skills training and supports to be furnished in the setting where they must be used. Otherwise the individual may have difficulty transferring skills. One of the advantages of the rehabilitation option is that it permits the delivery of services in any location.

Providing services in an individual's home, school or other natural setting affects a provider's costs in different ways. When using this approach, agencies generally lower expectations of productivity to reflect travel time, outreach activities and collateral contacts (other professionals, families, etc.). Time spent on these activities is critical to the efficacy of rehabilitative services, but it is not usually considered billable.

Reimbursement rates must strike a balance between offering adequate financial incentives for an agency or professional to provide the service and ensuring that states are not "overpaying" for services.

Medicaid rates may also be lower than those of other public payers, such as state mental health or substance abuse authorities. State mental health authorities may have set rates for services to non-Medicaid individuals using a different methodology—in some cases, including costs that are generally not allowable under Medicaid. The difference in rates may make some agencies reluctant to bill Medicaid. This reduces the matching funds states must come up with, but it also limits the federal Medicaid dollars states can draw on to help pay for community services. When a state's Medicaid reimbursement policies effectively shift the cost of care for Medicaid-covered individuals to state and local funding sources, the result can be a significant reduction in the funds available to serve individuals who need services but are not Medicaid-eligible.

To create "reimbursement equality" among providers, states may choose to set reimbursement rates to mirror Medicaid rates for physician or mental health professional services furnished under the Medicaid Clinic Option. Rehabilitation Services are often defined to include more and different administrative, clinical and

financial infrastructure requirements than a state usually requires of its physicians and mental health professionals. These requirements are often related to providers' capacity to meet the needs of adults with more serious mental illnesses and children with serious mental or emotional disorders. Fidelity to most, if not all, of the evidence-based mental health treatment practices requires a much different cost structure for providers.

COMMON REIMBURSEMENT METHODOLOGIES

States must describe their rate-setting methodology in Medicaid state plan amendments. Most states use a fee-for-service methodology to reimburse agencies for rehabilitation services. Under the fee-for-service approach, a provider is paid a predetermined amount for each unit of service provided. Providers are usually reimbursed after the service has been provided.

The methodologies used to determine a provider's rate for a service vary among states. Generally, states use one or a combination of several options to develop rates. These options are discussed in more detail below. A matrix of methodologies used by select states can be found in Appendix C and examples of state policies on reimbursement methodologies are listed in Appendix D.

Cost Reports

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

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

States generally include both program and administrative costs

when setting reimbursement rates. Programmatic direct costs include the allowable salaries, benefits and other costs of the program directly related to the delivery of the service. States also allow certain indirect costs, which, while not directly part of the rehabilitation service, support program operations. These indirect costs include salaries and benefits of administrative and support staff, building and equipment maintenance, repair, depreciation, insurance expenses, employee travel and training expenses, utilities and supplies.

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

Cost reports are usually developed on an annual basis and audited by the state to ensure accuracy and to inform reimbursement-rate adjustments. Rates based on cost reports can be applied statewide or to specific provider categories. Some states employ a cost-settlement process to retroactively adjust payments to Medicaid providers, including providers of rehabilitation services. The retroactive adjustment represents the difference between the amount received by the provider the previous year and the amount determined to be the provider's actual costs for delivering services. Some states make these adjustments only downward, while others will furnish an additional payment to cover provider costs not previously accounted for.

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

Several other issues regarding the cost-reporting and settlement processes are worth noting. The reporting process itself may require significant resources, increasing providers' costs. Many community mental health rehabilitation providers may have little experience with a cost-reporting process. Identifying specific costs for rehabilitative services may be challenging if providers lack adequate financial tracking and reporting systems.

Cost reporting and adjustment processes also require significant state resources. Medicaid agencies or state agencies responsible

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for reviewing and auditing cost reports may not have enough resources to review these documents adequately. Some states are several years behind in their review of cost reports and others can only perform a perfunctory review. Therefore, it may take several years for these states to establish reimbursement rates.

States that use the Medicare cost-report form to establish rates may face additional problems. This document was developed to collect costs for inpatient and outpatient clinics and does not translate well for community mental health rehabilitation service providers.

Service Budgets

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

Some states collect budget, utilization and productivity information from provider agencies to establish a rate for a service.... The state may also establish various "reasonableness" thresholds for certain budget items.

The service-budget methodology has several advantages, but also has some drawbacks. On the positive side, the methodology is prospective and so may better project present and future program expenditures than historical costs, which may under-represent future costs. Still, service-budget methodology is laborious for state agencies that must determine allowable and non-allowable budget items. The state must also then develop and apply certain thresholds for included indirect costs. No federal guidelines exist for developing program budgets, although the Medicare principles of "reasonable and necessary costs" still apply.

Usual and Customary Charges

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

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

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Reimbursement Rates from Other States

When states add a new activity to their psychiatric rehabilitation service, they may not have cost or budget information to support their reimbursement methodology. In some instances, states may look to other states' reimbursement rates to guide them in establishing their rate. These states use a "peer" state approach to determine a unit rate for new services. The peer state approach involves several critical steps:

◆ Reviewing another state's service description to ensure that it is consistent with the proposed definition and service standards. For instance, the review can ensure that the same level of professional (physician, psychologist or licensed social worker) or team is providing the service in both states. It also ensures that the unit of service (days, hours or minutes) is comparable and that the analysis includes the most current reimbursement rate for the service.

◆ The peer state's rate is then adjusted to reflect various differences in the cost of providing the services among peer states. Examples of several critical indices typically used include:

1. The most recent cost-of-living salary analysis available from

national sources. The analysis compares the cost of living in urban and rural areas of each state.

2. Most recent Median Annual Household Income from the United States Census.
3. The 2000 Health Professional Salaries Index from the most recent United States Census. This index lists salary levels for various community mental health and substance abuse professionals, including social workers and other individuals who deliver behavioral health services.

◆ After applying the adjustment factors to each of the other state's rates, a mean rate for the new service is calculated.

Comparing rates is not an exact science. Two services can be defined in exactly the same manner by different states having the same service definition, provider qualifications and unit of service, yet state-specific nuances may still affect individual reimbursement rates.

Comparing rates is not an exact science. Two services can be defined in exactly the same manner by different states having the same service definition, provider qualifications and unit of service, yet state-specific nuances may still affect individual reimbursement rates. For instance, a state's rate may have been established years ago using information from cost reports. These rates may not have been adjusted recently or may have been adjusted by using a different market-based index, such as the consumer price index as opposed to medical inflation. One state may have established a rate for a particular service using a negotiated fee schedule , while another may adopt a rate based on cost reports. States may also have different approaches to annual adjustments that are made using a local or national price index. These factors may help explain slight differences between state reimbursement rates for similar services.

Services with no historical basis may receive more federal scrutiny when states submit their plan amendments. States may be asked to implement cost-based reimbursement methodologies aimed at ensuring that services are provided in a manner consistent with CMS's guiding principles of efficiency, economy and quality of care.

Medicare Reimbursement Methodology

Several states have applied Medicare methodology to develop a fee schedule for their Medicaid program. The Medicare program is a 100-percent federally funded insurance program for people

over age 65 and individuals with disabilities who have worked and paid into the program enough to qualify for Social Security disability benefits. The Medicare program covers a limited mental health benefit. Since many of the licensed professionals who provide Medicaid rehabilitation services—physicians, physician assistants, clinical social workers, psychologist, nurse specialists and practitioners—are also eligible to provide Medicare services, some states have concluded that published rates for comparable services provided through Medicare can, with a some adjustments, be used as a good approximation to determine reimbursement rates for Medicaid.

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

Reimbursement rates for rehabilitation services provided in a residential setting present many challenges.

However, adoption of the Medicare RBRVS methodology for mental health rehabilitation services may not be appropriate. RBRVS is a practitioner-based payment methodology and does not account for services provided by a team of individuals or for program-based services, such as those provided in a crisis residential program or a psychosocial rehabilitation program. In addition, the RBRVS is based on services delivered by a practitioner in a clinic setting and may not adequately account for services provided in a person's home or other natural community setting.

Residential Rates

Most states' fee schedules reflect rates for Medicaid community mental health services based on increments of hours or fractions of hours. However, this is not the case for rehabilitative services provided in a residential setting.

Reimbursement rates for rehabilitation services provided in a residential setting present many challenges. Generally, room and board cannot be reimbursed under the Medicaid program for adults between the ages of 21 and 65 or for children who are not placed in an accredited residential program meeting standards under the Under 21 Psychiatric Services category. Only the rehabilitative and treatment services provided to individuals in these settings can be reimbursed by Medicaid. Therefore, states must identify costs associated with delivering treatment and rehabilitation services to these individuals.

CMS has generally accepted the time-study methodology for establishing fees for treatment and rehabilitative services in residential settings.

This may be difficult for several reasons. Interventions in residential settings may not always be structured and may therefore be difficult to document. People in a residential setting do not necessarily need or receive the same amount of services every day. Two individuals in a residential setting may be at different stages in their recovery and may, therefore, need different services at various frequencies. The qualification of the professional providing the residential services may also be different.

Many states that have included residential rehabilitation services have developed rates through the use of a time study. CMS has generally accepted the time-study methodology for establishing fees for treatment and rehabilitative services in residential settings. A time study requires that individual staff in each facility account for their time each day (usually in 15-minute increments) for a specified period, such as two to four weeks. Staff must account for time spent providing various rehabilitation and treatment services (e.g., skill building, therapeutic recreational programs, medication monitoring) as well as time used for watchful oversight, administration and leave. Time-study results are then analyzed and applied to establish a daily rate for treatment and rehabilitation services in residential programs.

Implementing a time study can be difficult. The process can be laborious for residential program staff, who must be trained to complete the time-study forms. Entering, analyzing and calculating a residential rate from a time study may also consume significant state resources, especially if all residential programs are required to participate in the time study. CMS or the state Medicaid authority

may require an annual time study, and states should generally anticipate at least six months to complete the process.

A simpler approach used in many states avoids these complications by not requiring that all costs be paid to the same entity. Continuity of care is important when a single community agency is responsible for furnishing rehabilitation services in community settings as well as in the person's residential setting. In this case, room and board costs are met through other funds. This arrangement also allows completely separate payment of the non-Medicaid costs for the housing placement, whether in an independent apartment, a group home, a therapeutic foster home or another setting.

Case Rates

Some states have established a case rate for certain bundled rehabilitation services. Case-rate methodology is risk-based reimbursement to providers for individuals who belong to an identified target population. Generally, case rates are a monthly or annual payment for each individual enrolled. The case rate differs from a capitation rate in that all individuals covered are to receive services, while capitation rates cover a specified enrolled population, some of whom may need services and some not.

Case rates give the recipient agency the flexibility to determine the specific type, frequency and intensity of services to furnish each person in its care.

Case rates give the recipient agency the flexibility to determine the specific type, frequency and intensity of services to furnish each person in its care. Some individuals may receive services costing significantly less than the case rate, while others receive services that cost more. While agencies must recoup necessary costs for the entire population for whom the case rate is paid, the case rate allows providers to deliver flexibly a broad range of services without billing separately for each component—a feat that is sometimes impossible in a comprehensive program that meets various treatment and rehabilitation needs.

For adults, bundled rates are commonly used to pay for assertive community treatment (ACT). As a condition of payment, the ACT provider is expected to deliver all the medical and rehabilitation services for that individual through a team approach that utilizes a number of mental health professionals,

paraprofessionals and peer specialists. For example, Louisiana has developed a case rate for Medicaid children and adults who need intensive rehabilitation services.

Case rates may be used to finance systems of care for children who need multiple services financed by multiple public agencies. By pooling funds and providing to a single entity the resources to meet all of the child's needs, case rates enable delivery of a flexible package of services without duplicating efforts among agencies.

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Adjusting Rates

Once a fee schedule for rehabilitation services has been established, the state has the discretion to review and adjust rates for future years. Rates may be adjusted if new regulations, legislation or economic factors arise that affect the cost of the service.

Most states' Medicaid state plans are not explicit about the frequency with which rates will be reviewed and adjusted. States that have not used a cost-reporting process for changing rates apply a cost-of-living factor to adjust rates. In other instances, states may review similar rates paid by other states and the private sector to perform the rate adjustment.

Some states' rates are reviewed and adjusted annually through the cost-report process. In many instances, though, states have not adjusted their rates for rehabilitation services for several or more years.

Chapter 3
Developing and Managing the Provider Network

States have adopted various approaches to decide how to manage providers who deliver rehabilitation services. These strategies reflect each state's unique mental health regulatory and financing structures, the proximity, nature and quality of other agencies' relationships with the state Medicaid agency, and the general policy and management culture of the state. For example, some states have consolidated the organization of health care purchasing in an agency that has responsibility for purchasing Medicaid, mental health, substance abuse, mental retardation and developmental disabilities, child welfare and public health services. Such states may have adopted provider requirements that are common across several of these funding streams.

In other states, the Medicaid agency may make all of the decisions about provider qualifications, usually within a "medical model" framework, without giving special emphasis to qualifications of mental health rehabilitative services. In still other states, especially where the mental health authority manages significant amount of state funds, the Medicaid agency may look to the state mental health authority to determine most provider qualifications in an effort to avoid having a service system that is fragmented by payer.

Regardless of the organization and management approach, Medicaid agencies frequently seek input from state mental health authorities and private and public managed care organizations to help determine how best to manage the provider network. Federal law allows the Medicaid agency to delegate to other state agencies and local political subdivisions—with some limitations—aspects of the day-to-day operations of the Medicaid program.

States where local authorities are charged with mental health planning and management can delegate provider-network management to local entities once state-level functions, such as

Regardless of the organization and management approach, Medicaid agencies frequently seek input from state mental health authorities and private and public managed care organizations to help determine how best to manage the provider network.

determining who is a qualified Medicaid provider, occur. A state's approach to these delegation arrangements will likely reflect its organization and management approach, as well as the state mental health authority's capacity to meet performance expectations.

Key considerations associated with managing the provider network include:

- defining and then determining who is a qualified Medicaid provider under the Rehabilitation Service category;
- detailing an administrative and regulatory framework for network development;
- issuing and administering provider agreements for Medicaid (and often for services not funded by Medicaid); and
- performing ongoing provider relations, at the "trade association" level and at the individual provider level.

PROVIDER QUALIFICATIONS AND THEIR RELATIONSHIP TO SERVICE DEFINITIONS.

One of the major tenets of the Medicaid program is that Medicaid recipients have freedom to choose among any qualified, willing provider able to furnish needed services. The Medicaid agency, in its state plan, establishes the minimum qualifications a provider must meet in order to participate in the Medicaid program. A primary concern of the Medicaid agency is ensuring that provider qualifications are related to the description of the services to be covered and the capacity of providers to deliver these services. These system attributes, along with a description of the reimbursement-rate methodologies used to pay for the services, must be filed as part of the state Medicaid plan and approved by CMS.

In many states, these considerations result in provider qualifications that are community agency-based, rather than practitioner-based. Rehabilitation services are usually developed through specialty agencies and networks, which state mental health authorities rely on to provide most of the rehabilitation services for people in need of the most intense mental health services.

People who use rehabilitation services often have complex needs that may change over time. They will require access to a variety of clinical interventions and supportive services provided through a "comprehensive" agency provider or coordinated network of providers.

States have found that agencies—collections of specially skilled practitioners working together within an administrative, financial and clinical infrastructure—are often best suited to meet the needs of many children with serious mental or emotional disorders and adults with serious mental illnesses. Individual and small-group practitioners on their own tend to lack the capacity to consistently provide 24-hour crisis response, for example, or to transfer consumers to different levels of care while maintaining sufficient clinical and supportive "connectedness" to the person served. Moreover, many of the most effective rehabilitation services are "team-based" and an agency provides the framework necessary to support and coordinate the team's efforts.

This ready-made service capacity and the specialty system's expertise often leads the Medicaid agency to look to the state mental health authority to help define the criteria for assessing community-based organizations' administrative and clinical capacities. The Medicaid agency can agree, in a memorandum of understanding, to rely on the mental health agency in determining who is a qualified Medicaid provider for mental health services. The collaborative relationship can foster understanding and appreciation by the Medicaid agency of the merits of the mental health system's community-based service perspective. That perspective can then be reflected when determining provider qualifications for Medicaid-funded rehabilitation services.

For adults in particular, there are advantages to using an agency-based, recovery-oriented approach to provider qualifications. First, by requiring providers to demonstrate a range of clinical and administrative capacities, a greater variety of services is made available to address individuals' needs. The state Medicaid agency can also be assured that providers have the necessary financial, information-services and other administrative capacity to serve many individuals with varying needs. In other words, by bundling these requirements, a state can offer incentives to providers to meet individual's unique needs, rather than operating a "one fits all" program. States can also assure comprehensive providers a volume of consumers sufficiently large to be financially viable in a fee-for-service—or even capitated—reimbursement environment.

People who use rehabilitation services often have complex needs that may change over time. They will require access to a variety of clinical interventions and supportive services provided through a "comprehensive" agency provider or coordinated network of providers.

Some states have established single administrative entities to serve as systems of care for children with serious mental disorders. This has some of the same advantages as agency-based rehabilitation for adults, but it is far more complex because of the number of different systems with which children are often involved, such as education, child welfare and juvenile justice. In many states, even where systems of care exist, individual providers may bill directly for their services when they are administratively separate. For example, an outpatient clinic under the control of the mental health authority will bill separately from a school-based day treatment program.

Medicaid and the mental health authority both have an interest in assuring that qualified providers in the network have sufficient capacity to meet consumers' needs.

Generally, states that use an agency-based approach to regulate the type and size of their provider network—by applying a set of core clinical and administrative expectations to include the availability of a variety of services within a provider's repertoire—find that controlling the size and quality of their provider networks is more achievable than in a framework where the provider network is mainly composed of individual practitioners. This type of arrangement is usually the result of close collaboration between Medicaid and the mental health agency. The Medicaid agency will want to understand how consumer choice—among the agencies as well as among individual practitioners—can be maintained.

Medicaid and the mental health authority both have an interest in assuring that qualified providers in the network have sufficient capacity to meet consumers' needs. Some individual practitioners argue that they alone have the necessary resources to provide rehabilitation services, but resist being required to develop a range of services—quality-improvement programs, necessary clinical supervision, utilization-review protocols, crisis prevention and response systems and HIPAA-compliant information and billing systems, to name a few. Most states build these types of requirements into their provider qualifications. Because only so many providers are able to meet the requirements, the network is limited by the number of providers willing to furnish the services. Thus, the market is shaped by the requirements themselves, which are related to the unique service needs of the people served.

ADMINISTRATIVE AND REGULATORY FRAMEWORK

Once a state has included criteria for providers in its Medicaid plan, it must operationalize its system of credentialing providers. Each state's approach varies, based on the state's unique approaches to how system-wide expectations are communicated. For instance, one state may require itself to promulgate extensive, detailed administrative rules, while another may rely more on guidelines, such as provider manuals, or even contracts or scope-of- work statements in requests for proposals. The authority and organization of each state agency involved will also help determine how the credentialing system is operationalized.

Similarly, each state will, in its own way, determine how to identify that a particular provider meets its requirements for that type of provider. States usually choose between certifying or licensing individuals and agencies to perform a set of core services, or even certifying individuals to provide specific service-types. Approaches to these choices can differ depending on how the Medicaid agency typically administers the overall Medicaid plan and how the mental health authority administers its service system. Medicaid programs typically utilize administrative rules, contracts and detailed provider manuals.

"Mandatory" Medicaid services are usually defined by referencing national service descriptions and procedure codes and requiring some measure of uniformity with regard to provider qualifications. In the case of rehabilitation services, however, the state has more flexibility.

Accordingly, the medium used for communicating system-wide expectations, as well as the particular requirements themselves, should reflect the state's approach to mental health services while respecting the parameters of federal and state Medicaid requirements. The mental health agency and the Medicaid program should work together to develop materials that "translate" across both the Medicaid and community mental health systems. To the extent that these can be consistent with certain non-Medicaid services, the system will be more efficient for taxpayers, providers and consumers alike.

The mental health agency and the Medicaid program should work together to develop materials that "translate" across both the Medicaid and community mental health systems.

CONTRACTING FOR MEDICAID AND NON-MEDICAID SERVICES

The third key component is contracting. Every Medicaid provider must by federal law have a provider agreement with the single state Medicaid agency. Just as it is important that provider qualifications and service descriptions be compatible across Medicaid and the public mental health system, so should contracting for Medicaid and non-Medicaid services be coordinated. This is important to ensure that Medicaid funds do not duplicate, supplant or, in some cases, discourage providers from making the best use of the limited resources available to support care for people with mental health needs.

Again, states have often looked to the mental health agencies to help the Medicaid program achieve the greatest value by integrating the Medicaid contracting process into the public mental health system's contracting methods. This enables the public mental health system to provide non-Medicaid funds to support services that may be needed by Medicaid recipients but cannot be covered by Medicaid. Coordinated contracting for Medicaid and non-Medicaid services through a single agency makes it more likely that funds will become "person-centered." The most effective agency is usually the public mental health authority, whether at the state or local levels.

States have often looked to the mental health agencies to help the Medicaid program achieve the greatest value by integrating the Medicaid contracting process into the public mental health system's contracting methods.

This model is most prevalent in states where the mental health authority certifies Medicaid matching funds expended from the mental health authority's budget. Contracting, care coordination, provider-network management, matching-funds requirements and non-Medicaid funding become fully aligned in such systems. The result is a single point of accountability toward which the state Medicaid agency can look to ensure that its rehabilitation services are comprehensively managed, in both the fee-for-service and managed-care environments, depending on the enrollment status of the Medicaid recipients.

At the same time, it is important to remember that federal law gives recipients the freedom to choose among qualified providers. Even as they recognize the value in having systems closely aligned, states have been cautious not to tie the Medicaid and non-Medicaid systems too tightly together.

ONGOING PROVIDER RELATIONS: SYSTEMS APPROACH AND INDIVIDUAL PROVIDERS

Ongoing provider-network management activities are very important to assure that providers understand reimbursement and regulatory requirements, give appropriate feedback regarding the impact of state policies, and share their observations and recommendations for improving services. Ideally, these interactions occur both at the policy level and in the course of day-to-day operations.

The state mental health authority is a likely place for coordinating this interaction, given the specialized nature of community-based systems of care. An effective model is where the mental health authority facilitates regular forums for state-level provider associations to interact with the mental health authority and the Medicaid agency at the same time.

The more day-to-day provider-relations activities can be focused through a single system, the more efficient the arrangement will be.

The more day-to-day provider-relations activities can be focused through a single system, the more efficient the arrangement will be. It is not helpful to have providers "answer shopping" among the Medicaid agency, state mental health authority and/or the managed care contractor. A better approach would be to reorganize a number of these activities to reduce the multiple points of contact for providers.

At the individual-provider level, states have found that having to navigate different systems, such as Medicaid and mental health, may discourage providers from Medicaid participation. Many states have assigned the primary provider-relations responsibility to the mental health authority, at least with respect to rehabilitation services.

Conclusion

This report documents the wide variety of approaches states use to design and implement critical components of the Medicaid Rehabilitation Service category for community mental health services. The states have great flexibility in defining the type of practitioner who can provide each service and the standards and processes used to certify agencies to provide these services. States may also employ various reimbursement methodologies for Medicaid community mental health services, as long as they are consistent with efficiency, economy and quality of care.

However, many states have not revisited their standards and reimbursement methodologies for community mental health services for many years—in some cases, a decade or more.

As providers continue to face workforce shortages, rethinking who could provide these services is critical. Agencies may not have enough licensed professionals to provide both clinic-based treatment and rehabilitation services. Paraprofessionals and peer specialists can provide some relief to workload issues, but they must be well trained and supervised.

Medicaid rates for community mental health services have not kept pace with the cost of living or other inflationary indices for health and human services. Providers sometimes find themselves providing services at rates that may no longer cover all or even a significant percentage of their costs. Old reimbursement rates may not always reflect recent "best practices" in delivering services. These best practices may suggest different team staffing or activities that were not accounted for when the rate was last determined.

As more states continue to take a critical look at their Medicaid community mental health benefit, they should consider changing both their service definitions and the mechanics of operating their programs.... Many changes can be cost-effective and, in some instances, budget neutral.

As more states continue to take a critical look at their Medicaid community mental health benefit, they should consider changing both their service definitions and the mechanics of operating their programs. There is enough collective wisdom from other states to guide decisions that promote recovery services for adults with serious mental illnesses and children with serious mental disorders.

Many changes can be cost-effective and, in some instances, budget neutral.

Volumes One and Two of ***Recovery in the Community*** aim to help states increase the availability of services needed by people with mental disabilities to live successfully in the community.

The first volume offers advocates and state officials information to compare their state's use of Medicaid rehabilitation services for adults with that of other states and to ensure compliance with federal rules. However, improving Medicaid service descriptions can sometimes be stalled by more technical questions, such as who will provide a service and how that service will be paid for.

States can use the technical information in this second volume of ***Recovery in the Community*** to help answer those questions. Together with the first volume, this publication can inform state efforts to cover an appropriate array of evidence-based and best-practice services in the community using the Medicaid Rehabilitation Service category.

Judge David L.
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Update on Medicaid for Adults

Since this publication was produced, significant changes have been made to the Medicaid program by two new laws: the Deficit Reduction Act (DRA, P.L. 109-171), signed into law in 2006, and the Affordable Care Act (health reform, P.L. 111-148), enacted in 2010. The Bazelon Center has produced summaries of the impact of both these laws on adults with mental health issues. The DRA summary can be accessed at http://www.bazelon.org/LinkClick.aspx?fileticket=C5qWWjIo20E%3d&tabid=242 and the health reform summaries at http://www.bazelon.org/Where-We-Stand/Access-to-Services/Health-Care-Reform/Final-Law-and-Implementation-.aspx.

These laws will affect adults with mental health issues in the following ways:

- ***Eligibility***

  - ✓ Medicaid eligibility is expanded to require coverage of all individuals with incomes at or below 133% of the federal poverty level (as of 2010, $29,400 for a family of 4, or $14,400 for an individual). This provision becomes effective in 2014 and, at least until then, states must maintain adult eligibility rules that were in place early in 2010. This is a major change to Medicaid eligibility for adults. For the first time their eligibility will be based only on income and they will not be required to fit into a category, such as receiving federal Supplemental Security Income (SSI) disability benefits. However, some newly eligible individuals might not receive full Medicaid benefits, as described below (Affordable Care Act).

  - ✓ Eligibility for Medicaid is now available only to U.S. citizens, and applicants must be able to prove their citizenship (Deficit Reduction Act).

- ***Benefits***

  - ✓ States have been given new authority to limit benefits for certain groups of adults on Medicaid by enrolling them in "benchmark" plans. These plans are modeled on private insurance benefit packages. However, individuals who receive SSI benefits and members of certain other groups cannot be required to enroll in these limited plans. Although benchmark packages can be full Medicaid, they may also comprise a more limited package of benefits. Some beneficiaries with serious mental illnesses are likely to receive limited mental health coverage in states that choose to provide a more limited benchmark benefit. These individuals might not have access to effective intensive community-based services, such as psychiatric rehabilitation. While the state can still offer additional wraparound benefits to them, this is not required. Very few states have

chosen to limit benefits under this (DRA) option, and not all of those that initially used it still do. Although there are limits to which groups of Medicaid-eligible individuals states may *require* to enroll in a benchmark plan, a state may *offer* these benefits to anyone enrolled in Medicaid (Deficit Reduction Act).

- ✓ Newly eligible individuals (those with incomes up to 133% of poverty, see bullet above) also might not have full access to all Medicaid-covered services. Under the ACA, they will be provided a "benchmark" benefit package (see description above). Benchmark packages can be full Medicaid or they may offer a reduced package of benefits. Beginning in 2014, however, all state benchmark plans must provide at least the same essential benefits that are required for health plans purchased through the newly established state-based health insurance Exchanges, including coverage of mental health services at parity (Affordable Care Act).

- ✓ The definition of targeted case management is clarified, as is when other programs must pay for case management because Medicaid is the last payer. The new legislative definition is essentially the same as the definition that has been in regulation for some years. The clarification regarding other programs' responsibility for case management focuses particularly on child welfare systems but there is also language regarding how some adult-oriented programs have the responsibility to be first payer. However, this language has not yet been clarified in the final federal regulations (Deficit Reduction Act).

- ✓ The two laws create a new state plan option for home- and community-based services under Section 1915(i) of the Medicaid law. Eligibility and services covered are the same as for home- and community-based waivers under Section 1915(c). Unlike under a waiver, however, individuals do not need to be either in or at risk of placement in a Medicaid-covered institution in order to qualify. States may not limit the number of people eligible for services under a state plan option, though they may target specific populations, such as adults with serious mental disorders. (Originally enacted under the Deficit Reduction Act but important improvements were made by the Affordable Care Act.)

- ***Premiums and Cost-Sharing***

  - ✓ States may now impose premiums, deductions and co-payments for groups of Medicaid-covered individuals. Medicaid beneficiaries can now be denied coverage for failure to pay their premium within 60 days and denied a service if they fail to pay co-payments. Allowable levels for state-imposed premiums and cost-sharing vary by income. Adults (18 and older) with incomes between 100% and 150% of poverty cannot be charged premiums. Adults with family income not exceeding 100% of federal poverty level can be subject to new cost-sharing requirements of $3 for non-emergency use of the Emergency Room. There are limits on total cost-sharing, by service and/or income (Deficit Reduction Act).

- ***Long-Term Care***

  - ✓ A new state plan option has been created, the Community First Choice Option, through which states can offer community-based attendant services and supports to provide an expansive array of services to beneficiaries with incomes under 150% of poverty who

would otherwise require an institutional level of care. This is Section 1915(k) of the Medicaid law (Affordable Care Act).

- ***Other Provisions***

  - ✓ To simplify the enrollment process, states must establish a state-administered website through which all individuals may apply for and enroll in Medicaid, CHIP or the new state health care Exchanges set up as a result of the health reform law (Affordable Care Act).

  - ✓ To assist states with the increased costs of the Medicaid expansion, the Affordable Care Act provides for an increase in the federal share of Medicaid costs of services for the newly eligible individuals (Affordable Care Act).

Appendix A

State	Licensed Practitioners of the Healing Arts/Qualified Mental Health Professionals*								
	Psychiatrist/ Physician	Physician Assistant	Psychologist	Marital and Family Therapist	Licensed Clinical Social Worker	Nurses			Mental Health Counselor/ Professional
						Registered Nurse	Psychiatric Nurse	Advanced Practice Nurse	
Alabama									
Arkansas	x		x	x	x				x
Arizona									
California*	x		x			x			
Colorado*	x								
Connecticut									
Delaware									
District of Columbia									
Florida		x	x	x	x	x	x	x	x
Georgia									
Hawaii	x		x	x	x			x	
Idaho									
Illinois			x	x	x				x
Indiana	x		x						
Iowa	x	x	x	x		x		x	x
Kansas									
Kentucky									
Louisiana									
Maine*									
Maryland									
Massachusetts*									
Michigan									
Mississippi									
Minnesota	x		x	x	x	x	x		

*Reference to state practice acts

Appendix A continued

	Licensed Practitioners of the Healing Arts/Qualified Mental Health Professionals*								
						Nurses			
State	Psychiatrist/ Physician	Physician Assistant	Psychologist	Marital and Family Therapist	Licensed Clinical Social Worker	Registered Nurse	Psychiatric Nurse	Advanced Practice Nurse or Certified Nurse Specialist	Mental Health Counselor/ Professional
Missouri									
Montana									
Nebraska									
Nevada*									
New Hampshire	x		x		x		x		
New Jersey									
New Mexico	x		x	x	x			x	
New York									
North Carolina*									
North Dakota									
Ohio	x		x		x				x
Oklahoma									
Oregon	x		x		x	x			
Pennsylvania									
Rhode Island	x		x	x		x			x
South Carolina									
South Dakota									
Tennessee									
Texas	x		x	x	x	x	x	x	
Utah	x		x	x	x	x		x	x
Vermont									
Virginia	x		x		x		x		x
Washington									
West Virginia									
Wisconsin									
Wyoming	x		x	x	x		x	x	x**

*Reference to state practice acts

Appendix B

State	Qualified Mental Health Professionals and/or Mental Health Professionals/Practitioners								
	Psychiatrist/ Physician	Physician Assistant	Psychologist	Marital and Family Therapist	Clinical Social Worker	Nurses			Mental Health Counselor/ Professional
						Registered Nurse	Psychiatric Nurse	Advanced Practice Nurse	
Alabama									
Alaska									
Arkansas	x		x		x	x			x
Arizona	x		x	x	x	x			x
California									
Colorado									
Connecticut									
Delaware									
District of Columbia	x		x		x	x			x
Florida									
Georgia	x		x		x	x	x	x	
Hawaii	x		x	x	x			x	
Idaho	x		x		x	x			x
Illinois	x		x			x			
Indiana	x		x		x	x	x		
Iowa		x	x		x	x		x	x
Kansas									
Kentucky	x		x		x			x	
Louisiana									
Maine	x	x	x		x	x	x	x	x
Maryland									
Massachusetts									
Michigan									
Mississippi									
Minnesota	x		x	x	x	x	x		

Appendix B continued

	Qualified Mental Health Professionals and/or Mental Health Professionals/Practitioners								
State	Psychiatrist/ Physician	Physician Assistant	Psychologist	Marital and Family Therapist	Clinical Social Worker	Nurses			Mental Health Counselor/ Professional
						Registered Nurse	Psychiatric Nurse	Advanced Practice Nurse	
Missouri	x		x	x	x		x		x
Montana									
Nebraska									
Nevada									
New Hampshire	x		x	x	x	x	x	x	x
New Jersey									
New Mexico	x		x						
New York									
North Carolina									
North Dakota									
Ohio	x		x		x				x
Oklahoma	x								
Oregon	x		x		x	x			
Pennsylvania	x		x		x	x			
Rhode Island									
South Carolina									
South Dakota									
Tennessee									
Texas						x			
Utah									
Vermont	x		x		x	x	x		
Virginia	x		x		x	x			
Washington									
West Virginia									
Wisconsin									
Wyoming									

Appendix C

Reimbursement Methodology for Select States					
State	Costs	Charges	Budget	Medicare	Other
Alabama		x			
Alaska			x		
Arkansas	x		x		
Arizona			x		
California	x	x			
Colorado					
Connecticut					
Delaware			x		
District of Columbia	x				x
Florida	x				
Georgia	x				x
Hawaii	x				x
Idaho		x			
Illinois	x	x			
Indiana		x			
Iowa	x				
Kansas		x			
Kentucky	x				
Louisiana			x		
Maine					x
Maryland		x			
Massachusetts	x				
Michigan		x			
Mississippi	x		x		
Minnesota		x			
Missouri		x			
Montana			x	x	
Nebraska	x				
Nevada		x			
New Hampshire		x			
New Jersey		x			
New Mexico					
New York	x		x		
North Carolina	x				
North Dakota	x				
Ohio	x				
Oklahoma				x	
Oregon			x		
Pennsylvania	x				
Rhode Island				x	
South Carolina		x			
South Dakota	x				
Tennessee	x				
Texas	x				

Reimbursement Methodologies for Select States					
State	Costs	Charges	Budget	Medicare	Other
Utah		x			
Vermont		x			
Virginia	x				
Washington	x	x			
West Virginia		x			
Wisconsin		x			
Wyoming					x

Appendix D

Reimbursement Methodologies for Rehabilitation Services--Samples

State of Delaware

New providers will submit projected costs of services. The rate-setting committee will compare the provider's proposed budget against a statewide model budget to determine the reasonableness of various cost components. The prospective rate for providers of new community support service programs (other than Psychosocial Rehabilitation Centers and Residential Rehabilitation) will be initially set based on anticipated 40 percent utilization of budgeted billable units in the first year, 70 percent in the second year, 90 percent in the third year and 100 percent in the fourth and successive years. Psychosocial Rehabilitation Center services will be initially set based on anticipated 90 percent utilization of budgeted billable units in the first year, and 100 percent in the second and successive years. Residential Rehabilitation services will be established based on an anticipated ongoing occupancy rate of 90 percent. Rates for new providers will be set and reviewed semi-annually during the implementation years for each. Actual providers utilization of budgeted billable units will be monitored. A significant upward variation from that upon which the rate was initially set will prompt a prospective mid-year rate adjustment commensurately based upon utilization during the previous period.

State of Washington

Each community mental health provider participating in the Medicaid program is required to submit a cost report. These cost reports are aggregated and subjected to statistical test, and the resulting information is used to determine a cost-based rate for each provider. These rates are arrayed from lowest to highest and statewide maximum rates are set using the 55th percentile of provider-reported costs. Providers are required to bill their usual and customary charge (UCC) and they are paid at the UCC or the statewide maximum rate, whichever is lower. This process ensures that 100 percent of cost is covered for the most efficient 55 percent of the providers and provides and incentive for higher cost providers to lower their cost of providing service.

State of Nebraska

Specialized mental health and substance abuse treatment services include day treatment, treatment crisis intervention, treatment foster care, treatment group home and residential treatment center services, provided to children and adolescents under the EPSDT program. Payment rates for specialized mental health and substance abuse services are established on a unit (per day) basis. Rates are set annually. Rates are set prospectively for the annual rate period and are not adjusted during the rate period. Providers are required to submit annual cost reports on a uniform cost-report form. In determining payment rates, the Department will consider costs that are reasonable and necessary for the active treatment of the clients being served. Those costs include costs necessary for licensure and accreditation, meeting all staffing standards for participation, meeting all service standards for participation, meeting all requirements for active treatment, maintaining medical records, conducting utilization review, meeting inspection of care, and discharge planning. The Department does not guarantee that all costs will be reimbursed. The submitted cost reports are used only as a guide in the rate-setting process. Payment rates do not include the costs of providing educational services.

Appendix A

State	Licensed Practitioners of the Healing Arts/Qualified Mental Health Professionals*								
	Psychiatrist/ Physician	Physician Assistant	Psychologist	Marital and Family Therapist	Licensed Clinical Social Worker	Nurses			Mental Health Counselor/ Professional
						Registered Nurse	Psychiatric Nurse	Advanced Practice Nurse	
Alabama									
Arkansas	x		x	x	x				x
Arizona									
California*	x		x			x			
Colorado*	x								
Connecticut									
Delaware									
District of Columbia									
Florida		x	x	x	x	x	x	x	x
Georgia									
Hawaii	x		x	x	x			x	
Idaho									
Illinois			x	x	x				x
Indiana	x		x						
Iowa	x	x	x	x		x		x	x
Kansas									
Kentucky									
Louisiana									
Maine*									
Maryland									
Massachusetts*									
Michigan									
Mississippi									
Minnesota	x		x	x	x	x	x		

*Reference to state practice acts

Appendix A continued

State	Licensed Practitioners of the Healing Arts/Qualified Mental Health Professionals*								
						Nurses			
	Psychiatrist/ Physician	Physician Assistant	Psychologist	Marital and Family Therapist	Licensed Clinical Social Worker	Registered Nurse	Psychiatric Nurse	Advanced Practice Nurse or Certified Nurse Specialist	Mental Health Counselor/ Professional
Missouri									
Montana									
Nebraska									
Nevada*									
New Hampshire	x		x		x		x		
New Jersey									
New Mexico	x		x	x	x			x	
New York									
North Carolina*									
North Dakota									
Ohio	x		x		x				x
Oklahoma									
Oregon	x		x		x	x			
Pennsylvania									
Rhode Island	x		x	x		x			x
South Carolina									
South Dakota									
Tennessee									
Texas	x		x	x	x	x	x	x	
Utah	x		x	x	x	x		x	x
Vermont									
Virginia	x		x		x		x		x
Washington									
West Virginia									
Wisconsin									
Wyoming	x		x	x	x		x	x	x**

*Reference to state practice acts

Appendix B

State	Qualified Mental Health Professionals and/or Mental Health Professionals/Practitioners								
	Psychiatrist/ Physician	Physician Assistant	Psychologist	Marital and Family Therapist	Clinical Social Worker	Nurses			Mental Health Counselor/ Professional
						Registered Nurse	Psychiatric Nurse	Advanced Practice Nurse	
Alabama									
Alaska									
Arkansas	x		x		x	x			x
Arizona	x		x	x	x	x			x
California									
Colorado									
Connecticut									
Delaware									
District of Columbia	x		x		x	x			x
Florida									
Georgia	x		x		x	x	x	x	
Hawaii	x		x	x	x			x	
Idaho	x		x		x	x			x
Illinois	x		x			x			
Indiana	x		x		x	x	x		
Iowa		x	x		x	x		x	x
Kansas									
Kentucky	x		x		x			x	
Louisiana									
Maine	x	x	x		x	x	x	x	x
Maryland									
Massachusetts									
Michigan									
Mississippi									
Minnesota	x		x	x	x	x	x		

Appendix B continued

	Qualified Mental Health Professionals and/or Mental Health Professionals/Practitioners								
State	Psychiatrist/ Physician	Physician Assistant	Psychologist	Marital and Family Therapist	Clinical Social Worker	Nurses			Mental Health Counselor/ Professional
						Registered Nurse	Psychiatric Nurse	Advanced Practice Nurse	
Missouri	x		x	x	x		x		x
Montana									
Nebraska									
Nevada									
New Hampshire	x		x	x	x	x	x	x	x
New Jersey									
New Mexico	x		x						
New York									
North Carolina									
North Dakota									
Ohio	x		x		x				x
Oklahoma	x								
Oregon	x		x		x	x			
Pennsylvania	x		x		x	x			
Rhode Island									
South Carolina									
South Dakota									
Tennessee									
Texas						x			
Utah									
Vermont	x		x		x	x	x		
Virginia	x		x		x	x			
Washington									
West Virginia									
Wisconsin									
Wyoming									

Appendix C

Reimbursement Methodology for Select States					
State	Costs	Charges	Budget	Medicare	Other
Alabama		x			
Alaska			x		
Arkansas	x		x		
Arizona			x		
California	x	x			
Colorado					
Connecticut					
Delaware			x		
District of Columbia	x				x
Florida	x				
Georgia	x				x
Hawaii	x				x
Idaho		x			
Illinois	x	x			
Indiana		x			
Iowa	x				
Kansas		x			
Kentucky	x				
Louisiana			x		
Maine					x
Maryland		x			
Massachusetts	x				
Michigan		x			
Mississippi	x		x		
Minnesota		x			
Missouri		x			
Montana			x	x	
Nebraska	x				
Nevada		x			
New Hampshire		x			
New Jersey		x			
New Mexico					
New York	x		x		
North Carolina	x				
North Dakota	x				
Ohio	x				
Oklahoma				x	
Oregon			x		
Pennsylvania	x				
Rhode Island				x	
South Carolina		x			
South Dakota	x				
Tennessee	x				
Texas	x				

Reimbursement Methodologies for Select States					
State	Costs	Charges	Budget	Medicare	Other
Utah		x			
Vermont		x			
Virginia	x				
Washington	x	x			
West Virginia		x			
Wisconsin		x			
Wyoming					x

Appendix D

Samples of Reimbursement Methodologies for Rehabilitation Services

State of Delaware

New providers will submit projected costs of services. The rate setting committee will compare the provider's proposed budget against a statewide model budget to determine the reasonableness of various cost components. The prospective rate for providers of new community support service programs (other than Psychosocial Rehabilitation Centers and Residential Rehabilitation) will be initially set based on anticipated 40 percent utilization of budgeted billable units in the first year, 70 percent in the second year, 90 percent in the third year and 100 percent in the fourth and successive years. Psychosocial Rehabilitation Center services will be initially set based on anticipated 90 percent utilization of budgeted billable units in the first year, and 100 percent in the second and successive years. Residential Rehabilitation services will be established based on an anticipated ongoing occupancy rate of 90 percent. Rates for new providers will be set and reviewed semi-annually during the implementation years for each. Actual providers utilization of budgeted billable units will be monitored. A significant upward variation from that upon which the rate was initially set will prompt a prospective mid-year rate adjustment commensurately based upon utilization during the previous period.

State of Washington

Each community mental health provider participating in the Medicaid program is required to submit a cost report. These cost reports are aggregated, subjected to statistical test, and the resulting information is used to determine a cost-based rate for each provider. These rates are arrayed, from lowest to highest, and statewide maximum rate are set using the 55th percentile of provider reported costs. Providers are required to bill their usual and customary charge (UCC) and they are paid at the UCC or the statewide maximum rate, whichever is lower. This process ensures that 100 percent of cost is covered for the most efficient 55 percent of the providers and provides an incentive for higher cost providers to lower their cost of providing service.

State of Nebraska

Specialized mental health and substance abuse treatment services include day treatment, crisis intervention, treatment foster care, treatment group home, and residential treatment center services, provided to children and adolescents under the EPSDT program. Payment rates for specialized mental health and substance abuse services are established on a unit (per day) basis. Rates are set annually. Rates are set prospectively for the annual rate period and are not adjusted during that period. Providers are required to submit annual cost reports on a uniform cost reported form. In determining payment rates, the department will consider those costs that are reasonable and necessary for the active treatment of the clients being served. Those costs include costs necessary for licensure and accreditation, meeting all staffing and service standards for participation, meeting all requirements for active treatment, maintaining medical records, conducting utilization review, meeting inspection of care, and discharge planning. The department does not guarantee that all costs will be reimbursed. The submitted cost reports are used only as a guide in the rate-setting process. Payment rates do not include the costs of providing educational services.